

Article

Television Dramas, Disability, and Religious Knowledge: Considering *Call the Midwife* and *Grey's Anatomy* as Religiously Significant Texts

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Abstract: Images and narratives of people with disabilities in popular culture shape the perceptions of people with and without disabilities. When these narratives raise philosophical and religious questions emerging from the lives of people with disabilities, and depict meaningful engagements between people with disabilities and religious practices, an underexamined body of knowledge emerges. The television series *Call the Midwife* and *Grey's Anatomy* both have episodes that depict families responding to a disability diagnosis in a newborn infant, and each offers a potentially significant account of what it means to be a person born with a disability. While popular culture depictions of disability often reinscribe stigmatizing stereotypes, they can also disrupt those stereotypes and identify people with disabilities as authoritative, underrecognized sources of knowledge and experience, including religious understanding.

Keywords: disability; popular culture; television; epistemology; *Grey's Anatomy*; *Call the Midwife*

1. Introduction

In what ways do popular television programs shape cultural understanding of people with disabilities, particularly with respect to their religious identity, their place in the family and the community, and the significance of their experiences? Depictions of people with disabilities in popular culture often reveal a set of underlying cultural assumptions and practices related to disability. These depictions can be powerful in shaping and disrupting perceptions about disabled identity.¹ Ria Cheyne argues, “The narratives circulating in popular culture play a significant role in shaping wider understandings of disability and impairment” (Cheyne 2012, p. 117). Some portrayals of people with disabilities are deeply problematic, from the trope of the villain’s true nature being revealed in his or her impaired body, to the sentimentalized depiction of the noble person with a disability whose narrative role is to teach others how to suffer uncomplainingly, to the idea of disability as a punishment for wrongdoing and even the seemingly positive but still-distorted trope of the “supercrip.”² As Paul Longmore argues, these sorts of characterizations are not morally neutral: “Disability has often been used as a melodramatic device not only in popular entertainments, but in literature as well. Among the most persistent is the association of disability with malevolence. Deformity of body symbolizes

¹ Zhang and Haller (2013) argue, in an article discussed below, that stories about disability in news media not only provide frameworks for able-bodied people in their understanding of disability, but shape the self-understanding of people with disabilities as well.

² See one very recent example of the first trope, the character Dr. Maru (also known as Dr. Poison) in the 2017 film *Wonder Woman*, played by Spanish actress Elena Anaya. Originally created by Wonder Woman author William Moulton Marston as a Nazi scientist, the character is dislocated in time in the film. A chemist, Dr. Maru is the source of toxic gas the German military is using in combat during World War I; her face is partially hidden in the film by a ceramic prosthetic. As the film comes to a climax, her prosthetic is blown away and her disfigured face is revealed. She functions as a foil for the supremely good and unusually beautiful Wonder Woman, played by Gal Gadot.

deformity of soul. Physical handicaps are made the emblems of evil" (Longmore 2003, p. 133). This use of disabled bodies in popular culture to symbolize evil in turn affects actual people with disabilities.

Other representations of disability in popular culture offer three-dimensional characters or thoughtful analyses of experiences of disability. These depictions include people whose lives are rich and who are socially engaged, whose disabilities are only one dimension of their existence, and who have meaningful relationships with family members and other people in their communities. As Rhonda S. Black and Laura Pretes argue in their analysis of popular films depicting people with disabilities, "The media can play an active role in challenging society's fear and misunderstanding of disability by consciously seeking to portray characters with disabilities realistically, fairly, and frequently" (Black and Pretes 2007, p. 82).

Depictions of people with disabilities can also explicitly disrupt common negative stereotypes, and can extend beyond simple positive representations into thoughtful, nuanced analyses of the lived experiences of people with disabilities and their families. One essential feature of such narratives is that they emerge from the perspective of the person with a disability; as G. Thomas Couser observes when discussing life writing, "Long the objects of classification and examination, disabled people have only recently assumed the initiative in representing themselves; in disability autobiography particularly, disabled people counter their historical subjection by occupying the subject position" (Couser 2006, p. 401). Subject positions are naturally complex and multifaceted. Narratives that touch on religious identity, race, and social class as features that intersect with disability have particular potential to be meaningful, constructive portrayals.

Two recent television depictions of families responding to disability offer food for thought. Each is substantive and religiously nuanced, and each pushes back against damaging portrayals of people with disabilities. Neither is a perfect model of a disruptive narrative about people with disabilities from their own perspective, but both have something to offer and are positioned within widely viewed programs. First, the BBC television series *Call the Midwife*, which often includes plot arcs featuring disability and impairment, offers a particular episode wherein a family, the midwives who provide care, the Anglican nuns who host their clinic, and the British response to disability in the 1950s are all interrogated. The series functions on a number of levels: it is a dramatization of a memoir written by former nurse-midwife Jennifer Worth, narrating her experience as a midwife to a working-class community in London in the 1950s. It also offers modern-day viewers a chance to reflect on and respond to changes in healthcare and in practices around disability over the last sixty years.³ Finally, it provides an ongoing and consistent Anglican religious framework through which all of the characters are viewed.

The second series is the popular American medical drama *Grey's Anatomy*, the first in a number of successful programs developed by producer Shonda Rimes. Rimes's approach to depicting race, wealth, power, and family relationships in this drama, all through the lens of a particular community of doctors and their patients, is innovative and consistently challenges viewers. The narrative arc of Season 11 picks up a number of threads already present in the characters' backstories and over the course of several episodes weaves them into a powerful commentary on disability, religious beliefs about abortion, and the formation of community around religious practices and beliefs.

Because both programs are explicitly set within the context of a medical community, the disability studies critique of the medical model of disability must be kept in mind as we consider each of the narratives. Tobin Siebers argues, "The medical model situates disability exclusively in individual bodies and strives to cure them by particular treatment, isolating the patient as diseased or defective" (Siebers 2006, p. 173). One question to consider, then, is whether medical dramas like *Call the Midwife*

³ For example, Series 3, Episode 5, broadcast in 2014, featured a storyline about a couple who became pregnant and sought to marry, but whose families were opposed because each member of the couple had a disability. Actor Colin Young reprised his role as Jacob, discussed below, for this story line (www.bbc.co.uk).

and *Grey's Anatomy* reinforce or disrupt the medical model of disability, and whether any other models of understanding disability are visible in their narratives.

2. Significance

Here we should ask explicitly: of what value is a discussion of popular television and its depictions of people with disabilities to our understanding of disability and as a possible source of religious and philosophical understanding? Two central issues emerge: one, the influence of popular television programs on people's understanding of and beliefs about disability, and two, the presence of religiously and philosophically significant themes within the two television series.

2.1. Influence

Depictions of people with disabilities in popular culture shape cultural views about disability, both for people with and without disabilities.⁴ There are many influential narratives in popular culture about infants born with a disability; we will consider a small sampling below. Considering what depictions of disability are produced, how they are constructed, how widely they are viewed, and whether they reinscribe or disrupt stigmatized views of disability provides a window into what people outside the academy may be thinking about people with disabilities. In this case, we will focus on two television story arcs about infants who have been diagnosed with disabilities and analyze how that theme is explored and how the trope of disability intersects with other human experiences (including religious identity, race, and social class.) Of particular interest are the following issues: whether the child is depicted as a valuable human being unto himself or as a burden on his family; what religious doctrine or belief is brought to bear on the family's response to the child; how the child's broader community responds to his birth and his diagnosis; the purpose of telling this particular story in this way (are the baby and his disability intended to function as a symbol for something more important or to make a larger argument about something?); how race and class intersect with disability in each narrative; how stereotypes about disabilities are reinforced or disrupted; the extent to which the narrative identifies with and reinforces a medical model of disability or some other model; and, particularly since the focus of each narrative is an infant, whether any adults with disabilities are depicted as experienced, authoritative voices within the narrative. In short, we will consider whether the full personhood of people with disabilities is a visible and essential part of the narratives.

How powerful are popular TV shows in shaping beliefs about disability? The notion that images of and narratives about disability can influence people's thinking is widely accepted (Moody 2008; Harnett 2000; Wohl 2017; Zhang and Haller 2013; Black and Pretes 2007; Van Kraayenoord 2011), but that influence is interpreted in a variety of ways.

For example, Sara Weinberger and Dov Greenbaum are sharply critical of what they identify as prodisability themes in popular culture: "While the demand that we protect genetic diversity at the risk of allowing for the birth of disabled children is arguably abhorrent, there are some disabled communities that take offense at efforts to eliminate their disabilities through genetic selection; typically, the deaf community comes to mind" (Weinberger and Greenbaum 2015, p. 32). They identify the films *Gattica* and *The Perfect 46* as "cultural references" that demonstrate that "when we do try to remove genetic diseases from humanity, we are guaranteed to quickly slide down that slippery slope toward genetic discrimination and eugenics where an ever-increasing set of heretofore relatively benign or even neutral traits will be selected against" (p. 33). The risk, as they see it, is that dystopian films depicting high-tech eugenics will shape popular opinion and eventually interfere with the "unprecedented opportunity" available to "putative parents" to "select against a whole host of genetic diseases, conditions, and predispositions for their next generation" (p. 33). They argue that parents should have an increased opportunity for genetic selection in order to counteract "the

⁴ See, for instance, the discussion of Zhang and Haller (2013) and Black and Pretes (2007) below.

long-standing ability [for parents] to select for disputably detrimental traits within their children” (p. 33). Weinberger and Greenbaum argue that science fiction films are responsible for opposition to the use of reproductive technology to eradicate some disabilities. They do not appear to consider that their position advocates eugenics.

Those invested in the well-being of people with disabilities have a much different analysis. Linling Zhang and Beth Haller argue, “How media represent stigmatized groups has the potential to shape their identities and self-images” (Zhang and Haller 2013, p. 323).⁵ Accordingly, they identify three key models for media framing of people with disabilities—the medical model, social pathology model, and supercrip model⁶—and use these lenses to examine how “mass media . . . affect . . . self-esteem and self-perception” of individuals with disabilities. They explain, “Perceived positive media depictions of themselves affect the identity of people with disabilities positively in a way that they are more likely to appreciate their disability, whereas perceived negative media representations impact their identity negatively in a way that they are more likely to reject their disability” (p. 323). Notably, Zhang and Haller are interested specifically in the self-understanding of people with disabilities and how that is related to media construal of disability, a perspective that they argue is overlooked in the literature (p. 320).

Their findings suggest that media portrayals of disability, both negative and positive, do affect the self-perceptions of people with disabilities. “Negative media representations reinforce the necessity for disability activists to openly discuss the disabling environment created by mass media and engage in an effort to promote changes in the social discourse about disability portrayals because media have the power to shape what [the] public knows about disability” (Zhang and Haller 2013, p. 329). People interested in depictions of people with disabilities, then, have an incentive to take media representations seriously, as they affect the understandings and beliefs of both those with disabilities and those without disabilities.

The specific experience that we are examining—when a child with a significant disability is born or has a disability diagnosis before birth and his or her family and community responds—is frequently portrayed and discussed in popular culture. Recent examples include the news coverage of the life and death of British baby Charlie Gard. Gard had been diagnosed with a genetic disorder that causes muscle weakness and brain damage and leads to early death (“Who Is Charlie Gard”) (Telegraph 2017). One analysis of the news coverage of Gard and his parents, who sought experimental medical care for him in the United States, suggested that the stories had all the characteristics of a TV drama: “Imagine a story with the following characters: doctors, lawyers, protestors, judges, paparazzi . . . and a President, a Prime Minister, and the Pope. Imagine the plot weaves through hospitals and court rooms, spills into the streets of countries around the world, and gathers a viral momentum that becomes irresistible to politicians, special interest groups, and—of course—journalists. And at the center of it all is infant Charlie Gard—dying of a rare and incurable disease—and his desperate parents (Connie Yates and Chris Gard)” (Joyce 2017). Michael Joyce, the author of this piece, argues that the “emotional” aspects of Charlie’s story were reported at the expense of the “clinical details” and the “complex medical and ethical considerations” of which the various physicians involved in Charlie’s treatment were aware.

The *New York Times* offers this analysis of Charlie’s life and his family’s situation: “The hard question is when medical interventions become too extreme and pointless, when illness and death

⁵ This analysis does not take up popular culture broadly and does not appear to include television dramas; however, “media” was not precisely defined by the researchers, and thus I am arguing that the results of this study are applicable to non-news television programming like the two series under discussion here.

⁶ The first is described in their survey with the statement “In most news stories you read about disability issues, disability is presented as an illness dependent on health professionals for cure or maintenance.” The second is described as follows: “In most news stories you read about disability issues people with disabilities are presented as disadvantaged who must look to the state or to society for economic support, which is considered a gift, not a right,” and the third is described with the sentence, “In most news stories you read about disability issues, people with disabilities are portrayed as superhuman, inspirational, or ‘special’ because they live with a disability” (Zhang and Haller 2013, p. 325).

should be allowed to take their course. The easy question, whose answer makes the case a moral travesty, is who should decide the hard question: doctors and judges, or Charlie's mother and father" (Douthat 2017). The *Times* article goes on to argue that physicians, presumably informed by a variety of bioethicists, should not have the authority to overrule the wishes of the parents of a critically ill child with respect to his treatment.

Another, happier depiction in popular culture of a child born with significant medical complications and her family is the memoir *Juniper: The Girl Who Was Born Too Soon*, written by Juniper's parents, Kelley and Thomas French. The book emerged from a series of articles Kelley French, who, like her spouse, is a journalist, wrote for the *Tampa Bay Times*. Juniper was a micro-preemie, born just shy of 24 weeks' gestation, and spent more than six months in the Neonatal Intensive Care Unit (Bancroft 2016). Like Charlie Gard's parents, the Frenches wrestled with making informed medical decisions and with the prospect of their daughter's death; the title of the book reflects the choice Juniper's father made to read the Harry Potter books aloud to her in the NICU because he thought she should hear the story of a child who lived. Thomas French writes, "I was pretty sure Rowling would understand Junebug, because her books followed a child who did not know who he was, who endured losses and pain that might have crushed him, who longed for his parents to stand beside him and who triumphed over death again and again" (French and French 2016, p. 246). The Frenches eventually brought Juniper home, and she is now a healthy child.

Other examples of this narrative genre include the *New York Times* article "You Should Not Have Let Your Baby Die" by philosophy professor Gary Comstock (2017), in which Comstock describes, in the second person, the birth and death of his son Sam, diagnosed after birth with trisomy 18, a genetic disorder that results in death before the end of the first year of life in 90 percent of cases. The essay reads like a piece of fiction, and the effect of this narrative style is to both intensify and depersonalize Comstock's experience. The reader is implicitly invited to consider the story of this child's life, and his parents' decision to withhold care from him, as an ethical case study, a hypothetical rather than a real account. While Comstock describes his son as "the love of your life" he also recounts in clinical detail the history of his wife's pregnancy, writing, "You and your wife had no warning during the pregnancy that the child might be genetically abnormal. You were offered the services of amniocentesis, a test that may have revealed his condition. You and your wife refused to have genetic testing done on the fetus because your wife opposes abortion on theological and moral grounds . . . The two of you have support in deciding to let your baby die". Comstock recounts the responses of family and friends, who describe his son as "mentally retarded" and call the couple's decision "courageous." He relates that it takes him years to consider the possible voice of his dying child, whom he imagines saying, "'This hurts. Can't someone help it stop?' He didn't know your name, but if he had, he would have said: 'Daddy? Please. Now.'" (2017) Omitted entirely from Comstock's essay is an exploration of the personhood of people with disabilities as individuals or as possible experts to consult as he and his wife made their decision. Response to the essay among people with disabilities was powerful; journalist and disability rights activist David Perry writes, "The piece was written in second person . . . that's how I reacted to it at first on twitter [sic] as I watched disabled friends reel in shock, pain, and horror at seeing their lives compared to that of animals needing to be put down . . . I understand why [Comstock] needs to use his training as a theologian and philosopher to work through the difficult choice he and his wife made. I'm not even going to say that it was the wrong choice. We need, however, to consider for whom else we might want to have empathy" (Perry 2017). While Perry, like others with disabilities, focuses his empathy on the child's experience, philosophers have not always been as interested in seeing from the perspective of those with disabilities.

One of the most well-known thinkers to openly entertain questions about the value of human beings with disabilities, particularly infants, is ethicist Peter Singer. Like Comstock, Singer defaults to considering people with disabilities as hypotheticals, providing for his readers a thought exercise that glosses over the perspective and voices of people with disabilities. His position has been well documented; the 2003 essay in response to Singer written by the late Harriet McBryde Johnson,

“Unspeakable Conversations,” begins, “He insists he doesn’t want to kill me. He simply thinks it would have been better, all things considered, to have given my parents the option of killing the baby I once was, and to let other parents kill similar babies as they come along and thereby avoid the suffering that comes with lives like mine and satisfy the reasonable preferences of parents for a different kind of child. It has nothing to do with me. I should not feel threatened” (McBryde Johnson 2003). While Singer and McBryde Johnson go on to engage in collegial and thoughtful conversation with each other, she remains diametrically opposed to his argument that it is better for people with disabilities not to exist because their quality of life would be subpar. She writes, “To Singer, it’s pretty simple: disability makes a person ‘worse off.’ Are we ‘worse off’? I don’t think so. Not in any meaningful sense. There are too many variables. For those of us with congenital conditions, disability shapes all we are. Those disabled later in life adapt. We take constraints that no one would choose and build rich and satisfying lives within them. We enjoy pleasures other people enjoy, and pleasures peculiarly our own. We have something the world needs” (McBryde Johnson 2003). McBryde Johnson locates her own value, and the value of other people with disabilities, in her own and others’ experience of lives well lived, in her conviction that these lives are substantive and contribute to the overall fabric of the community.

In a 2017 interview with the *Journal of Practical Ethics*, Singer said that he would choose, if he and his wife had a child with Down Syndrome, to find an adoptive family (no word on whether Singer’s wife is inclined to agree): “For me, the knowledge that my child would not be likely to develop into a person whom I could treat as an equal, in every sense of the word, who would never be able to have children of his or her own, who I could not expect to grow up to be a fully independent adult, and with whom I could expect to have conversations about only a limited range of topics would greatly reduce my joy in raising my child and watching him or her develop” (Singer 2017). Like Comstock, Singer’s philosophical methodology does not include deep analysis of the testimony or experiences of people with disabilities. Instead he reduces them to the status of objects for his own reflection. Singer does acknowledge, perhaps mindful of McBryde Johnson’s position, that “‘Disability’ is a very broad term, and I would not say that, in general, ‘a life with disability’ is of less value than one without disability. Much will depend on the nature of the disability” (Singer 2017). However, his assessment of what it would mean to be the parent of a child with an intellectual disability is both frank and focused almost entirely on his own experiences of pleasure and joy. This suggests that his valuation of the lives of people with disabilities is in some way connected to his own experience of those lives; interestingly, this leaves open the possibility that people who are not Singer—those hypothetical adoptive parents, perhaps—might value and draw great pleasure from the experience of parenting a child with a disability, suggesting that deep embrace by a family or a community helps establish a meaningful life. He does not seem to consider that people with disabilities, including intellectual disabilities, might have meaningful lives in their own right even if their pleasures are different from his own.

Thus Singer, McBryde Johnson and Comstock, those writing about baby Charlie Gard, the Frenches, and many others join a range of voices, some those of people with disabilities and some adjacent to experiences of disability and some seemingly unconnected. What they have in common is great potential to influence their readers, listeners, and viewers as they form beliefs and opinions about what it means to be a person with a disability. While some popular cultural explorations of disability invite the reader or viewer to consider the complexity of experience of families responding to their infants’ serious medical diagnoses, others instead reiterate the construct of these infants as problems to be solved, bundles of data to be evaluated, and ethical puzzles to be dispassionately considered. Each of these approaches shapes the beliefs of readers and viewers, and affects the social context in which people with disabilities live. I will argue below that both *Call the Midwife* and *Grey’s Anatomy* are part of this conversation and can shape a constructive depiction of what disability might mean and how it intersects with religious belief and religious epistemology.

2.2. Religious and Philosophical Discourse in Popular Culture

What value do reflections on and depictions of disabled people and their bodies have for our religious self-understanding, specifically in the field of philosophy of religion, including epistemology? What can discourse about disability add to our understanding of God? The sources for theology are typically held to be scripture, tradition, reason, and experience. Theologian Paul Tillich argues that the job of the theologian (and he includes in this broad category those whose work is in philosophy of religion; see note below) is to correlate the questions that arise from our existential experiences as human beings and the answers provided in revelation.⁷ He identifies the various fields in which human beings generate knowledge and questions about their meaning and their being (psychology, sociology, philosophy, biology, physics, art, music, and so on) as providing the first half of this equation and holds that biblical texts and other religious doctrine provide the second half. He understands experience and reason broadly; human beings encounter God through scripture, within their own cultural, historical, and intellectual framework.

Experiences of disability, and the related field of disability studies, are therefore sources for religious knowledge, according to Tillich's analysis of theological method. He argues, "The sources of systematic theology can be sources only for one who participates in them, that is, through experience. Experience is the medium through which the sources 'speak' to us, through which we can receive them" (Tillich 1951, p. 40). Just as psychology or history can inform human self-understanding and can shape and generate human engagement with religious traditions, being a person with a disability can provide distinctive and important insights from which to raise particular issues of importance to philosophers of religion. Thus for religious disciplines, disability studies is as useful a position from which to engage with religious teaching as any other, and the kinds of questions and experiences that are disability-specific generate reflection and religious insight that is not derived from other positions.

The second part of what Tillich calls the method of correlation is the expression of religious understanding or belief. Why would a television series be a locus of religious meaning or a means of communicating religious knowledge? Television writers, producers, and actors creating secular programming typically do not hold or claim any particular religious authority, nor do they necessarily have any religious training, stated beliefs, or evangelizing agenda.⁸ However, this non-ecclesial context does not preclude the expression and exploration of deep religious meaning.

While Tillich does not explicitly identify secular venues for theological reflection and expression of religious knowledge, he certainly does not restrict the title "theologian" to a select group of trained churchmen and women. Religious analysis outside of the church or academy can be tremendously valuable, especially if it explores something that is otherwise neglected. The questions, Tillich argues, emerge from human experience, not only from the church; this suggests openness to recognizing the value of theological expression that is also outside the church. From the point of view of the theologian, then, the religious themes and elements in popular television programs qualify as potentially significant religious reflection. The experiences of people with disabilities and the field of disability studies are the places where questions about what it means to experience disability first arise; popular culture is one place where religiously rich answers can be expressed.

The first step in analyzing popular culture depictions of disability for religious insights is to ask how philosophy of religion works with respect to bodies. Bodily experiences are only one facet of disability, but they are important. What are the possible connections between bodily experience and

⁷ Tillich argues in *Systematic Theology I* that while there are disciplinary disputes over what is properly theology and what is philosophy of religion, "the problem 'Natural theology or philosophy of religion?' is answered by a third way—the 'method of correlation'" (Tillich 1951, p. 30). For the purposes of this article, I will follow Tillich in arguing that what he calls the method of correlation, although he describes it as a theological process, also functions in the area of philosophy of religion. He argues, "In no case does the theologian as such stand against the philosopher as such and vice versa" (p. 27).

⁸ As we will discuss below, this is not an absolute: individual religious experiences and beliefs, along with experiences of class and race and disability, may influence the plot lines of television series.

religious knowledge? The first connection is between bodily experience and philosophical knowledge broadly understood.

Mark Johnson, in his book *The Meaning of the Body*, argues that, contra Descartes and much other influential thinking in the history of Western philosophy, knowledge is to a significant degree embodied, and human knowledge cannot be separated from our experiences as embodied selves. He writes, “Coming to grips with your embodiment is one of the most profound philosophical tasks you will ever face” (Johnson 2007, p. 1).

Interestingly, Johnson does not take up the experiences and knowledge that emerge from people with disabled and impaired bodies as knowing subjects, although he gestures toward that knowledge. Johnson observes,

In addition to focal disappearance of our perceptual organs, there is also a necessary “background disappearance” of other processes and activities that make perception possible, processes of which we are seldom, if ever, aware. This includes things such as the complex of bodily adjustments and movements that make it possible for a certain perception to occur. I see *with* my eyes . . . but that seeing would be impossible without those eyes’ existence in a body that makes a number of fine adjustments, such as holding the head in a certain way, keeping the body erect and pointed in a certain direction, and moving the body in ways that ensure a clear line of sight.

(Johnson 2007, p. 5)

What Johnson does not consider is that for many people with disabilities, the “background disappearance” of the knowing, observing body is not only not necessary but not typical. Intentional positioning of one’s wheelchair to align one’s gaze with an object under observation, for instance, is not necessarily an unconscious process. Johnson continues, “When I reach out to pick up a cup, I am not aware of the multitude of fine motor adjustments or the ongoing cooperation of hand and eye that make it possible for me to locate and touch the handle of the cup” (Johnson 2007, p. 5). For a person whose body is not normate, the action of reaching to take hold of a cup may entail a series of highly intentional, perhaps nonstandard movements; while the person picking up the cup in such a situation may not be aware of precise fine motor adjustments, he or she may be highly attuned to the process of moving the body to accomplish the task.

Disability rights activist and artist Sunaura Taylor, in conversation with Judith Butler for the film and book *Examined Life*, offers a possible explanation for the omission of this kind of knowing from philosophical consideration:

I could go into a coffee shop and actually pick up the cup with my mouth and carry it to my table, but that becomes almost more difficult because of the normalizing standards of our movements and the discomfort that’s caused when I do things with body parts that aren’t necessarily what we assume that they’re for . . . So this is something I’m very interested in: how disabled people can creatively redo or reinvent these movements. Or how they have to create their own concepts of what a movement is and what their body parts are for.

(Butler and Taylor 2009, p. 191)

That is, Taylor suggests that nonstandard use of one’s body for tasks like reaching for and carrying a cup represents a different kind of knowledge of the body than might be available to people with normate bodies. She continues, noting that this practice can be unsettling for non-disabled people: “I think we’re sort of taught that hands are for giving things, picking things up, they’re for shaking hands, that mouths are for drinking, for kissing, for talking. And when I go into a coffee shop and mess those up—when I, with my mouth, pick up a cup instead of using my hands—it’s sort of undoing this assumption that people just take for granted” (Butler and Taylor 2009, p. 191). Butler suggests in response that even when able-bodied people engage in similar practices, like fans at a baseball

game eating with their hands or using their mouths “in all kinds of ways, uncorking and spitting and putting their mouths into bowls of whatever,” that the behavior is regarded as unremarkable (Butler and Taylor 2009, p. 191). She speculates, “When an able-bodied person maybe uses their mouth in an unconventional way, it’s OK, but if a disabled person does, there’s some kind of challenge to our idea of what human functions are or what certain body parts are meant for” (Butler and Taylor 2009, p. 191). Thus, the insights people with disabilities have about their bodies, and the contribution that those insights might make to human knowledge, are muted by social distrust of their bodily innovations.

Tobin Siebers argues that this is an issue not only within philosophical analyses of knowledge, but for theorists studying the body as well: “The disabled body changes the process of representation itself. Blind hands envision the faces of old acquaintances. Deaf eyes listen to public television. Tongues touch-type letters home to Mom and Dad. Feet wash the breakfast dishes. Mouths sign autographs. Different bodies require and create new modes of representation. What would it mean for disability studies to take this insight seriously? Could it change body theory as usual if it did?” (Siebers 2006, p. 173).

Johnson does not think to ask this question. He argues that his own position, that an analysis of embodiment is key to epistemology, is seen among philosophers as somewhat radical, and yet he maintains a normate account of embodiment. It seems *prima facie* impossible that the embodied knowledge of people with disabilities—itsself a category too wide to support much generalization about what experiences might be included—is identical with the embodied knowledge of able-bodied people. In short, disabled knowing is a neglected philosophical category, but one that is explored, at least in narrative form, by popular cultural depictions of people with disabilities.

Even among philosophers like Johnson who are invested in creating a phenomenology of the body and who regard the body as epistemically valuable, the body with a disability is overlooked. This leaves a philosophical gap. As Michele Moore and Roger Slee argue, this gap is papered over with what they call “bestowed understandings”—that is, flawed epistemologies generated from an exclusively able-bodied experience—and perpetuated as true. They write, “Bestowed understandings build oppressive epistemologies that disable. How do we come to understand disability? . . . Knowledge is formed through the building blocks of expert discoveries and explanatory frames—typically medical—religious pronouncements, cultural representations and cultural bricolage. Nursery rhymes make way for novels, plays, films, television and art to build a composite knowledge. This knowledge is mediated by and may augment expert statements and personal biography” (Moore and Slee 2012, p. 227). Popular culture, then, is a means of distributing this bestowed understanding of disability.

One robust discussion of this problem comes in a conversation among scholars on the idea of a disability epistemology, or “cripistemology.” Respondents were asked to consider “How, when, where, and why do queer, feminist, and disability epistemologies converge? What does it mean, in our own moment or historically, to respond to impairment (of body, mind, even behavior) in queer, feminist, or crip ways?” (McRuer and Johnson 2014, p. 149). Each thinker contributed a short essay exploring the theme and responding to one another; as we will see below, these insights help to identify salient aspects of the depictions of disability we are investigating.

One participant, Emma Kivisild, makes an argument similar to Johnson’s: her bodily experiences influence her knowing. However, Kivisild emphasizes that her social location, “the situated i of my disability,” is crucial: “My motorized chair, homophobic doctors, no curb cuts, the hope of new treatment, the academy, support groups: from these i learn. It’s crip learning, utilizing a crip lens through which i look back 30 years to re-member and re-evaluate politics and identity” (McRuer and Johnson 2014, p. 151).

Another contributor to the roundtable, Jack Halberstam, argues, “Any cripistemology worth its name should identify modes of not knowing, unknowing, and failing to know” (McRuer and Johnson 2014, p. 152). This is suggestive of the apophatic approach to knowing God, and (as we will see below) provides an analytic category for the question of the two mothers regarding their infants’ diagnoses: Why did this happen? What is God doing?

Finally, Carrie Sandahl argues that any account of knowledge from a disability perspective “must include not just the easily assimilated able-disabled but our brothers and sisters who have the most to lose in becoming visible—those who are completely socially marginalized, stigmatized and hidden away in institutions (residential, prisons, etc.). What they know, how they know, and why it matters is most threatening to the status quo” (McRuer and Johnson 2014, p. 157). The narrative emphasis on the knowledge of institutionalized people with disabilities is one of the most powerful themes in the *Call the Midwife* story arc that we will examine.

In a somewhat different vein, Amos Yong takes up the issue of disability-informed epistemology within the context of philosophy of religion. He argues, “When the human experience of disability interfaces with the philosophical discussion of religion, one of the results is a ‘performative philosophy of religion’ whereby philosophical reflection does not exclude the speculative moment but is an activity that shapes human dispositions, activities, and political life” (Yong 2009, p. 54). When the human experience of disability is characterized primarily by able-bodied people, these dispositions, activities, and political pursuits, along with religious doctrine and practice, reflect the bestowed understanding that Moore and Slee identify. Religious teaching that does not include knowledge generated from discourse by as well as about people with disability is inadequate religious teaching. Yong argues that “the religious knowledge of people with disabilities has been understandably marginalized in philosophy of religion simply because they have not been involved in such discussions. Now, although this situation is gradually changing, it remains true that the case needs to be made for securing rather than marginalizing disability perspectives from the philosophy of religion roundtable” (Yong 2009, p. 65). The questioning of ableist assumptions embedded in prevailing epistemologies must recognize, Yong says, that such disability perspectives are varied; each must be “heard on its own terms” (p. 65).

What might this disability-specific religious epistemology look like? *Call the Midwife* explores what Yong calls “the social and political character of the nature of evil.” *Grey’s Anatomy*, in turn, problematizes an inflexible doctrine of divine sovereignty. A third, less explicit but shared theme in the television plotlines is a clear rejection of what Yong calls the uncritical association of disability with evil (Yong 2009, p. 57). Finally, both narratives suggest that the presence of God can be most strongly felt in the experience of being loved, named, and supported by family and community.

3. *Call the Midwife*

The popular and highly acclaimed BBC television series *Call the Midwife* (now in its sixth season) is based on a three-volume memoir written by former nurse–midwife Jennifer Worth. Her alter ego in the memoirs and the television program is Nurse Jenny Lee. The television series, extending beyond the memoir, provides a religiously grounded depiction of mothers and infants, as well as of members of the broader community who come into contact with the midwives. Worth was a nurse–midwife in the late 1950s, living in and working from a convent, which she calls “Nonnatus House,” situated in London’s Poplar neighborhood. At Nonnatus House, some nurse–midwives were nuns and others were laywomen; the laywomen were not necessarily highly religious. However, the Anglican sisters with whom they lived and worked, whose order provided midwifery and other medical care for some of London’s poorest residents, offered an emphatically religious model of care to their patients. They provided prenatal care, delivered babies, and offered antenatal care for both mother and child. In addition, they gave medical care to other residents of Poplar, especially those who were housebound. Care for people with disabilities was a regular part of their work.

The nurse–midwives, both nuns and laywomen, represented a powerful religious and medical authority for the people whom they served. Worth writes,

The St Raymund [Nonnatus] midwives worked in the slums of the London Docklands amongst the poorest of the poor and for about half of the nineteenth century they were the only reliable midwives working there. They laboured tirelessly through epidemics of cholera, typhoid, polio, and tuberculosis . . . In the 1940s, they remained in London and

endured the Blitz with its intensive bombing of the docks. They delivered babies in air-raid shelters, dugouts, church crypts and underground stations. This was the tireless, selfless work to which they had pledged their lives, and they were known, respected and admired throughout the Docklands by the people who lived there. Everyone spoke of them with sincere love.

(Worth 2012, p. 7)

The television series adapts Worth's original narrative, which depicts her experiences with the advantage of years of hindsight, to add another layer of analysis for modern viewers. The producers intentionally focus on issues of disability in many episodes; plots constructed around the experiences of the nurse–midwives, their patients, and their community invite modern viewers to reflect on what it means to be a mother of a child with disabilities. Like *Grey's Anatomy*, the healthcare-focused setting raises the possibility of analyzing disability with a medical model; for the most part, however, the series avoids reducing people to their medical diagnoses. Stories of the people the midwives encounter are typically nuanced, including a review of cultural memory of the individual people and their history, a sometimes sentimental but never patronizing depiction of the neighborhood and its inhabitants, and an ongoing emphasis on the strength and generosity of the Poplar community.

One particular narrative about disability that challenges prevailing social norms comes in *Call the Midwife*, episode 4, series 2, (Goldby 2013), where a mother's initial response to her newly born infant, diagnosed with severe spina bifida, is an intensification of cultural practices of rejecting and institutionalizing children with disabilities.⁹ The baby is expected to have a shortened lifespan and significant mobility and other impairments. In telling this story, the episode explores the responses of the midwives and the religious reflection of the nuns, and identifies both a young man with disabilities and the somewhat disreputable father of the new baby as loci of knowledge who create a path for the baby to be raised by his family.

What might a working-class family whose baby was born with spina bifida have encountered in 1950s London? *Call the Midwife* depicts the newly born baby being whisked off to a hospital with assurances that medical advances are growing by “leaps and bounds,” although Ruby, the baby's mother, reports with distress that “Doctor said he'd be lucky to see his sixteenth, and he'll need all sorts of looking after, so why did they save him?”¹⁰ The sound of the nuns singing at prayer immediately follows his birth; while scenes of the midwives at work are juxtaposed with scenes of the nuns at prayer in many episodes, in this episode only the music serves to invoke that sacred ritual.

Later, among themselves, the midwives discuss the baby's possible complications; Sister Evangeline, whose character is tough and pragmatic, summarizes: he may have problems with bowel control, renal complications, and a drastically reduced lifespan, and he will use a wheelchair (surely a complication for a family living in an urban house with several flights of stairs). Sister Monica Joan, a nurse–midwife and nun whose work with patients has ended because of her age and increasing dementia, reports that when she was first practicing midwifery, the “humane course of treatment was considered to be chloral hydrate”—that is, euthanasia immediately after delivery (Goldby 2013). The other midwives gasp, shocked by this disclosure.

The final word is given to Sister Julianne, who is in charge of the convent and who functions as the moral center of the series; unfailingly patient and kind, she regularly reminds the young midwives and the nuns alike of the love of God for the people whom they encounter and treat. In this instance, she counsels, “Life is never without hope” (Goldby 2013). Nurse Lee, the midwife who attends to the

⁹ Spina bifida is a neural tube defect and “can cause physical and mental disabilities ranging from mild to severe, depending on the size and location of the opening in the spine, and whether the spinal cord and nerves are affected” (National Institutes of Health n.d.) The causes are both environmental and genetic, and folic acid has been shown to be effective in preventing spina bifida.

¹⁰ Episode 4, Series 2. Hereafter, television show episodes are cited in the text as S2E4, and so on.

family after the baby's birth and who struggles to support them, repeats this assertion to the parents: Life is never without hope.

This belief that parents should continue to hope eventually prevailed within the medical community as well. Historically, the late 1950s and the 1960s saw a shift in treatment of infants born with spina bifida in Britain and the United States. A review of treatment standards in the journal *Pediatrics* reports,

In 1967, W. J. W. Sharrard, Robert Zachary, and John Lorber, pediatric surgeons at Children's Hospital, Sheffield, UK, reviewed the cases of 526 children born between 1955 and 1962 and treated for myelomeningocele. They concluded that there was "no place for the selection of patients for conservative treatment rather than operative treatment on the grounds of paralysis, deformity or hydrocephalus present at birth." As a result of this and similar studies published in the mid-1960s, most centers in the United Kingdom and United States adopted the practice of operating within 12 to 48 h of birth on all infants who did not have other defects incompatible with life.

(Pruitt 2012)

The care that Ruby's baby gets, then, is relatively progressive—he is treated by surgeons immediately and with the expectation that he will survive infancy. However, the response of her neighbors reflects a deeply rooted stigma, perhaps intensified by Ruby's open pursuit of a higher social class than the one she currently occupies. While she is still struggling to adjust to her son's situation, a neighbor whom she had previously snubbed sees her on the street and mentions that Ruby and Nurse Lee have temporarily left the baby on the doorstep in his pram: "I do believe you may have left your baby outside, Ruby dear, not that anyone would want to steal a cripple . . . [Speaking directly to Nurse Lee, she continues:] Not so high and mighty now, is she?" (Goldby 2013). Plainly, there is tension between Ruby's aspirations to move her family out of the neighborhood into a higher social class and the birth of a child with visible, significant disabilities. This brings to mind Carrie Sandahl's observation that "becoming visible" as a person with a disability may be complicated by other marginalization; here, the family's economic aspirations are seen by their neighbors as deflated by the birth of their disabled son.

One strategy sometimes chosen by parents in this context was institutionalization; this became increasingly common in the early to mid-twentieth century. "Parents who needed care for children with disabilities, especially if they were working class or lived in urban areas without extended families, increasingly found institutionalization their only option . . . Many doctors pressured parents to relinquish disabled children to the state just after birth" (Rose and Michel 2012). This began to change in the 1950s and 1960s because of exposure of abuse in many institutions, the growing disability rights movement that advocated for independent living, and the cost of institutionalization (Rose and Michel 2012). In the setting of *Call the Midwife*, Ruby and her family are living under circumstances where institutionalization might well have been recommended: they are working-class, they live in an urban setting, and Ruby's husband laments that both of their mothers have died, leaving them without family support.

Indeed, Ruby and her husband Douglas explore the possibility of placing their son at St. Gideon's Home, described by one of the midwives as an asylum for "mental cases as well as incurables" (Goldby 2013). Douglas is opposed to placing the baby outside the family, but Ruby finds herself unable to take over his care. She tells Nurse Lee, "Douglas told me to stop working, but I carried on, lifting them baskets. I used to rest them on my bump when I was loading up, what if that hurt his back? . . . He came out of me, like that. Or was it God? He punishes people, doesn't he? Vanity is one of the deadly sins, they say. Maybe it was Dougie's gambling. Doesn't Jesus hate all that? We did something. One of them things, made him like that. What did we do?" (S2E4). She explains that she cannot bring herself to pick the baby up and hold him: "If I hold him, I think I might die of the sadness" (Goldby 2013). Thus the family considers institutionalization.

The discourse of the midwives provides a nuanced counter narrative to Ruby's concerns about the cause of the baby's disability. She thinks God is punishing her, her husband, or both of them for some infraction, though she cannot identify it precisely.¹¹ The aging Sister Monica Joan suggests that green potatoes might be the cause, but the more recently trained Nurse Miller tells her that potatoes are not the issue although no one knows, at that point, what is. While there is not an extended religious discourse about the reason for spina bifida, the midwives take for granted that medical conditions have medical, and not theological, causes, and they never suggest that Ruby or her husband is somehow responsible for the baby's disability. Their religious authority does not directly address Ruby's questions, but the viewer is reminded that the baby's birth is not a punishment. This reminder reflects "concern that disability is uncritically associated with evil" (Yong 2009, p. 57). While Ruby seems to consider this possibility, the midwives dismiss it out of hand.

As the family explores the possibility of institutionalizing the baby, two characters emerge, one a current resident of St. Gideon's and one a former resident. The two serve to some extent as proxies for Ruby and Douglas's baby, speaking to the quality of life within St. Gideon's but emphasizing the very high cost of broken family relationships. Both of these characters are adults with disabilities, one with cerebral palsy and one with an early diagnosis of mental illness. These scenes are not only important to advance the plot of the episode, but key to avoiding a narrative where the baby is made into an object lesson for others' growth or spiritual reflection.

While visiting St. Gideon's, Douglas meets the director, a capable woman who—the narrative emphasizes—ensures that no abuse takes place there.¹² She tells him, "We would ask that the parents visit as often as possible; the bond needn't be broken just because the baby is at St. Gideon's" (Goldby 2013). Douglas turns to Jacob, a young man with cerebral palsy who is a St. Gideon's resident. Jacob has brought him tea, and he sees Douglas's discomfort with the movements of his impaired body as he brings the cup across the room. He jokes that the tea is not poisoned.¹³ Jacob has been affectionately described earlier to Nurse Lee by the director of St. Gideon's as "bright as a button and cheeky as a monkey" (Goldby 2013). Clearly Jacob is witty and intelligent, and he reliably performs everyday tasks; he was born with his disability and is portrayed as having the social authority to speak to the experience of institutionalization.

His experiences serve the viewer, and the baby's father, as a projection forward in time: what will happen to the baby if he is left here? Douglas asks him, "What's it like here?" and Jacob answers, "There's a biscuit factory next door; we get the broken ones" (Goldby 2013). This wry observation illustrates that the institution gets adequate but second-rate support, and while "we get the broken ones" seems at first blush to be a reference to the residents' bodies, the word "broken," coming immediately after the reminder that children's relationships to their parents need not be broken, suggests that it is the relationships, not the bodies, that are damaged. The broken ones, then, are those whose families have chosen to place them outside the home in an institution, and perhaps have to be reminded to maintain contact.¹⁴ As the facility's director tells Nurse Lee, "This is a home by name only. It is not home. If the child can stay with its family, I suggest that you do everything in your power to make that happen" (Goldby 2013).

¹¹ Yong (2009), as noted above, identifies this position as problematic, underscoring the need for an analysis of this situation informed by a disability studies perspective.

¹² Rose and Michel (2012) emphasize in their discussion that significant, brutal abuse and harsh neglect were typical in institutions for children with disabilities; whether St. Gideon's represents a historical anomaly or is fictionalized is not clear within the narrative.

¹³ As Butler and Taylor (2009) discuss, the nonstandard movement of Jacob's body while he is carrying a cup is unsettling to Douglas; Johnson overlooks this exact activity as potentially epistemically valuable.

¹⁴ The actor who plays Jacob, Colin Young, is a PhD candidate who reprises his role as Jacob Milligan in the 2014 season of *Call the Midwife*; in that episode his character seeks to marry a young woman with Down Syndrome. Young cites his brother, who has arthritis, and his brother's partner, who like Colin has cerebral palsy, as relationship role models for him (Strudwick 2014).

Jacob recognizes that the institution where he lives embodies a harmful construct of disability as requiring segregation; the social practice of removing people with disabilities from their homes is breaking the relationships and causing damage to the residents. Even this particular institution, which attempts to maintain family ties, does not provide a real home for the residents who have been displaced from their homes. Instead, they live in brokenness. As Sandahl argues, this testimony from a person who has been institutionalized about what his life is like is subversive: the most disregarded people with disabilities are “those who are completely socially marginalized, stigmatized and hidden away in institutions (residential, prisons, etc.) What they know, how they know, and why it matters is most threatening to the status quo” (McRuer and Johnson 2014, p. 157).

Jacob’s sorrow is echoed by Jane Sutton, a medical orderly and recent addition to Nonnatus House who was raised at St. Gideon’s. As she explains to Nurse Lee, “I was a patient, and then I became a trustee. I met Sister Julianne here; she’s been very kind to me” (Goldby 2013). Nurse Lee assures her that she will not tell anyone, underscoring the stigma placed on institutionalized people. Later, Jane tells another character, with whom she has been struggling to establish a friendship and perhaps a romantic relationship, that she was placed at St. Gideon’s because her behaviors related to her mental health were too much for her parents: “They say I used to sit bolt upright in bed and scream. My parents sent me away. I don’t blame them. But for a long time, I was . . . away . . . I still struggle. Life, for me, is full of fear” (Goldby 2013). Her difficulty in forming relationships is tied narratively to this early rejection; insofar as she can speak for the possible future of Ruby and Douglas’s baby, the act of placing him in even an above-average institution will cause significant harm.

Both of these positions reflect a social, rather than a medical, model of disability. It is neither Jacob’s cerebral palsy nor Jane’s unspecified mental illness that has been harmful; rather, the problem has been the fracturing of relationships, reinforced by misguided religious beliefs like Ruby’s and stigma in the community. Jacob speaks to this fact. The choice of an actor with a disability to play Jacob helps underscore the importance of recognizing people with disabilities as authorities on their own lives. Sandahl observes, “Disabled artists not only tell our stories, but critique both mainstream and alternative communities, show variety in the human form itself, and model how variety necessitates change to structures of all kinds” (McRuer and Johnson 2014, p. 157). Jacob’s reply to Douglas shapes the family’s choice, gives them a sense of what might be possible with their child, and confirms Douglas’s reservations about putting his son in an institution.

Contemporary medical research gradually recognized that there was good reason not to give up on infants with disabilities: “Acknowledging the unrealized potential of children with myelomeningocele [the most serious form of spina bifida], Zachary maintained that ‘extreme disability is not synonymous with unhappiness and we are only at the beginning of finding ways of developing the capabilities of these patients’” (Pruitt 2012). Within the storyline of *Call the Midwife*, Ruby and Douglas reach a similar conclusion.

While Douglas, after assessing the institution, feigns willingness to leave his son there, he is gambling on Ruby’s deep attachment to their child and her as-yet-unspoken regard for him as a valuable human being. Returning from his visit, he packs the baby’s things in a suitcase and tells her, “I’ll take this; you grab it,” as he reaches into the as-yet-unnamed baby’s bassinet to remove a presumably unnecessary stuffed toy. She responds, suddenly and fiercely: “He’s not it. He’s a baby. He’s my baby boy. How could you even think to send him away?” She lifts the baby and holds him for the first time, and then calls down the stairs to Nurse Lee, waiting to help transport the baby to St. Gideon’s: “Douglas Junior is going nowhere. He’s staying right here, with us.” The voiceover, from Nurse Lee reminiscing later in her life, says: “It had been the biggest gamble of Douglas Roberts’s life. The stakes had been high. But the dividends paid were permanent, and beautiful . . . Sometimes in life, one has to take a chance. Without risk, there’s no possibility. Without potential loss, no prize. The Roberts’s baby defied all odds and thrived and was cherished always” (Goldby 2013). The family’s embrace of their child reflects Worth’s admiration for the family stability and strong social fabric of Poplar. While she does not shy from describing the significant poverty, the realities of living in a rough

area, and the sometimes desperate living conditions, she recognizes the deep love that the members of the community had for each other.

Ruby's choice to name her son, and to use pronouns that affirm his identity as a human being and not an object, represent the family's shift away from some cultural expectations, such as placing their son in St. Gideon's and seeing him as a "cripple," and toward others, namely those modeled by the midwives: remaining hopeful about the baby's future, affirming his identity as a child of God—reinforced by the sacred music played following his birth—raising him at home, and presenting him to the community as proudly as any parents would.

4. *Grey's Anatomy*

In *Grey's Anatomy*, the religious dilemma embedded in a story arc in season 11 about a baby diagnosed with a disability was proposed by Sarah Drew, the actor playing Dr. April Kepner. In the episode, entitled "All I Could Do Was Cry," April discovers in the second trimester of her pregnancy that her son has osteogenesis imperfecta (OI), sometimes called brittle bone disease. OI is a "genetic bone disorder characterized by fragile bones that break easily" ([Osteogenesis Imperfecta Foundation 2015](#)). Deeply religious, April hopes throughout the experience that God will intervene and provide her child with a miraculous recovery. As is typical for the structure of *Grey's Anatomy* episodes, stories about other characters and various medical situations are interwoven with this plotline; in this episode, a man whose eyesight has been impaired has his sight restored, and a woman who had believed she could not get pregnant discovers while in labor that she is expecting a child. While miraculous stories that mimic biblical narratives unfold around her, April does not receive the intervention she had hoped for.

After the initial diagnosis of OI in episode 10, April engages in research and diagnostic evaluation of her own ultrasound images. She recites what she has learned to her husband Jackson Avery, a plastic surgeon, giving basic information about OI: "There are four types of OI, ranging from a manageable disability to completely fatal. Types II and III are the most severe. I studied my ultrasounds. Best case: our kid gets surgery after surgery; worst case, our kid lives only minutes after birth" ([Wilson 2015](#)).

The OI Foundation, a useful but by no means comprehensive resource for people with OI and their families, lists six types of OI, but confirms that Types II and III are most severe and describes people with the other types as having a longer lifespan and needing less medical intervention. However, the foundation emphasizes that "understanding the individual's OI Type provides a starting point for understanding the person's health care needs. But due to all of the variable features, care for each person needs to be individualized" ([Osteogenesis Imperfecta Foundation 2015](#)). Thus, while a few episodes of *Grey's Anatomy* may familiarize viewers with OI, that information might not be applicable to individual people living with OI; the depth and accuracy of medical information provided by the program is, unsurprisingly, limited.

Why is this baby's diagnosis framed as a crisis? As the OI Foundation explains, "With good medical management and supportive care, the majority of people who have OI will lead healthy, productive lives and can expect an average life span" ([Osteogenesis Imperfecta Foundation 2015](#)). This reality is somewhat unevenly presented in *Grey's Anatomy*, though April and Jackson's obstetrician, Arizona Robbins, tells them that babies with Type III (and, as she implies but does not make explicit, other types as well) can have a "very, very happy life" ([Wilson 2015](#)). This reminder is brief but is reinforced to some degree by the identity of the speaker. Long-time viewers will recall, although this episode does not discuss it in much depth, that Robbins, who has recently ended her marriage to another female doctor, uses a prosthetic leg after being injured in a plane crash and having part of her leg amputated. Her identity is multiply marginalized. In a subtle way, then, she represents for viewers an adult with a disability whose voice is authoritative on the subject of quality of life for people with disabilities.

Robbins's narrative role as a stand-in for their infant is not perfect, however; she does not have OI, she did not grow up with a disability, and her disability is not a focus of these episodes. The fit between Robbins and April's baby is not as clear as the analogy between Jacob and Ruby's baby; no

adult with OI is provided to viewers or the characters as authoritative, and there is very little evidence of the reality that many people with OI lead rich, ordinary lives. Similarly, the obstetric surgeon from whom the parents seek a consultation, Nicole Herman, is herself in the midst of a diagnostic process for a brain tumor, the removal of which will make her blind, but her situation is not framed at this point in the season as a disability experience.

The tension between the medical model of disability, which sees people with disabilities primarily as patients in need of medical intervention, and a model of providing care that recognizes the patient and his family as whole people is depicted in the conflicting language that Robbins and Herman use when discussing prospective candidates for fetal surgery. Herman is reviewing files and tells Robbins, “I have found us the most incredible surgeries . . . I have hunted down the most screwed up, medically compromised fetuses I could find” in order to schedule interesting procedures. They sort the files into three categories: impossible, possible, and maybe. Robbins argues that engaging with families whose babies are already born is easier: “Their kid is right there, and you can hold them and hope for the best . . . This feels so theoretical.” While the unborn infants are still patients needing medical care, the contrast between babies who have already arrived, who can be held and comforted, and files classified as “impossible” is clear (Underwood 2015).

Religious language and practice are used throughout the story line to establish the value of individual people aside from any medical diagnosis, but this process is not straightforward. April’s character is from a white farming family in Iowa, and she is devoutly Christian; her conservative religious beliefs have been featured in previous seasons. Her husband was raised by his black mother and is biracial. Jackson is not religious, and the disparity between the married couple’s beliefs has previously been a source of conflict. April’s mother-in-law, surgeon Catherine Avery, proves to be a greater source of support than April’s religious family, and Catherine proposes a path forward for April that honors her religious beliefs and emphasizes the baby’s personhood. While April’s mother advocates prayer, whisks her off to church, and hopes for a miracle, April’s mother-in-law suggests induction and baptism for the baby.

Like the character April, actor Sarah Drew is a conservative evangelical Christian.¹⁵ Drew says that although the idea for the storyline was hers,

I pitched it accidentally. In an episode in Season 10, Catherine Avery makes an assumption about April being pro-life and what her attitude would be as a person who is pro-life. In discussing it with the writers, I had offered a not-so-black-and-white look at how a person of faith might deal with that. That came in the form of a story that happened to my mom’s friend, who was pro-life and they had a baby with O.I. Type 2. They ended up inducing and baptizing [their] baby. Everything that happened on our show happened to my parents’ friends.

(Abrams 2015)

Thus, Drew’s suggestion of the story line where a religious woman, married to a nonreligious man, responds to a serious medical diagnosis of her unborn child and must consider her strongly held beliefs against abortion emerges from her own family’s social circle. Here the knowledge about a disability experience is the parents’ knowledge rather than the firsthand subject experience of a person with a disability. As an evangelical Christian, Drew expressed a desire to portray a family’s deep religious beliefs in the midst of making a very difficult set of choices about their child. The other themes present in these episodes emerge as the writers have embroidered on that original pitch: the possibilities for a person born with OI, the religious resources of April’s mother-in-law, the inadequacy of April’s family’s religious teachings in this crisis, the markers with which parents might recognize the personhood of a very medically fragile baby.

¹⁵ Drew was raised in the Presbyterian Church of America; her father is a pastor (Brasher 2004).

Discussing her character's hope for a miracle, Drew continues: "Moving forward, I actually think that in some ways in going through this, she has this miracle happen to her . . . I felt the sense of, 'God is covering April and holding her and he's walking beside her. He has not abandoned her and he's not evil, bad and cruel. He's with her.' . . . Having a tragedy like that happen and then feeling God show up for you is something that impacts someone tremendously and actually strengthens her faith" (Abrams 2015). One drawback of this framing is that Drew's description instrumentalizes the baby's life as an opportunity for April's religious growth; he is not, in this account, portrayed as a person in his own right.

The episode as written and acted is somewhat more nuanced than Drew's description. When April expresses a belief that God has deserted her, the rest of the characters provide significant support, suggesting that instead of abandoning April, God is present within the community of people seeking to support the couple. She exclaims, "This isn't fair; this isn't just. I have spent my life believing in a God who is just. He gave me a calling and I followed it . . . and then to be handed this? It's cruel and I feel like God is laughing at me." This expression of grief eventually meets with some comforting, but the beliefs of April's family of origin and her somewhat narrow view of God's love and protection as transactional are upended. April is raising questions about the nature of God that her religious beliefs cannot answer.

Invited to visit by April, April's mother tells the couple, "There's really no point in even getting those [test] results. God gives what he wants to give. No test is going to change that . . . It's not good for the baby; focus on loving that sweet little baby; that's all that matters . . . It's hard to understand how his plan will unfold. He never gives us more than we can handle" (Wilson 2015). This reassurance proves insufficient for April, who learns in the next episode that the diagnosis is OI II, and she translates this into nonmedical language for viewers, "My baby's bones are breaking inside my belly? He can feel it, right? So he's in pain" (Underwood 2015). Her mother's absolute rejection of abortion on religious grounds, framed to Jackson as "something [April] knows in her heart and soul she does not want to do," leaves April without options for responding to her son's situation: he will likely survive only briefly if she carries the pregnancy to term, and even in the second trimester he is experiencing pain in utero (Wilson 2015).

At this point the religious dynamics of the episode shift subtly to suggest that the religious knowledge and practices handed down from Jackson's mother are necessary for the family to embrace their child's existence. While Jackson is clearly depicted as nonreligious, the explicit religious views of his mother Catherine Avery are unclear. However, she provides a plan for the baby using language that emerges from the African-American Christian tradition.

April tells Catherine, "There's no way for me to do what I need to do and what I believe that I should do." Catherine replies, "There is always a way. Here's what we'll do. You will choose a day, soon. Set it aside and arrange to be induced. You will give birth to your beautiful little boy, and have him baptized right then and there. Then you're going to get to hold that baby, and you'll pray for him and sing to him. You're gonna look at him and memorize every little detail of his face, and you will do that as long as he lives, you will do that until God takes him" (Underwood 2015).

This phrase, "There is always a way," offered in response to April's despairing statement that "there is no way" for her to respond to her son's medical situation while remaining faithful to her religious beliefs, is an echo of the saying "God will make a way out of no way." Although Catherine does not invoke religious authority in her phrasing of the aphorism, she goes on to offer April an affirmation of her son's dignity, the certainty of the opportunity to baptize him, and an acknowledgment of the power of God. Her use of the phrase "here's what we'll do" shifts the decision from April alone and instead suggests a shared family recognition of the baby. Wolfgang Mieder writes of this proverb, "It

grew out of the African American experience of searching to carve out a life of equality and dignity.” (Mieder 2010, p. 181).¹⁶

What does this mean in context? This framing of the baby’s life not only gives April a pragmatic plan that honors her child as beloved and is compatible with her religious beliefs, it also envelops him in the black church tradition. Catherine Avery is drawing from her own cultural and religious experience to comfort and counsel her son and daughter-in-law, and by extension she is recognizing the place her grandchild will hold in her family and as a participant in that experience. Notably, when the baby Samuel is born, he is named (his middle name, Norbert, is after one of Jackson’s uncles) and then baptized immediately in the hospital by an African-American pastor. His life and death proceed as Catherine Avery has described; the couple hold him until he dies. Neither April’s mother nor Jackson’s mother is present, but Jackson’s family ethos has prevailed.

What of April’s anguished complaint that God is not just? Yong raises the issue of traditional theodicy as subject to critique from a disability perspective. He argues, “Disability advocates caution against the traditional association of freedom and evil . . . This is because as traditionally articulated [theodicies emphasizing free will] have been called on to either justify why disabilities happen to people with them (i.e., because of their sin, carelessness, or irresponsibility), or to enable a sort of resigned posture in the face of human evils” (Yong 2009, p. 164). April’s mother offers an account of God that emphasizes God’s sovereignty and God’s goodness, which leaves very little room to explain why April’s baby is dying; April can only speculate that God is torturing her and rejecting her obedience and diligence in following God’s call. In contrast, the religious perspective that Catherine offers, formed in a tradition well versed in reflection on suffering, does not insist on God’s sovereignty, although it affirms that God is the actor who will end the baby’s life; she says instead, “There is always a way.” In this case she provides a means for April to remain in relationship with God while also making choices that conflict with what April has long believed God requires. The issue of whether God is just is set aside; as Jack Halberstam argues, not knowing is a mode of cripistemology (McRuer and Johnson 2014, p. 152).

The ongoing visual image of candles, lit in the hospital chapel in recognition of the baby’s birth and his parents’ struggle, emphasizes religious themes. Near the beginning of the episode, several colleagues are discussing what to do to show support for April and Jackson, and another surgeon, Amelia Shepherd, says, “I lit a candle in the chapel. You can all just give them privacy. That’s all they are gonna want” (Underwood 2015). The episode closes with Amelia in the chapel, disclosing to a friend that she also lost a baby shortly after birth. Thus, her suggestion is framed as empathetic and authoritative.

As the episode progresses and April and Jackson struggle to proceed with the induction, the number of lit candles increases as various friends and coworkers visit the chapel. In another nod to the religious depth of the black church tradition, the only characters who seem to know how to pray, apart from Amelia, who is white, are a black physician, Miranda Bailey, and a black resident, Stephanie Edwards. Both are interrupted by white women while at prayer, and while people flow in and out of the chapel, most express some discomfort at their own lack of expertise in a religious setting. Notably, in other scenes during this episode Bailey helps to deliver the unexpected, “miraculous” baby born to the woman who believed she was infertile, and Edwards assists with the procedure that restores a patient’s sight. Neither echoes April’s belief in miracles, and both model a religious identity compatible with the scientific method and modern medicine.

Together, Catherine Avery, Bailey, and Edwards embody Jennifer Nash’s description of the intersection between race, feminism, and disability: “Black feminism has revealed the epistemic advantages that emerge from marginality. In so doing, black feminism validates embodied forms of

¹⁶ Mieder traces the origin of the proverb back to at least 1900, its first recorded appearance in print, but speculates that it may have been an oral tradition earlier than this. Given the importance of the oral tradition in transmitting the black religious experience in the United States, this seems very likely.

knowing, legitimizes experiential knowledge, and endorses forms of knowledge too often dismissed by the academy” (McRuer and Johnson 2014, p. 151). Like Arizona Robbins, both Bailey and Edwards have a back story of disability, not highlighted in this episode but familiar to long-time viewers: Bailey was diagnosed with obsessive–compulsive disorder after a traumatic event, and Edwards was frequently hospitalized as a child with sickle-cell disease, which has in previous episodes emerged as a source of empathy and has been portrayed as a valuable addition to her capacity as a physician.

5. Conclusions

What do these television programs provide us, and the broad range of people who view them, that is constructive for reflecting on the intersections of disability, religious identity, race, and class, and for developing a disability-influenced religious epistemology? Each of the narratives is culturally influential and each offers explicitly religious framings for stories of families responding to a diagnosis of disability in a much-wanted baby son, but is this significant to religious engagement with disability?

First, we must identify the limitations that emerge from a close reading of these narratives. Yong reminds his readers of the disability rights slogan “Nothing about us without us!” and emphasizes that it applies to religious discourse as much as anything else (Yong 2009, p. 70). One problem is that each of these stories is a retelling of the experiences of a person with a disability by an able-bodied person. Although nurse–midwife Jennifer Worth and actor Sarah Drew provide detailed, thoughtful accounts of events they have witnessed for adaptation into television shows, both women are recounting someone else’s life story. That both of the narratives selected for analysis are about infants makes this problem somewhat inevitable; even an adult with a disability would be hard-pressed to recount the story of her own infancy with much accuracy.

Call the Midwife has a more effective strategy than *Grey’s Anatomy* for mitigating this problem of narrative authority, and it more successfully deploys adult characters, Jacob and Jane, to speak on behalf of the infant Douglas than do the writers of *Grey’s Anatomy* for the infant Samuel. Jacob’s and Jane’s descriptions of St. Gideon’s are historically improbable, however. The reality of institutions created to, as one of the midwives says, house the “mental cases as well as incurables” (S2E3) is glossed over. Such institutions arose out of eugenicist policies designed to cull people with significant disabilities, the so-called “feeble-minded,” from the reproductively active population and to permanently segregate them; while deaf and blind children were removed from their homes to be housed and educated rather than to be permanently segregated, the rationale made to their families was the same: they were a burden (Rose and Michel 2012, p. 242). *Call the Midwife* offers the gentlest possible depiction of such an institution, although it is clearly critiqued.

Although some adults with disabilities on *Grey’s Anatomy* help shape the narrative around the baby Samuel, a viewer who had not kept track of the character development of many different characters over the course of eleven seasons would not necessarily remember the disability narratives of Robbins, Bailey, and Edwards. Furthermore, none of those women speaks on behalf of Samuel. This eliding of adults with disabilities, not to mention adults with OI, makes the story less complex and accurate than it could have been, and the program fails to give voice to the experience of a person of any age living with OI.

The unfolding narrative in *Call the Midwife* also lacks a discussion of the prospects for Douglas Junior as he grows into childhood and perhaps adulthood. His family’s home has stairs; both of his parents have jobs. As his mother notes, he will need care. The degree of accessibility his world will have to offer is unclear, and although Nurse Lee’s voiceover affirms the goodness of his life very clearly and strongly, the viewer is left to wonder what happens to Douglas Junior and his family as he outgrows his pram and gets his first wheelchair: Will the family move as they had hoped? Will the new home have stairs? Can he go to school? While the newly created British public health system provides for his medical care, will his parents’ love and determination be sufficient to meet his other needs? Nurse Lee is reassuring, but details that might provide context for a political analysis of access are thin on the ground.

What *do* these stories add to a religious epistemology of disability? Again, our use of these programs for analysis of the bodily experience of people with disabilities is limited in part because each television episode is focused on an infant. While infants are constantly having new bodily opportunities, it is difficult to capture their firsthand reflections on these experiences. However, there are some important moments. Both narratives portray the acts of holding the baby and naming the baby as significant. This intimate exploration of the babies' naming and their embodied contact with their parents recalls "the situated i of my disability" that Kivisild writes about (McRuer and Johnson 2014, p. 151). Each child is situated within his family, his racial and class context, and his religious community.

In *Call the Midwife*, Ruby and Douglas's baby remains nameless as they struggle to understand his diagnosis, as Ruby finds herself unable to respond to him emotionally, and while they consider placing him at St. Gideon's. When she finally is required to pick the baby up, she reacts to his physical presence in her arms by refusing to take him down to the waiting car, by naming him loudly and deliberately after his father, and by naming him explicitly as her son. Although there is no scene of a baptism, the voiceover from Nurse Lee reassures the viewer that the baby was cherished "always," suggesting that his parents' love for him covered his life and his death, and hinting at their expectation of an afterlife. The family's social class makes them vulnerable to the social system of institutionalization but also provides a community model of deep attachment to family. Sister Evangeline provides a maxim that the family is able to live out: Life is never without hope.

In *Grey's Anatomy*, April and Jackson discuss names as they prepare for the baby's induction, and April decides to move forward with the procedure that will lead to the baby's birth and death only after selecting a name for him. While the baptism is depicted with background music rather than dialogue, the two scenes together signify that the baby has been named and has been explicitly, ritually recognized as a child of God. After the birth, April tells Jackson as she is holding the baby, "He squeezed my finger . . . And then he let go" (Underwood 2015). This very limited physical movement signifies some agency on the infant's part during his short life; he sought connection and then released himself from it.

These depictions of physical touch between parents and children emphasize that although infants cannot speak for themselves, physical engagement can signify deep emotional bonds. In narratives where the infants are vulnerable to separation from their families (in one case by being placed in an institution, in the other by death), the image of a mother holding the baby close serves to stabilize his place in the family and in the community. Given the harm done by isolating people with disabilities geographically, socially, educationally, religiously, and in other ways, the strong refusal of that practice—holding the baby close and creating a place for him in the family—is a powerful one. Each mother has asked what role God has played in her situation, and the resolution of that question is connection: God has given this baby.

The naming scenes also remind the viewer that the act of selecting a name for one's child is an affirmation of that bond and of the baby's inherent value as a human being. While the idea that names are important and represent connection to family is hardly a disability-particular concept, within each story here, the personhood of the infant, somewhat tenuous at least in the case of Douglas Junior, is firmly and intentionally recognized by the parents. What does it mean to have a name and to be baptized? It means that a person is seen as both an individual and as part of a family. Each child is given a name that connects him to his father, and in each case this serves to underscore his identity.

Grey's Anatomy also offers a complex depiction of the African-American Christian tradition as flexible, deeply spiritual, and practical; without sacrificing the notion of God who is all-powerful, Catherine provides a means for April to both affirm the God she believes in and take necessary steps to end the life of the child she loves. The plot arc both demonstrates the tensions between some Christian doctrines and the experience of disability and offers an account of faith that suffices for the situation, fosters community, and permits recognition of Samuel as beloved.

Both series also push against a concept of God as all-powerful and punishing. Both Yong and Halberstam explore the problems of seeking to fully understand the actions or nature of God. Yong cautions against too strong a doctrine of divine sovereignty that asserts that God is personally directing each event in a person's life: "The problem arises . . . when people with disabilities are told by the nondisabled that their disabilities are part of God's plan for their lives. It is one thing for an individual to come to accept his or her own disability as the result of God's intentions, and embrace this as his or her own confession; it is quite another for others to be told by well-meaning and able-bodied people that God has basically chosen to inflict their disabilities for God's own reasons" (Yong 2009, p. 58). Halberstam, describing how disability shapes epistemology, uses language often invoked in religious discourse: he says a cripistemology "should identify modes of not knowing, unknowing, and failing to know." He continues, "If conventional epistemologies always presume a subject who can know, a cripistemology will surely begin and end with a subject who knows merely that his or her ability is limited and that the body guarantees only the most fragile, temporary access to knowledge, to speech, to memory, and to connection" (McRuer and Johnson 2014, p. 152). Surely the bodies of infants are capable of communicating this knowledge.

Each of these narratives presents an experience that also pushes viewers in the direction of unknowing: What will happen to Douglas Junior, and why was he born as he was? His family and his midwives do not know, but in the not knowing about his biology there is knowing about his identity. Why was Samuel born with OI? Why did April's expected exchange with God, having faith in return for God's blessing, go awry? She cannot know God in the way she thought she could. Samuel's life and connection to his family are brief, and his inner experiences cannot be known. In this unknowing April names and baptizes and holds him.

Television is certainly not the only, and likely not the best, means to access disability-specific knowledge, about God or anything else. It is, however, a potentially disruptive locus for asking questions, telling stories, offering accounts of lives, real and imagined, that are overlooked or regarded as inconsequential elsewhere. Insofar as people with disabilities and their families, friends, classmates, and coworkers watch television—and they do (U.S. Department of Labor 2017)—television programs offer the chance to think about, discuss, critique, and meditate on the lives of others and their particular experiences and insights. They are often, as in these two cases, worth our consideration.

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