The politics of crisis, care and vulnerability in "This is Going to Hurt (2022)"

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Abstract

This article explores themes of crisis, care and vulnerability in the 2022 BBC series *This is Going to Hurt*. Arguing the series is significant within the genre of medical-themed television because of its complex representation of a "broken" NHS, the article analyses the ongoing, gendered and racialised dimensions of the public healthcare crisis it depicts. Despite the series concluding that the NHS holds the potential to provide universal care in the future, such a promise rests on eliding the unequal and precarious institutional realities the series has revealed. This suggests a feminist analysis is essential for diagnosing the gendered and racialised forms of labour and recognition within the healthcare system and resisting the differentiated forms of precarity a discourse of crisis can exploit and obscure.

Keywords

Care, crisis, Vulnerability, NHS, medical television

Introduction

This article explores the way in which the NHS — as a response to vulnerability, but also an institution so often framed as itself vulnerable — is represented in the 2022 BBC series *This is Going to Hurt* (hereafter*: TIGTH*). Released in January 2022 to positive reviews, the series is one example of a "renaissance" (Hannah Hamad 2016, 137) of NHS themed television over recent decades which has intervened in a broader crisis discourse surrounding national healthcare provisioning and resourcing. As a darkly comic and dramatic portrayal of life on an NHS Obstetrics and Gynecology ward, the series' medical realism granted it authenticity in an era in which the structural precarity of the NHS has been central to debates over austerity, Brexit, and COVID-19. With comparisons between *TIGTH* and contemporary struggles of the NHS featuring in positive reviews (Giles Dawnay 2022; Lucy Mangan 2022) this article argues that

TIGTH's exploration of the gendered and racialised politics of institutional, relational and medical vulnerability in the NHS is revealing of the feminist stakes of the crisis discourse surrounding public healthcare in the UK.

In this article I analyse themes of crisis, care and vulnerability in the series which was intended as a "love letter" (Manori Ravindran 2022) to the NHS. As an intervention into the crisis narrative, *TIGTH* complicates straightforward representations of the NHS as an already "broken system" (Episode 7) by concluding that it continues to hold the potential for universal public care. But in reading the secondary character narratives of junior doctor Shruti Acharya and head midwife Tracy, I suggest that *TIGTH* also exposes the asymmetrical, gendered and racialised politics of care which such a universal promise relies on. Through stories of the differentiated forms of labour and "wearing out" (Lauren Berlant 2011, 7) of the characters in the context of ordinary crisis, *TIGTH* reveals the implicit boundaries to an imagination of universal care within the NHS and the subjects who can be cared for within it. As in the broader discourse, a diagnosis of crisis invigorates the differentiated recognition of deservingness and need which has always been central to debates about this institution. In what follows, I establish the significance of medical themed television to understandings of the NHS and the history of the crisis discourse, before analysing how *TIGTH* explores and exposes its implicit racialised and gendered boundaries.

"Our" NHS on contemporary Television

Set in 2006 and based on the best-selling memoir of the same name, *TIGTH* follows the story of Adam Kay, a junior doctor in Obstetrics and Gynecology. Across 7 episodes, we are presented with the posh, muddled, but almost always successful DIY ethos of Adam and the other hardworking healthcare workers on the ward. Adam breaks the fourth wall frequently to muse on the day to day of the job. He tells us he is "generally sailing the ship alone — a ship that's massive, on fire, and no one has had the time to teach you how to sail" (Episode 1). When he is not sleeping between shifts in his car, or avoiding his fiancé's text messages, Adam moves skillfully through a sea of patients and shows aptitude for recognising medical emergencies. But Adam is also arrogant, crude, disparaging of the enthusiastic new doctor Shruti Acharya and most of his colleagues. Of his patients — the "twats" of the ward he calls "Brats and Twats" — Adam is often scathing. Overworked and under-resourced, Adam narrates the ridiculousness, the chaos, the resilience of the NHS which he (and we) can only love in spite of it.

"Notwithstanding the longevity" of televisual representations of the NHS, Hamad argues that discourses of crisis and controversy in public health care have "been accompanied by a renaissance in medical TV" (2016:137). Within this renaissance, *TIGTH* reflects growing focus on the struggles faced by patients and healthcare workers (*Getting On, Trust Me*), in contrast to more heartwarming depictions of continued NHS success (*One Born Every Minute, Call the Midwife*). The intertextuality between representations, political debate and daily experience of healthcare, means medical themed television can be analysed as a cultural artifact around which public investment in, and understanding of, the NHS is negotiated and constructed (Patricia Holland, Hugh Chignell and Sherryl Wilson 2013; Matthew Thomson and Roberta Bivins 2017). In this way, feminist media analysis has particularly focused on depictions of medicalised

childbirth and motherhood in TV and cinema (Madhurima Das and Dibyadyuti Roy 2019; Tanya Horeck 2016; Julie Roberts and Sara De Benedictis 2021; Chikako Takeshita 2017; Imogen Tyler and Lisa Baraitser 2013; Emily Winderman 2017). Yet, the genre also offers space to analyse the feminist stakes in the crisis discourse particularly as it is constructed around representations of NHS care and working conditions.

Indeed, the popular reception of *TIGTH* must be considered alongside its release during the COVID-19 pandemic. While the Conservative government had initially toyed with a strategy of "herd immunity" (Ed Yong 2020), as COVID-19 spread globally, it threatened to overwhelm healthcare services in the UK. In March of 2020, much of the UK would enter its first wave of social restrictions under the promise of "protect[ing] our NHS" (DHSC 2021). As the impacts of longer-term underfunding were revealed in news of drastic under provisioning across NHS Trusts, Government Ministers joining in to "Clap for Care Workers" was critiqued by many (Helen Wood and Beverley Skeggs 2020). Minoritised NHS and care workers disproportionately died from the virus — reflecting racialised mortality rates overall (Otu, Akaninyene, Bright Opoku Ahinkorah, Edward Kwabena Ameyaw, Abdul-Aziz Seidu and Sanni Yaya 2020). While the vaccine rollout from December 2020 shifted COVID-19 morbidity and social restrictions, by mid-2021, reports of patients suffering in waiting rooms for emergency services, unprecedented ambulance waiting times and delayed essential treatments dominated the news (Denis Campbell 2021). When *TIGTH* aired in January 2022, one hundred and fifty thousand COVID-19 related deaths had been reported (Becky Morton 2022). Thus, the popularity of the series can be considered to reflect its resonance in times of medical, social and administrative crisis and the uneven forms of suffering, illness and isolation they had laid bare.

Public interest in televisual representations of the NHS can also be attributed to what Holland, Chignell and Wilson (2013, 29) call the NHS's "myth" of origin within a state model of redistribution developed from recommendations in the Beveridge Report (*Social Insurance and Allied Institutions*) of 1942. While Beveridge's recommendations have been critically revisited as informed by eugenic conceptualisations (Indy Bhullar 2022), the post-war development of the NHS by the Labour Government is considered to reflect democratic socialist principles, influenced by the voluntary care performed by working class communities prior to World War 2 (Holland, Chignell and Wilson 2013, 27). While there was some professional opposition to a national health system, the NHS is now frequently cited as a *shared* political and public service in which this myth of origin has become more secure (Holland, Chignell and Wilson 2013). Early political consensus over a "free at the point of delivery" and "universal service" (Rudolph Klein 2019, 274), means the NHS remains framed as a "much loved" (Klein 2019: v) institution for recognising the universality of human vulnerability and the necessity of care. While decades of structural change leading to the *Health and Social Care Act 2012* have redefined the functioning and funding of the NHS in ways that have "arguably swung the balance of power from the public to the private sector" (Gareth Lacobucci 2015, 1) and facilitated the context from which much of the recent crisis discourse has emanated (Wood and Skeggs 2020), even the "Case for Change" for the Act promised a "commitment to [these] Founding Principles" (DHSC 2012, 1). In 2015, Chancellor of the Exchequer, George Osborne (2015), claimed that the Coalition Government's austerity agenda was necessary precisely to save publicly "cared about" institutions such as the NHS. Just as the promise to "save our NHS" was infamously plastered across *Vote Leave* campaign materials in 2016 (Des Fitzgerald, Amy Hinterberger, John Narayan

and Ros Williams 2020), it seems that despite decades of structural change which have challenged the NHS capacities as a public institution, its positioning in the national imaginary maintains political and cultural weight.

Indeed, in contrast to the "wholly individual" (2014, 113) way Erinn Gilson suggests vulnerability is entrenched within US health insurance debates, the NHS does seem to reflect a somewhat anomalous recognition of the universal need for care in the UK context — particularly when compared to the not so readily sustained investment in other aspects of post-war welfare like unemployment benefits or social housing. Yet, this imagination must still be understood as existing despite the stark realities of unequal access, care and entitlement across its history (Charlotte Williams 2012). In what follows, I argue that an exploration of crisis in *TIGTH* reiterates a promise of universal care in the NHS, while also revealing the gendered and racialised forms of injury that such a promise relies on. In the final sections of this paper, I argue that this imagination of the NHS as "ours" must be considered alongside another founding premise of the UK welfare state: access as a right of imagined (but exclusionary) citizenship (Bivins 2015).

An ordinary experience of crisis

TIGTH uses the sounds of alarms and pagers, rushing staff changing bloodied scrubs and ceilings literally falling down to convey a sense of constant struggle. Early on in Episode 1, Adam intends to discharge a pregnant woman who he regards as an unintelligent time waster in the context of his overfilled day. When an emergency alarm later goes off in her ward, he

condescendingly suggests she may have “farted”. But Adam is soon forced to deliver her premature baby, leaving both in critical condition. Advised to lie about his diagnostic error in the incident report, Adam’s mistake becomes central to the narrative of the series as he struggles to overcome his guilt and is investigated for professional fitness. Heartbroken, he visits the baby regularly in the ventilation crib, confessing his mistakes: “I was really tired, and I just wanted to get home… this place is insane”. In *TIGTH*, the hospital, the staff and patients are all under threat of this “insanity”.

Certainly, a crisis discourse surrounding the NHS has grown over the last 20 years. The public inquiry from 2010 into the failings of care within the Mid-Staffordshire NHS Trust acted as the backdrop to the fundamental changes to the NHS instigated through the aforementioned *Health and Social Care Act 2012* (HoC 2013; see also Hamad 2016). Over the last decade, both the Conservative and Labour Parties have run election campaigns promising to respond to the challenges faced by the institution, just as the *Vote Leave* (but also *Stronger In*) campaigns in 2016 mobilised the referendum as an issue of border and health service security (Fitzgerald et. al. 2020). In 2017, the British Red Cross shared the explicit diagnosis of an NHS “crisis” (Denis Campbell, Steven Morris and Sarah March 2017) and three years later, the COVID-19 pandemic would place “unprecedented” (NHS 2021) pressure on healthcare services as reports of limited access, care and treatment followed. In 2022, further cuts and the continued impacts of the pandemic saw the NHS Federation call for recognition of a “crumbling service” under “danger” (James Tapper 2022). In October 2022, the published inquiry into maternity and neonatal services in East Kent found failings which contributed to multiple deaths (Bill Kirkup 2022). In the same year, research into experience of childbirth and pregnancy demonstrated that Black

women in the UK are four times more likely to die during childbirth than white women and Asian women are twice as likely, reflecting long term unequal treatment in maternity and aftercare (Awe, Tinuke, Clotilde Abe, Michelle Peter and Reyss Wheeler 2022; Knight, Marian, Kathryn Bunch, Roshini Patel, Judy Shakespeare, Rohit Kotnis, Sara Kenyon, Jennifer J Kurinczuk 2022). Juliet Allen, Daniella Jenkins and Marilyn Howard (2020, 584) argue that this crisis discourse points to the ongoing material impacts of neoliberalism as well as "the gendered and racialized nature of work, employment, social care, and welfare" such processes rely on.

Indeed, as Sara Ahmed argues, the consolidation of a crisis discourse is not to "'make something out of nothing': such declarations often work with real events, facts or figures" (2004, 77). And yet, the ongoing nature of the crisis discourse over 15-20 years (exemplified by the *TIGTH* being set in 2006 and reference to its unchanged relevance to 2022), demonstrates a significant malleability to the unprecedented nature of this contemporary political frame. Affective claims to periods of crisis (Covid-19, austerity) risk masking the consistency of such precarity and inequity, just as the diagnosis of a crisis fails to suspend the ideological investments that surround such structural processes. Indeed, because the declaration of a crisis produces "the fact/figure/event and transforms it into a fetish object that then acquires a life of its own" (Ahmed 2004, 77), it is of interest not just what these facts or figures are, but in what ways they "stick", in Ahmed's phrasing, to responses, solutions or imaginations of what should be done and how the NHS should be saved, as well as which figures or groups are mobilised as the cause of (or solution to) the problem under neoliberalism. Indeed, over the last decades an array of figures have been amplified as causing the crisis: migrants labelled as *health tourists*, smokers who require *behavioural* adjustments, *cov-idiots* as risks to public health, junior doctors and GPs, the

European Union and most recently, striking workers. But whilst *TIGTH* explicitly engages with more structural questions of resourcing in Episode 7, and the series evidences issues of NHS buffering of private healthcare in Episode 6, it importantly maps the ongoing precarity of the NHS, where the crisis becomes disparate and cumulative across episodes — a problem that attaches to different causes, bodies and outcomes in multiple ways.

My analysis of *TIGTH* thus reads against the popular take up of the series (and the crisis discourse in general) in the suggestion that the NHS is already "a broken system" (Episode 7). Rather, like the slowly dwindling supply of scrubs in the dispensing machine that Adam returns to in each episode, the pressures on the NHS in *TIGTH* are positioned as ongoing, mundane and common — "it was exactly the same [for me]" (Adam, Episode 7). The majority of *TIGTH* episodes present the problems of the NHS as cumulative and procedural, figured through the ongoing work of NHS staff. Dramatic tension relies on building sites of pressure: too many emergencies alongside bureaucratic requirements; work being carried out by overcommitted staff who are sustaining operations amid administrative and staffing shortages. And apart from Adam's serious misdiagnosis which travels across the episodes, in most cases we follow the doctors, midwives, nurses and administrative staff making the right decisions — just in time.

Similarly to Ahmed, Berlant (2011) argues that in trying to apprehend the conditions of intense social and structural pressure, activists and others often declare a state of crisis to inflate the scene as an *event* that can be recognised. For Berlant, a crisis discourse more often prohibits an understanding of social precarity which is rarely exceptional or unprecedented, but rather "interwoven with ordinary life" (2011, 102) for many. Berlant theorises that precarity under

neoliberalism might be understood as "crisis ordinariness" (2011, 10), better capturing its impacts through the temporal frame of "slow death" (2011, 96). Slow death allows Berlant to contemplate that structural crisis is experienced in slow, intimate and uninflated ways. From this perspective, the crisis of the NHS can be better understood as an ordinary aspect of its working within the neoliberal present. Indeed, it is the *ordinariness* of such conditions that *TIGTH* most richly captures.

Such a slow death is evidenced by the growing exhaustion of Adam and Shruti as they differently manage their professional and personal distress. Adam buckles under the weight of the investigation into his fitness for practice alongside planning an engagement and experiencing flashbacks to the delivery from Episode 1. Shruti studies for her exams in her few free moments, withdrawing from her personal life. For Adam, physical and emotional exhaustion culminates in obsessive fears of professional failure. Shruti barely manages daily disrespect and bullying whilst shielding her family from her experiences. An atmosphere of anticipated limit pervades the decision making, stresses and "wearing out" (Berlant 2011, 7) of staff in the context of ordinary crisis. *TIGTH* contrasts these intimate failings with rolling scenes of (often disembodied) childbirth, where such clinical, routinised and medicalised depictions jar against close-ups of staff exhaustion. Across the episodes we see: uncaring, hurried consultations; births that go painfully (or at least awkwardly) because of room shortages or inexperience; and harrowing moments where patients consent to life-changing interventions without really knowing the risks of what is involved. Reiterated in *TIGTH* is the shared stake of everyone in this ordinary crisis — differently, but certainly vulnerable to, this ever-pending threat.

In Episode 3, Adam meets a young woman who is bleeding profusely from her genitals. Initially misunderstanding the context of the injury, Adam soon discovers the patient has attempted self-surgery on her labia. Understanding this as self-harm, Adam finds the on-call Psychiatrist. In an abrupt and mutually rude conversation the Psychiatrist explains:

> I've got a woman who tried to jump of a bridge this morning, a student in frank psychosis… another suicide attempt. There's only one of me... Tell her to see her GP for a referral to community mental health. It's just not an emergency… You losing your shit at me isn't going to magic up any more doctors!

The young woman goes home unseen. In Episode 4, Shruti perceptively intuits that a woman is being abused by her seemingly affable partner. But after securing the patient a bed and safe accommodation, Shruti's lack of training, impatience and minimal support from distracted colleagues sees the patient likely to return home. Later, a despondent Shruti is supporting the busy out-patient clinic where we see stacks of medical files loaded on her desk. A couple undergoes a routine early ultrasound in which Shruti discovers there is no heartbeat. Rushed and withdrawn, Shruti coldly tells the distraught couple "not to think of it as a baby, it's just a bunch of cells" (Episode 5).

In these scenes, — and unlike other contemporary examples (*One Born Every Minute*; *Call the Midwife*) where intimate human-interest stories serve as the proof of the NHS's ability to perform care well (Hamad 2016) — *TIGTH* highlights moments in which care is bad, clinical and fraught. Moments of episodic hopefulness — a new baby, a close escape from medical

tragedy, a potential date, a good joke with a colleague — are strategically interwoven with the reality of staff struggling to perform the basics of care, for themselves or others. Reflecting consistently higher rates of burnout within Gynecology and Obstetrics professions, especially amongst young doctors who have trained in the UK (Tom Bourne, Harsha Shah, Nora Falconieri, Dirk Timmerman, Christoph Lees, Alison Wright, Mary Ann Lumsden et. al. 2019), Shruti manages her resultant shame by drinking excessively before her medical exam. Adam humiliates his fiancé with a distracted speech at their engagement party after upending the celebrations by accusing his colleagues of ruining his career. Watching these intimate failings of Adam and Shruti amongst their unchanged working conditions, a suspense befalls the series. Can they manage to provide care not only within the context of their patients' medical vulnerability, but also within a faltering system given their diminishing emotional resources to do so?

The gendered politics of good care

Whilst the series was widely well received for this depiction of staff experience, a significant backlash emerged over the representation of patients. Some critiqued the clinical and disembodied scenes of childbirth alongside unnamed mothers who Adam condescendingly describes (Francesca Specter 2022). But while such critiques accused Kay (as writer) of misogyny for failing to tell women's stories, they have been less engaged with the narratives of women staff through which the series arguably explores the gendered and racialised politics of care within the NHS. While mindful that *TIGTH* might, as Horeck argues of other medical television, continue to "shore up existing power structures of the medical authorities over the female patients and of the viewer" (2016,173), it is through the stories of women staff that

TIGTH more meaningfully reflects on the politics and structures of medicalised childbirth as *women's* stories in the context of neoliberalism. Reflecting historic representations of care as "strongly associated with the 'feminine'" (Andreas Chatzidakis, Jamie Hakim, Jo Littler, Catherine Rottenberg and Lynne Segal 2020, 890), *TIGTH* relies on reparative representations of women staff to buffer the overall crisis narrative through individual scenes of good and enduring care, and to temper the consequences of Adam's failings.

In many ways, *TIGTH* represents women health workers as naturally and vocationally drawn to perform care: "I'm worried," says a comically fretful midwife in Episode 2 as she tends to *another* patient she is a bit too concerned about. Much of the burden of competency is performed by women in the series. That is, by Tracy, as a knowledgeable, Black British midwife who is really "running the ward" (Episode 1); Ms. Houghton, a tough, white, working class, senior consultant; and Shruti, a British South Asian, working class, junior doctor who eventually proves herself to be a better surgeon than Adam. But it is particularly through the stories of Tracy and Shruti — as consistently under-valued, racialised women staff — that the series reflects on the gendered politics of care. Working their way around the limitations of the NHS by demonstrating strategic thinking and good humour, these characters are framed in ways that reflect ambivalent historic representations of women — and often women of colour (Bivins 2017) — as the empathetic frontline of healthcare who, through their ingenuity and passion, "ensures just outcomes that policy and due process cannot" (Kathleen McHugh 2012,16; see also Beth Johnson 2016).

In Episode 1, a white patient raises accusatory questions about Tracy's qualifications and Adam is quick to dismiss the woman's racism. When Tracy resists the scene — particularly Adam's desire to act as a "white knight" — Adam defensively pulls rank, choosing not to hear Tracy's implicit request to recognise the commonness of racist and sexist assumptions that she must navigate within this setting (see: Gloria Likupe, Carol Baxter, Uduak Archibong and Mohamed Jogi 2014). Later in the episode, Shruti falls victim to a grotesque racist diatribe from the same patient and the scene ends with Adam sewing up the patient's cesarean wound to ensure her tattoo is misaligned. When Adam casually dismisses a scolding from Tracy, it initially appears this white, middle class, male doctor will use a brand of macabre justice to resolve the racism and sexism his colleagues experience.

However, the series later questions such a framing when Adam comes under investigation and risks losing his medical license. Adam discovers that one of his colleagues has made the complaint against him and — panicking and paranoid — exclusively accuses two of his non-white colleagues of making it. Julian, another male doctor, is genuine in his concern for Adam despite the tone of the accusation. Adam proceeds to accuse Shruti, labelling her a "terrible doctor" the night before her exams. In the end it is Tracy who speaks boldly to Adam by explaining her reasons for lodging the complaint. As she lists a series of actions which have threatened the safety of patients and staff: disconnecting the alarms; taking personal phone calls during deliveries; sewing up the woman's tattoo deliberately to "assault" her; Tracy asks: "How can I trust you with my patients?" (Episode 5). The *my* of Tracy's question interrogates the authority we have uncritically afforded Adam throughout the series. Here it is Tracy who comes to embody the NHS's universal values — especially notable in that we have observed she is less

often afforded the institutional respect that Adam enjoys. A later scene echoes this realignment when Shruti overtakes Adam's muddled management of an emergency and demonstrates calm and knowledge to save a woman's life. In these scenes, it is Tracy and Shruti who are deployed to illustrate the sustained care provided within, and through, the limitations of the NHS. Indeed, as frequently as *TIGTH* questions the very capacity for the NHS to perform care well, a universal belief in care is sustained in the series mostly through representations of individual (particularly minoritised women) workers' passionate dedication to performing it.

Ahmed's (2004, 79) discussion of crisis discourses considers how the mobilisation of a crisis can work as a discursive move to preserve what is "ours". Indeed, while *TIGTH* maintains a suspense about the precarity of the NHS and the kind of care it can perform, this is coupled with the NHS being consistently loaded with good affective sentiments of love, dedication and passion — often through portrayals of minoritised women staff who keep the system afloat. Presented as something that all staff share in their desires to protect — Shruti's dismay at Adam's private hospital shifts, Tracy refusing to distinguish between her patients who racially assault her and those who do not — *TIGTH* mobilises a longer running belief and nostalgia for the NHS as "our" universal service, a belief which is shared by those whose labour ensures our care within it. The feminist stakes of such a positioning are significant, in that the series' uplifting moments rely on this confirmation of universality, while the responsibility to carry out such work (in the series and in life) is consistently demonstrated as feminised and racialised (Allen, Jenkins and Howard 2020). The final scene of the series sees Adam successfully delivering a baby in the hospital parking lot before his shift, committing to this vocation. "Thank you so much doctor" a grateful patient exclaims as Adam returns to his car to discover he has

received a parking ticket. Adam swears — bemused — before heading into work. As we zoom out across the ageing NHS trust to which Adam has dedicated his life, *TIGTH* ends on a note of optimism for these sustained forms of labour and care that will save *"*our*"* NHS and a reminder of why we should cherish (and fight for) it.

Universal Care — for whom?

However, I want to intervene in this optimistic conclusion by revisiting junior doctor Shruti's story across the series. Throughout the episodes, Adam frequently tells Shruti he had the same experience (and vulnerability) as her, often seeking to shore up the similarities between them ("Why did I think your father is a doctor [too]?"). Yet Shruti's treatment reflects institutional racisms, classisms and sexisms of which Adam has been unburdened and often an enabler. From a working class, South Asian background, Shruti studies and works exceptionally hard throughout the series. She sleeps in a single bed apartment while working extra shifts to cover her training hours. Her requests for support are regularly rebuffed by Adam and though Ms. Houghton speaks to solidarity as a fellow working-class woman, she later ignores Shruti's pleas for help by suggesting she may not be cut out for the job. Shruti faces racialised assumptions about her background, condescending lectures from colleagues and two explicitly racist or violent encounters with patients. Throughout the series, it is unclear whether her progression will be impacted by Adam's misdiagnosis in Episode 1 because she was shadowing the operation.

Shruti's experiences reflect continued research and findings about experiences of NHS work. Despite racially minoritised staff having been central to the workforce of the "imperially

resourced" (Fitzgerald et. al. 2020, 1161) NHS across its history — currently making up at least 21% of the NHS workforce (Otu et. al. 2020, 1) — racism and inequity in job experience, promotion and satisfaction have been consistently highlighted. The published evidence review by the NHS Race and Health Observatory found that staff from minority ethnic backgrounds are less likely to be shortlisted for jobs and more likely to experience abuse from patients (Dharmi Kapadia, Jingwen Zhang, Sarah Salway, James Nazroo, Andrew Booth , Nazmy Villarroel-Williams, Laia Bécares and Aneez Esmai 2022, 80). Black and minority ethnic nurses and midwives face excessive scrutiny compared to white counterparts (Pendleton 2017). For example, a study on progression development opportunities found that Black African nurses are less often invited for these or recognised for undertaking them (Likupe et. al. 2014). During the pandemic where infection rates were higher for particularly Black and Asian staff, unsafe working environments, inadequate access to PPE and a "greater negative effect of the pandemic on ethnic minority staff mental health" were found (Kapadia et. al. 2022, 86). Staff from minoritised backgrounds were overexposed to the virus in that they were more likely to be carrying out frontline work and unsupported when voicing concerns about this or other inequities (Jehanita Jesuthasan, Richard A. Powell, Victoria Burmester and Dasha Nicholls. 2021). The stakes of such were emphasised by the first 11 doctors who died from COVID-19 all being of Black, Asian or minority ethnic background, just as mortality rates in English hospitals were significantly higher for people of Black African, Pakistani and Black Caribbean backgrounds when compared to those among white British people (Otu et. al. 2020, 1).

Such inequities are reflected in Shruti's narrative. Particularly in Episode 6, Shruti appears to be a remarkable doctor. When a patient falls unconscious due to an ectopic pregnancy after hours,

Shruti literally breaks down a door to perform life-saving surgery (mirroring Adam's less successful attempt in Episode 1). Later, Adam arrives from a well-paid shift at a private hospital with an emergency delivery that clinic could not perform. He watches — ashamed but impressed — as Shruti saves the patient's life. But as Adam tells Shruti how "proud" he is, Shruti empties her locker and speaks vaguely of taking some leave. In the harrowing final moments of the episode, Shruti exits the hospital and for the first time breaks the fourth wall. She flatly apologises to us, the audience: "I'm sorry, I really did try". We understand the weight of her apology through the faces of her shocked parents as the police arrive at their door. As Tracy tearfully cries: "I don't know what she was thinking", it dawns on Adam that Shruti has taken her own life. Here, the stakes of the crisis are directly realised when an exhausted Shruti passes her exams, has a successful day of work, but decides it is not enough. Reflecting globally consistent findings of higher suicide rates amongst physicians (Bourne et. al. 2019) and seemingly responding to the discursive figuration of staff as at fault for the problems within the NHS, Shruti uses her final words to apologise to us — her potential patients — to promise us that she cared. In slowing down the scene of crisis to explore the multiple forms of vulnerability that are managed, sustained and exploited under the conditions of the NHS, *TIGTH* consistently shows the NHS is a place that staff do (and should) care about. But their (and our) investment in this caring is often presented as uneven, impossible and cruel: "Medicine's not good for me. It's ruined my life" (Adam, Episode 7). Across the episodes we celebrate the delivery of multiple babies and resolutions to medical emergencies as our optimism for the NHS is renewed. But in Episode 6, we realise at the same time as Adam that we were looking in the wrong direction. It is Shruti for whom this institution that we believed would care has failed.

In Episode 7, Adam is reeling from Shruti's death whilst senior staff work to quickly absolve the NHS of wrongdoing. Planting a small tree in the depressing car park, Ms. Houghton uses an impromptu eulogy to blame "other forces" for Shruti's suicide. Whilst we know that Ms. Houghton had previously rebuffed Shruti's attempts to get help, when Adam questions the morality of lying to Shruti's parents, Ms. Houghton stresses the importance of protecting the institution:

> This hospital has got about 3 doctors and a budget of £12.50. So, if you want to change it, become a government minister because there is bollocks all any of us here can do.

Moments later, Adam is advised by another consultant to tarnish Shruti's reputation in his professional hearing to save his own career. Adam imagines Shruti supporting his plans: "You treated me like shit while I was alive. What does one more time matter?". Adam ultimately rejects this advice and provides Shruti with a more fitting eulogy which recognises the structural problems at the heart of her death. Humbled and critical of the "broken system", in his statement to the board he chooses to emphasise the work of his late colleague in lieu of defending his own actions:

> Doctor Acharya has since taken her own life… The idea of carrying on working in a broken system under shoddy conditions, didn't feel like any kind of future... Doctors, nurses, midwives, pharmacists, physios. A million and a half of them. They don't do this for the money… they do it because they care.

And yet, through Adam's words, Shruti's story is incorporated into a statement about the universal struggle of all NHS workers — *they* do it because *they* care. Despite the gendered, racialised and classed particularities of Shruti's experience across the series, Adam ultimately absorbs Shruti's pain and vulnerability as his own. His union representative expresses cynical admiration for Adam's speech, and while we believe Adam feels regret over his treatment of Shruti, *his* expression of vulnerability (unlike Shruti's) strategically saves his own career. Learning from this experience, Adam appears to commit to being kinder to the new junior doctor as his friendship with Tracy is also tacitly repaired. And so, just as Ms. Houghton rationalises her lies given the hospital's burdens, any exploration or meaningful recognition of the particularities of Shruti's suffering is ultimately set aside by those who remain. In this, *TIGTH* incorporates Shruti's experience into a universal learning for all NHS staff as they continue to get on with the job under conditions of ordinary crisis.

Shruti's treatment — in life and in death — thus reflects a longer history of the NHS and its prioritised subjects of need. While frequently praised for their contribution to the NHS, migrant workers and the generations who have followed have less often benefited from its rewards. Thinking through the development of the NHS in relation to post-war migration to Britain and colonial imaginations, Bivins (2015) argues that the apparent universalism of the NHS was always based on regulating public health in the context of arriving racialised migrants from British colonies who were becoming settlers. From its beginning, the guarantees of universal healthcare were defined in relation to British citizenship, linking the myth of the NHS's origin to the anxious racialised imaginary and political economy of British colonialism (Fitzgerald et. al 2020; see also: Gurminder Bhambra 2022). While Bivins explores the cultural construction of

the NHS as a national object through the possessive of "ours" across its history, Williams argues that the extensive and sustained difficulties that racialised groups have faced in accessing and benefiting from the UK welfare state (including the NHS) is reflected in the "alternative welfare provisioning" histories such as Sickle Cell activism, the Black Housing Movement and faith-based care organisations which offer "a parallel story" (2012, 147) to such universality (see also: Yasmin Gunaratnam 2013). Thus, just as the pandemic continues to expose vast inequities in care, access and health outcomes in Britain, it is vital that the racialised and gendered regulation of entitlement and labour implicit within this public healthcare model be recognised as the "hidden particularities" (Ben Pitcher 2016, 47) which continue to structure access to it.

Thus, while I have argued that the NHS as a cared for, national institution is concluded as universally shared by the end of the series, a closer reading of Shruti and Tracy's treatment reveals this universality remains implicitly tied to unrecognised gendered and racialised exclusions. Moreover, it is the withdrawal of recognition for these differentiated and structurally enforced vulnerabilities that becomes central to the universal conclusion of the series. When Ms. Houghton absolves the NHS of its wrongdoing, or when Adam is advised to tarnish Shruti's legacy in service of his own career, saving *our* NHS is articulated as at odds with a just recognition — or even extension of care — for the more ambivalent and uneven realities which are lived out by staff like Shruti. Such an analysis reflects Bivins (2017) examination of visual representations of the NHS across its history, where racialised women staff often appear visually to represent the NHS egalitarian values and capacity for good care. Bivins concludes that while these representations "reinforced the normative vision of British culture as fundamentally free

from racial bias …despite considerable evidence to the contrary" (Bivins 2017, 109), racialised subjects have far less frequently been positioned as deserving of NHS care.

Conclusion

This article has drawn two conclusions about the politics of care within *TIGTH* and the NHS crisis discourse more broadly. Firstly, that the NHS is presented as itself an ordinarily vulnerable institution, where individual acts of resilience and courage are too easily presented as central to its saving in lieu of meaningful structural change. The good and hopeful feelings which surround the NHS in the series — as in the broader crisis discourse — rest on a promise of care which is sustained by the labour of its most undervalued staff. Secondly, while the NHS is universally loved by all in the series, this does not in itself challenge the exclusionary frameworks which structure this promise of care. Rather, saving the NHS in Episode 7 is presented as at odds with recognition of its structural and institutional realities. I have argued that it is this refusal of care and the unequally applied obligation to care that becomes evident in the series. That is, through the story of Shruti, whose depletion goes unnoticed and who is ultimately forgotten in the pursuit of saving the hospital; and the pragmatic midwife Tracy, who sustains her commitment to universalism despite the lack of recognition, frequent disrespect and personal compromises her work exposes her to. In this, I have argued that *TIGTH* reveals the individualised, gendered and racialised logics through which a mandate for universal care is maintained, as well as the limited extension of reciprocal care in times of ongoing crisis. Whilst sharing the hopefulness for public healthcare that *TIGTH* presents us with — or rather, a belief in forms of non-discriminatory, public care that the NHS could provide — my analysis suggests the need to take seriously the

uneven politics of care and vulnerability at the heart of this institution and to be cautious of a crisis discourse which will continue to exploit and elide it.

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