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Misogynoir in Medical Media: On Caster Semenya and R. Kelly

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Abstract
Misogynoir describes the co-constitutive, anti-Black, and misogynistic racism directed at Black women, particularly in visual and digital culture (Bailey, 2010). The term is a combination of misogyny, the hatred of women, and noir, which means black but also carries film and media connotations. It is the particular amalgamation of anti-Black racism and misogyny in popular media and culture that targets Black trans and cis women. Representational images contribute to negative societal perceptions about Black women, which can precipitate racist gendered violence that harms health and can even result in death. As philosopher Linda Alcoff asserts, racism depends on perceptible difference to determine which bodies are expendable, and in this cultural moment of Black hypervisibility, Black women are particularly vulnerable (Philosophy). I use two culture examples to explore the real life impact of misogynoir in medical media. I explore the ways in which the biomedical knowledge produced by physicians reinforces certain bodies as normal and others as pathological. The case of Caster Semenya as well as the trial of R&B star R. Kelly, allow me to introduce Black feminist health science studies as a critical intervention into current medical curriculum reform conversations.
Introduction

As philosopher Linda Alcoff (2005) asserts, racism depends on perceptible difference to determine which bodies are expendable—and in this cultural moment of Black hypervisibility, Black women are particularly vulnerable. I use two cultural examples to explore the real-life impact of misogynoir in medical media, particularly the ways in which the biomedical knowledge produced by physicians reinforces certain bodies as normal and others as pathological. The case of athlete Caster Semenya and the trial of R&B star R. Kelly allow me to introduce Black feminist health-science studies as a critical intervention into current medical curriculum-reform conversations.

The 2009 controversy surrounding world-class runner Caster Semenya illustrates the unique synergy between socially constructed biases and medically derived standards, which collude to pathologize some bodies more than others. By focusing on the misogynoir-istic representation of Semenya in global media, I highlight the importance of aesthetics in both medicine and social logics, a correlation that is rooted in the origins of medical education. The prosecution team in the R. Kelly trial tried to adapt the didactic medical medium of the Tanner Scale to prove the age of the girl in the video, raising important questions about how observation becomes science and science becomes medicine that can be evaluated in a court of law (Vineyard, 2004). I argue toward a theory of Black feminist health-science studies that builds on social-justice science focused and centered on the health and well-being of marginalized groups.

Misogynoir describes the co-constitutive, anti-Black, and misogynistic racism directed at Black women, particularly in visual and digital culture (Bailey, 2010). The term is a combination of misogyny, “the hatred of women,” and noir, which means “black” but also carries film and media connotations. It is the particular amalgamation of anti-Black racism and misogyny in popular media and culture that targets Black trans and cis women. Representational images contribute to negative societal perceptions about Black women, which can precipitate racist gendered
violence that harms health and can even result in death. I see racism and sexism as public health concerns that critically impact medical treatment and medical science, as they touch all aspects of our culture and society.

I discuss the misogynoir that animates these stories within popular media that rely on medical media to communicate to the lay public. In these examples we see deeply rooted biomedical beliefs that stem from, as well as inform, sociocultural ideas about the bodies of Black women and reveal medical practitioners’ anxieties, which raises lingering questions for me about our expectations of justice and the amelioration of health disparities for those multiply marginalized in our world.

**Caster’s case**

On August 19, 2009, South African runner Caster Semenya competed in the Track and Field World Championships and vaulted into the headlines with a world-record-breaking time in the women’s 800-meter race. Shortly after her win, Semenya went into hiding and was placed on suicide watch. Her genitalia, sexual organs, and hormone levels became the subject of global discussion, seemingly before she had been able to make sense of the speculations herself. Semenya, then eighteen, said a few days after the firestorm erupted that South African athletic officials “should have left me in my village at home” (BBC News, 2009). How did a record-breaking athlete at the height of her career become suicidal in the course of a few days?

Semenya is one of many women who find themselves and their bodies caught in the crux of what science says exists and what society says should be, with little regard for what actually is. Caster Semenya was exposed as intersex, a person with a so-called “disorder of sexual differentiation,” meaning her body does not fit neatly into sociomedical categories of male and female (Fausto-Sterling, 2000, p. 45). It is unclear whether Semenya was aware of her non-normative female anatomy before it was brought to global attention through the leaked results of a gender test by the International Association of Athletics Federations.
Semenya had completed the required gender test for female athletes in her home country, but protests from fellow competitors prompted the IAAF to investigate further. She consented to the additional testing, although she was not initially informed of its purpose. Her genitals were photographed and examined, her internal organs X-rayed. Genetic and chromosomal analysis were conducted all to determine if she was in fact a she, according to a multipronged medical rubric designed to identify “true” sex through a process misleadingly called “gender testing” (Hart, “Caster Semenya’s gender test results force IAAF to call in outside help,” 2009). In addition to the invasion of Semenya’s privacy, the test itself inspired headlines around the world, which proclaimed “She’s a he!” or the more dubious “Is she really a he?”—sparking a global media frenzy with expert and lay opinions on Semenya’s case (Hurst, 2009; Jacobson, 2009).

The amount of publicity Semenya’s story received, and is still generating seven years later at the 2016 Olympic Games, overwhelms any commensurate reporting on other women athletes’ stories in the past (Hurst, 2009). A database search reveals over a hundred times as many listings for Semenya as for any other female athlete whose sex has been called into question. After Semenya won a silver medal at the 2012 London Olympic Games, journalists speculated that she purposely avoided the gold because she did not want to deal with the glare of the spotlight, effectively bringing her into the center of a media storm they said she was trying to escape (Thomas, 2012). What makes her different?

There is something about Caster Semenya that makes for a good news story. The intersections of race, sex, and nationality all come to bear in the marketability of Semenya’s triumph-turned-tragedy in the global media. The specter of the Black woman’s body at the intersections of socially constructed and medically reinforced hierarchies of biological difference remains a trope in contemporary media and dates back to our earliest uses of mass communications. I explore the feedback loop between popular media representation and medical media to tease out the undergirding structures that support their interconnection and the impact
on Semenya. It is through biomedical discourse that societal norms are solidified and rendered objective science. By examining the misogynoir embedded in this biomedical rhetoric accompanying media that is used to disburse it, I hope to offer sites for intervention and transformation that challenge hegemonic perceptions of Black women.

Gender testing developed in relation to professional sports to ensure that no men could pretend to be women to win competitions, the assumption being that men would easily defeat women in any sport (Fausto-Sterling, 2000, p. 3). Since the first international testing began in 1966, no male (assigned at birth) person has been discovered pretending to be a woman. However, women with non-normative female anatomy have had their identities challenged and their lives altered. Many have lost their careers and endorsements, been barred from competition, and had their personal lives ripped apart when biomedical science reveals that they are “really” male.

Western science proposes a dichotomous and streamlined relationship between sex, gender, and, ultimately, sexuality. Gender testing relies on the prevailing biomedical logic, which acknowledges two discrete sexes in the human species: male and female (Fausto-Sterling, 2000). The bifurcation of human sex into male and female is a constant feature of medical texts. The sexes are differentiated by the chromosomes that inform their development, with an XX chromosomal pairing for females and XY for males. Chromosomes dictate certain patterns of maturation that manifest as secondary sex characteristics, such as breast tissue, muscle mass, and facial hair. These physiological features of sex difference affect behavioral patterns that are then socially codified as gender roles. The logic then follows that these two gender identities are what drive sexual attraction, so that heterosexuals are people who desire the “opposite” gender.

Feminist science studies theorists expose dominant sociocultural scripts in objective science. Biologists like Anne Fausto-Sterling have challenged the linear explanation of sex, gender, and sexuality by identifying the societal factors that inform the narratives that their
colleagues create. In *Sexing the Body: Gender Politics and the Construction of Sexuality* (2000, p. 48), Fausto-Sterling states that approximately one in two thousand children are born with genitalia that place them outside the normative boxes of male and female. In the United States, babies with ambiguous genitalia are routinely given corrective surgery that makes them physically appear more male or female, a practice that serves to obscure the prevalence of intersex individuals; such individuals have self-reported devastating effects on their lives. In some intersex cases, internal testes (testes that have not descended) are more prone to developing cancer. This is a fact that the Intersex Society of North America (2011) reports is overstated in medical literature; however, as it is used to coerce fearful parents into surgery for their infants. Additionally, infants with genitalia that do not meet or exceed average sizes for their respective sexes are subject to surgery. The operations maintain the socially accepted idea of two sexes at the expense of the biodiversity that exists within humanity.

Deborah Findlay (1995, p. 36) expounds on the social production of biological sex and explores the relatively recent assertion that there are two “opposite” sexes. These findings have been extremely useful in supporting the intersex and transgender movements, which are based on the lived experiences of people around the world who find themselves butting up against the medical establishment’s dichotomy and subsequently not receiving the kind of care they need or desire.

Ruth Bleier, one of the first self-named feminist scientists, offered harsh criticism of sociobiology, a field that asserts that many human behaviors have evolved and are tied to our genetic make-up (Bleier, 1986). Many such behaviors, which are claimed to be universal, simply mirror behavior patterns in the white Western world. Bleier also critiques the science involved in sociobiology, as it omits animal data that does not support its theories. For example, evidence of same-sex sexual activity or male nurturing in species is often obscured or minimized in scientific research to support homonormative and sexist beliefs about humans.

These interventions have remained largely ensconced within the
field of feminist science studies. The degree to which they have influenced biomedical science literature is unclear (Fausto-Sterling, 2000, p. 17). Not all scientists believe that these biases exist; some see these findings as individual cases of “bad science” evidence or shoddy work rather than culturally embedded beliefs emerging in research. The prevalence and pattern of these findings belie this belief, with marginalized categories of social identity corresponding with biomedical determinations of subordinate qualities.

Biomedicine’s use of terms like normal and average has the effect of marginalizing minority forms of embodiment so that bodily diversity is pathologized. Lennard Davis (2006, p. 1) posits that “normal” is a relatively new concept, borne of nineteenth-century state and industrial demands for universal citizens and workers. Normal transitioned from being understood in strictly statistical terms to becoming a way to think about the body itself. These discourses of the normal body travel from science to society, reinforcing medicalized knowledge that is already culturally produced. Because of societal investments in medical authority, the public does not critically interpret the medical media that carries these messages. I do not suggest that this trust is misplaced, but that it is largely unquestioned. Those who attempt inquiries are often dismissed because they do not have the credentialing that would lend their arguments support in this context of medical authority.

**Representations of gender and health: Who is fit to be consumed?**

After performing gender tests, lying about what it was doing, and then leaking the results, the governing body of the International Association of Athletic Federations revealed that it had not informed Semenya of its findings. The delay was particularly alarming after the leaked report employed the rhetoric of medical urgency to describe the apparent “risks” associated with Semenya’s “rare medical condition,” her health as a world-class athlete notwithstanding (Hunter, 2013). IAAF officials had already accepted the South African certification of her sex required for competition.
Her physical appearance, particularly in relation to her white competitors, and the significant amount of time she shaved off her personal best were the impetus for the re-test, which was explained to her as a drug test. This led to charges of racist and imperialist ideology by Athletics South Africa (ASA). Leonard Cheue, then president of ASA, remarked, “Who are white people to question the makeup of an African girl?…I say this is racism, pure and simple….It is outrageous for people from other countries to tell us ‘We want to take her to a laboratory because we don’t like her nose, or her figure’” (Smith, 2009). Cheue’s words speak to the ways in which our notions of health are enmeshed with beauty ideals.

A strip club in South Africa called Teazers created a billboard shortly following Semenya’s gender testing controversy (Fourle, 2009). Owner Lolly Jackson claimed that the club was not referencing Semenya when it created the advertisement, although Jackson gave Semenya 20,000 rand as a “gift” from the establishment, saying, “She gave me a lot of mileage.” The billboard reads “No need for Gender Testing!” as the owner wanted to assure the patrons of his establishment that the dancers are “100% women” (Fourle, 2009). It seems unlikely that this billboard is not referencing Semenya, since the phrase “gender testing” is only used within the context of professional sports and in the time frame with her name attached (Jacobson, 2009). Additionally, the establishment’s monetary overture to Semenya belies any innocence on the part of Jackson.

The woman in the billboard fits mainstream Western conceptions of feminine beauty. She is white with long, straight blonde hair and very noticeable curves. The photograph draws attention to her large breasts. She has no visible hair on her body and her skin is tanned and oiled. Her nails are manicured and she wears high heels that are visible in her prone position. Her eyebrows are arched and she has makeup on her face. The viewer is instructed to regard her body as the epitome of femininity—no gender testing needed. Onlookers are invited to use their sense of sight to validate her femininity.

The implicit comparison delegitimizes the Black female body
through a visual omission but a literal referent. Though we do not see Semenya’s body, the text of the ad calls forth her image, inviting viewers to assess the gender of the woman in the advertisement and Semenya’s visually, at the same time. Semenya’s womanhood is up for debate and, comparatively, is deemed insufficient. There is no question about the woman in the advertisement. What is advertised is visually affirmed as real, 100% woman, and authentic, while Semenya’s image, so far from the one projected, remains in question. The blonde model’s manicured and augmented body is feminine because it is desirable and attractive as articulated through white Western standards of beauty. Her body is fit for consumption.

Representations derived from Western aesthetic preferences of the female body are used to promote the spending of capital (Gilman, 1999, p. 326). The ad instructs viewers that the model’s body sells and implies that Semenya’s does not. Not only is Semenya’s body unfit for athletics, it is unfit for public consumption. In sharp contrast to the model, Semenya has features that have been publicly labeled masculine and unattractive. Her short, non-dyed, tightly curled hair; dark skin; and natural breasts are in stark opposition to the model’s long, blonde hair; tanned skin; and what are likely breast implants. It is precisely Semenya’s fitness and natural body that make her unfit for consumption. Her muscled physique is not the desired way women should look. Likewise, the model that completes the juxtaposition is labeled “100% woman” because of body modifications that make her desirable. Gender testing is invoked because Semenya is not performing femininity well. The biological basis of sex takes a backseat to gender standards that regulate our understanding of what is real.

Semenya’s appearance prompted the gender testing she endured and the public notoriety she experienced in popular media. Her physically fit body and athletic prowess were the source of medical speculation about her “health” and furthered media representations of athletic Black women as less than appropriately feminine. She was the victim of “surveillance medicine” that marked her as potentially ill because of social investment in
discrete sexes (Clark & Olesen, 1999, p. 22). Rather than seeing Semenya’s body as her own, she was implicitly and then explicitly measured by an unarticulated, though agreed upon, sociomedical standard.

Black women have long been portrayed as masculine and inappropriately feminine in popular media; athletes are popular targets for this negative attention because of their muscles and physical prowess (hooks, 1999, p. 21). Venus and Serena Williams, the Black US tennis champions, are frequent targets of such sentiments; it has often been speculated that they are too aggressive and too masculine to compete with other (read: white) competitors. Like Semenya, they are implicitly masculinized because of their skin color and physiological difference. In 2009, other coaches and players harassed Sarah Gronert, a white professional tennis player, because she was believed to be intersex. Calls were made for her to be removed from competition, but no such action occurred. “There is no girl who can hit serves like that, not even Venus Williams,” said the coach of one of her rivals, alluding to the super- or more-than-feminine attributes of Williams (Johnston, 2009). Gronert, though described as “beautiful” in more than one article, surpassed the limit of what was considered feminine. Despite being ranked lower than many other women, charges that her physical prowess surpasses that of a “normal” woman, thereby giving her an unfair advantage, were levied. Gronert’s difficulties, however, remained ensconced in the world of women’s tennis, never becoming an international news story like Semenya’s.

In an attempt to properly feminize the athlete, the South African magazine *You!* provided Semenya with a makeover that included doing her nails, curling her hair, applying makeup, and wearing more feminine attire. The result was heralded with its own incredulous headline: “Wow, Look at Caster Now!” (*You!,* 2009). Semenya’s outward make over was a cultural way to put her back into the appropriate box of femininity, something the IAAF offered to do medically.

The benevolently paternalistic concern of the IAAF regarding
Semenya’s health contrastingly painted the ASA as antagonistic and insensitive. Some newspapers suggested that ASA was responsible for the fiasco by not alerting the IAAF to Semenya’s condition in the first place. The IAAF’s own rules at the time allowed intersex and transsexual athletes who have been using hormones for two years to compete, troubling their own justification for gender-testing Semenya.

The IAAF announced in late November 2009 that it would not release the test results publicly, a decision that came after the South African Parliament expressed outrage regarding the invasion of Semenya’s privacy (Hart, 2009, September 8). The generally held rule of doctor-patient confidentiality had to be rearticulated, since it had already been violated by an international media firestorm (see Holloway, 2011, for more on issues of privacy and patient rights). A panel of doctors, including gynecologists, internists, endocrinologists, and sex specialists, reviewed Semenya’s case, and in December more information was leaked to the press. The IAAF had apparently agreed to pay for Semenya’s corrective surgery, should she fail the gender test (Hart, 2009, December 11).

While Black South Africans called out the racism, imperialism, and some of the sexism that swirled in the press, ableist language that indicated a certain distancing from female masculinity and a subtle heteronormativity was simultaneously present. The ASA defended Semenya against the racist gender standards that created the controversy by highlighting the ways her Blackness played a role in her coming to the world’s attention, but their arguments often relied on the same biological determinism that they were questioning. For example, the South African minister of sport remarked, “There’s no scientific evidence. You can’t say somebody’s child is not a girl. You denounce my child as a boy when she’s a girl? If you did that to my child, I’d shoot you” (Dixon, 2009). Another official suggested that Semenya was being depicted as a monster, which was the kind of thing that drives someone to suicide. In the minds of those trying to protect her, affirming Semenya’s femininity and womanhood was essential to her humanity, suggesting their own fear of the non-normative body.
The IAAF failed to acknowledge the social norms that drove its urgent and bold offer to pay for Semenya’s surgery. The warnings about the potential “risks” associated with her “condition” repositioned a socially constructed panic as a medical one. Despite its concern, the IAAF was unable to properly protect Semenya from a global media inquest that remains interested in uncovering her “true” sex. In 2012, Semenya competed in the London Summer Olympic Games and won a silver medal after she was cleared to compete (Epstein, 2012). She won gold in the 2016 Olympic Games in Rio de Janeiro, Brazil, but her participation caused a stir again, this time because she was allowed to compete without testosterone blockers. Fellow world-class runner Dutee Chand argued in court that it was unfair to block her naturally occurring levels of testosterone and won, creating a two-year suspension of blockers for female athletes (Samuel, 2016). Joanna Jozowik who came in 5th in the women’s 800 meter final in Rio said of her finish, “I'm glad I'm the first European, the second white…” commenting on the fact that the three medal winners were Black (Flanagan 2016). She went on to talk about how her body does not measure up to the size and unfeminine nature of the Black women runners, invoking all the misogynoir Semenya experienced in 2009.

Caster Semenya’s experience demonstrates on an international level the trouble with fixed scientific categories that are not representative of the lived reality of people’s bodies. How do we understand bodies as they exist, without pathologizing those that are different from a standard rendering of what we imagine a body should be? And how does a standard body come to exist in the first place?

“Age ain’t nothin’ but a number”: Lessons from the R. Kelly trial

On June 13, 2008, R&B artist R. Kelly was acquitted on fourteen charges of felony child pornography possession and soliciting a minor (Streitfeld, 2008). A video of Kelly and a thirteen-year-old Black girl engaged in a myriad of sexual activities surfaced on the Internet at the same time that
social workers were following leads regarding the illicit nature of their relationship. This prompted an official police investigation beginning in 2002. The jury’s reported reasoning for acquitting Kelly is what makes the salacious celebrity scandal of interest to Black feminist health-studies science: When interviewed, several jurors voiced doubt that the girl was a minor. The jurors claimed to have been in agreement that it was R. Kelly in the video, but could not agree that the girl in question was underage (ABC News, 2008). The girl would not testify, although friends and family identified her as the person in the video. Jurors thought the unidentified girl looked “too developed” to be thirteen.

The case against Kelly hinged on the jury’s ability to ascertain the age of the girl on tape visually. If she was of age, then a crime was not committed. But how does one visually assess someone’s age? What, in fact, does a thirteen-year-old Black girl look like? Rather, as was the question in this case, what should a thirteen-year-old Black girl look like? With stakes as high as thirty years of jail time, age becomes more than a number; it is the marker that determines guilt or innocence. The intersection of racial and gender stereotypes, as enacted through the perception of the body of a thirteen-year-old Black girl, raises important questions about how the medico-juridical system in this country utilizes didactic medical media. The models and figures within medical materials are produced for healthcare providers as examples of health and disease, and as representations of who they are in relation to their patients. I label these representations didactic medical media as they are created with the intent to educate healthcare professionals and students about health and disease.

Didactic medical media provides doctors with representations of bodily function and anatomy that assist them in assessing health, as well as in offering constructions of their own role and place in the medical interaction. The standardization of these figures is valued because it supports consistency across the practice of medicine. However, this modeling can elide the abnormal with the pathological, making structures in real people that do not fit textbook examples not only different but
aberrant. My research shows that “normal” is aggregated through some bodies and not others, creating a standard that does not include all who will be measured against the rubric. This elision contributes to the creation of disparate care for marginalized patient populations in a medical system that assumes a white standard of “health” and “normality.”

I look at the controversy surrounding Kelly to demonstrate how these precepts from the moment of standardization of medical education play out in our contemporary world. The girl at the center of Kelly’s trial is less important than the work her body does as medicalized media. In this context, her body is a tool for the prosecution to prove that she is underage. Despite fourteen witnesses’ testimony that the girl in the video was thirteen, the prosecution faced an uphill battle trying Kelly, a man with at least six other legal skirmishes connected to his relationships with underage girls (Associated Press, 2008). The prosecution procured a forensic physician to demonstrate to the jury that the girl in the videos with R. Kelly was thirteen. Dr. Sharon Cooper of the University of North Carolina used the Tanner Scale to show that the girl on the tape was in her early teens (Vineyard 2008, June 13). Developed by James Mourilyan Tanner (1962), the five stage Tanner scale marks different phases in human physical sexual maturation. Each phase or stage of development corresponds to an age. By examining the primary and secondary sex characteristics of the girl in the video, prosecutors hoped this “scientific evidence” would “prove” the girl was under the legal age of consent.

Tanner created the scale in the early 1960s through examining boys and girls of European and North American ancestry, i.e. white children (Tanner, 1962). In the 1970s he completed a project that estimated global averages of development, noting the significant variation in developmental physiology across regions, ethnicity, and even within group populations (Eveleth & Tanner, 1990). Despite this subsequent work, all current representations of the Tanner Scale in medical textbooks depict thin white bodies or use colorless sketches that reflect European facial features and hair characteristics.

Tanner gathered previously produced growth studies and traveled
across the world, measuring children on multiple continents. They grouped them into only three racial categories, Europeans, Africans, and Asians. Tanner’s research showed that growth varied significantly across regional, racial, and ethnic groups. In his 1990 book, *World-Wide Variation in Human Growth*, he writes:

There is no guarantee however that all populations have the same growth potential. There are certainly large differences between populations, in height, weight, the age of puberty for example, and at present it is not clear how much of them is due to heredity and how much is due to environment. (Eveleth & Tanner, 1990, p. 1)

The scale has not been modified to reflect Tanner’s own findings across racial categories, nor does it have the elasticity to work independently of knowing the child’s age. Key to the scale’s development and use within medicine is knowledge of the child’s age, which is how “normal” development can be assessed (Rosenbloom & Tanner, 1998). Children’s bodies are compared to the average lengths, size, and width of sex characteristics of the white children Tanner studied years ago. In this context, age may or may not be correlated with the “appropriate” level of maturation. By attempting to estimate chronologic age through observable sex characteristics, biomedical visualization is privileged over testimony by people in the girl’s life. The body of the girl in question is measured against a scale she may or may not exceed, an interesting choice for the prosecution given this possibility.

The Tanner Scale is an incorrect match for the facts of the R. Kelly case, as it fails to account for the potentially different development timelines of Black children. A 1997 study in the journal *Pediatrics*, found that 50% of Black girls in the United States were beginning puberty by age eight, compared to less than 15% of white girls (Herman-Giddens et al., 1997). Studies in 2002, 2011, and 2012 support these findings as well (Wu, Mendola, & Buck, 2002; Reagan et al., 2012; Dorn & Biro, 2011). Black children are discussed as developing primary and secondary sex characteristics earlier than their white counterparts. Because Tanner created the scale using the measurements of white European and North
American children, Black children are understood to develop sooner. If Black children were the implicit standard, then the reporting would reflect that white children mature later. The studies could, however, discuss the differences without attributing a value to the maturation. These semantic choices reflect subtle power differentials that invoke the social hierarchies of our lived realities.

Ultimately, Cooper’s expert testimony was deemed inadmissible. The presiding judge stated that the scale had no legal precedent and that the high-profile nature of the case made him reluctant to allow it as evidence (Singersroom.com, 2007). Tanner himself was opposed to his scale being utilized within the legal system. In a 1998 editorial in the Journal of Pediatrics, Tanner and his colleague wrote:

We wish to caution pediatricians and other physicians to refrain from providing “expert” testimony as to chronologic age based on Tanner staging, which was designed for estimating development or physiologic age for medical, educational, and sports purposes—in other words, identifying early and late maturers. The method is appropriate for this, provided chronologic age is known. It is not designed for estimating chronologic age and, therefore, not properly used for this purpose. (Rosenbloom & Tanner, 1998)

Tanner’s own words make it clear that the stages should not be used to surmise age, but rather to decide if a child of known age is maturing properly. Its appropriation for the R. Kelly trial and subsequent legal cases raise additional questions about medical media’s import in the lives of those accused and those victimized. When bodies are centered over the people who have them, questions of “health” and “harm” become unclear. The purpose of the Tanner scale is reimagined without consideration of its limitations.

Cooper’s attempt to use the scale had the unintended effect of overshadowing the identifications made by fourteen witnesses, including the girl’s friends, teachers, and family, who had already testified that she was the person in the video (Associated Press, 2008). An eyewitness is no longer enough in the current legal system, where the burden of proof is
escalated by the desire for seemingly objective scientific evidence. Crime-drama shows have increased jury expectations of forensic evidence, resulting in eyewitness testimony no longer being as convincing (read: entertaining) as medically corroborated evidence. The “CSI effect,” as it is known in the field, forces lawyers to push for forensic tests at the expense of less costly and more obviously subjective testimony (Schweitzer & Saks, 2006).

Tanner’s understanding of his work differs from how it is being appropriated in other contexts. I want to make clear that recognizing bodily diversity does not invalidate all uses of the scale in its original context, nor does it imply that there should be separate scales for different races. In a moment where medical and corporate interests are attuned to the need to address issues of disparate treatment of people in color, the pharmaceutical industry has responded with race-specific medicine. Drugs like BiDil, which has been approved to treat heart failure in African Americans, attempt to medicalize physical disparities that are actually aggravated by social inequities. Dorothy Roberts and Evelynn Hammonds work on the way that healthcare has turned to the market to attempt to ameliorate inequality, and identifies a significant moment in reevaluating how we mobilize social justice in the sciences (Roberts, 2008; Shields et al., 2005). I signal a need to rethink medical media that relies on standards and norms for bodies that disproportionately affect marginalized groups, and instead approach an ethic of care that focuses on people’s full selves and well-being.

Black feminist theory clearly articulates the power of the image to serve the hegemony of “white supremacist capitalist patriarchy” by controlling the way society views marginalized groups and how we view ourselves (hooks, 1989, p. 14). bell hooks discusses the importance of producing images that counter the normalizing force of stereotypes, but also exposes the danger of reactionary positive images that can also constrain and confine. We need complex images that break the good/bad, white/Black dichotomy. Similarly, Patricia Hill Collins (2005, p. 85) argues against “controlling images” that attempt to delimit the potential ways of
being for Black women in the world. Both scholars offer endless insight into this dilemma by also exposing the link between these images and real-world consequences for Black women and others. However, uncovering this link is not the same as demystifying its production. A crucial next step is grappling with the link’s formation in an effort to change outcomes.

Black feminist health-science studies is a way to engage the complexity of a situation like the R. Kelly trial and move conversations beyond guilt and innocence. Rather than addressing the performance of justice through our legal system’s appropriations of some scientific tools, I would like to move toward a social-justice science that understands the health and well-being of people to be its central purpose—which requires more arenas of rectification to be addressed. This formulation of Black feminist health-science studies, when focused on this trial, provides evidence of the co-constitutive nature of medical science and popular perception, underscoring the need to engage them simultaneously.

Social-justice science attempts to interrupt the linear progression of observations turned scientific facts that are then used in medicine to guide rubrics of health and normal body representation. It is important for medical students to encounter a critique of positivist science, particularly as it relates to the perceived objectivity of the Western medical establishment. This practice goes beyond the surface level correctives usually deployed in invocations of “culturally competent medicine” or calls to “diversify” the healthcare professions. Students must understand that simply adding race, sex, ability, and sexuality as categories of analysis does not necessarily penetrate the deeply seated ideological structures of Western medicine and culture. A radical—meaning “from the roots”—approach is needed. The ethnocentrism of their medical-school environment informs the ways students understand themselves as future doctors and how they see their patients. Medical-school instruction assumes a white patient and practitioner, prompting marginalized groups to seek to understand how these assumptions affect care outcomes.

Embedded within the R. Kelly trial is another tale, one of age-old
constructs of the hypersexual nature of Black women. When questioned about the case, local-news interviewees felt that the girl's active participation precluded all talk of a crime having been committed. Some blamed the victim, asking where her mother was and insinuating that her actions made her age irrelevant. They insisted that she did not look thirteen doing what she was doing in the video. In these comments, we see the simultaneous engendering of the girl in question as a child with an unfit Black mother and as a hypersexual Black woman grown enough to engage in “disgusting” behavior. The maturity of her body, coupled with the taboo nature of her sexual activities with Kelly, was channeled through stereotypes about Black women and obscured readings of her participation as coerced. Like Sarah Baartman experienced centuries before her, the girl's physiology was used to suggest something freakish about her sexuality (see Crais & Scully, 2011; Gilman, 1989; Tuvel, 2011; Willis, 2010). Her body was too developed to be that of someone thirteen and her actions were too explicit to be those of a minor. As cultural critic Mark Anthony Neal (2008) notes, by the time of the trial, that thirteen-year-old girl was now a mature nineteen-year-old, a feat accomplished by the defense’s brilliant six-year delay of the trial.

And what of R. Kelly himself? What does it mean that his reportedly inappropriate and consistent relationships with girls, the subject of repeated legal actions, remain unchallenged? His brushes with the legal system have not curtailed his behavior. In an infamous interview with music journalist Touré following the acquittal, when asked if he liked teenage girls, Kelly paused and asks for clarification, “When you say teenage, how old are we talking?” (Vineland, 2008, September 17). Kelly seemed oblivious to the problems with his actions.

What kind of social justice does the use of the Tanner Scale provide for the girls solicited by Kelly? What would a conviction have accomplished for them or for girls whom Kelly may solicit in the future? These questions suggest a need for a social-justice science that actually poses different questions and has different objects of study.

I am arguing for a social-justice science that informs medicine and
does not assume that healing exists solely or even primarily within the reconfiguration of the doctor-patient interaction. For Black mothers who negotiate violent environments, the doctor-patient interaction is several times removed from the types of interventions that would produce useful outcomes for them and their families (see Beth Richie’s discussion of the stereotype of the “immoral” Black mother in Clarke & Olesen, 1999, pp. 283-299; see also Mouton et al., 1997). Issues of access and time, as well as the erosion of faith in doctors to treat Black women patients fairly make the clinical encounter a low priority or something to be avoided altogether (Holmes, 1989, p. 1). Black women are also more than twice as likely to be murdered than their white counterparts, a health reality that demands more intersectional remedies than can be theorized or even executed by healthcare professionals alone (Ruzek, Olesen, & Clarke, 1997, p. 32).

A more collaborative effort between the biomedical sciences and humanities might lead to different sites of inquiry that are much more beneficial to the project of creating a socially just world. In R. Kelly’s case, we see that the threat of a punitive judiciary system is not an adequate deterrent to his behavior and has yet to produce any accountability for his actions other than financial compensation to a few survivors. A conversation among social-justice activists working to end the prison-industrial complex, social scientists studying the impact of imprisonment on communities, and psychologists who study the impact of child sexual abuse on survivors might result in a new accountability structure that supports the healing of both Kelly and the girl in question.

My vision for Black feminist health-science studies involves this more collaborative approach to addressing the questions of our day, as it draws from multiple bodies of knowledge and attempts to focus both the macro and micro sociocultural factors that inform our notions of justice. R. Kelly is rumored to be a survivor of childhood sexual abuse himself, raising additional questions about punitive state practices that do not address the reality that many abusers are survivors themselves (Neal, 2008). I hope that this newly formulated lens of feminist health-science
studies, when focused on this trial, provides evidence of the co-
constitutive nature of medical science and popular perception,
underscoring the need to engage them simultaneously.

Interventions that address misogynoir must operate on multiple
levels. This means not only working to change the behaviors of
biomedical practitioners in different arenas of our society but also looking
closely at the ways that bias and prejudice are institutionalized in their
institutions of professionalization. Essential to this work is intervening in
the culture of medical legal and scientific institutions that allow members of
the community to feel as though they are objective and removed from the
biases and prejudices that pervade our society, particularly in media. This
requires shifts in our cultural understandings of certain professionals as
automatically objective and requires examining the ways in which media
perpetuates the hierarchy of oppression even when people believe their
training makes them immune.

_Cultural competence, cultural proficiency, and cultural brokerage_
are all terms healthcare professionals use to describe the necessary skills,
sensitivity and knowledge to treat diverse patient populations (Betancourt
et al., 2003; Brannigan, 2012; Burchum, 2002; Koehn & Swick, 2006;
Kosoko-Lasaki, Cook, & O’Brien, 2009). This research pushes
contemporary conversations about how to ameliorate healthcare
disparities further by centering the cultural component of medical
education materialized in representational media. The system of meaning
that students share by virtue of their matriculation is an important but
largely underinterrogated aspect of the medical education process
(Wachtler & Troein, 2003). By examining the culture of medical education,
I identify the components of the hidden curriculum within medical
education that supersede contemporary cultural competence instruction. I
locate the sites within medical education that need to be more seriously
interrogated for a more efficacious addressing of disparities in care for
Black women.

I expose the limits of cultural competence as the primary strategy
for ameliorating health care disparities by recognizing the need to address
doctors’ identities in future solutions. For medical education to shift, more attention to the hidden curriculum embedded in the sociocultural aspects of education is needed. A few classes in culturally competent medicine are not enough to counter a deeply embedded ethos that is tied up in the very identities and anxiety-management practices of future physicians. Doctors need not only to see their patients differently but also to hear them. Listening to patients requires doctors to see their patients’ humanity as somehow connected to their own (Charon, 2006, pp. 99-103). Cultural humility, as opposed to cultural competence, is self-reflexive by definition. The power imbalance between doctors and patients is identified as a problem to be redressed (Tervalon & Murray-García, 1998). While some hierarchy is attendant to the education required to become a doctor, the way in which doctors negotiate it needs to change. Medical-school faculty members must be leaders in the cultural shift as they are the ones who subtly shape the way that medical students understand their role over time. By allowing time and space for the culture of medicine to shift, we make room for more compassionate providers who are better able to serve patient populations across a wide spectrum of diversity.

Like Black feminist theorists, whose written work often makes me feel like I’m dropping in on a continued conversation among friends, I imagine Black feminist health-science scholars talking with and across (as opposed to to or down) disciplinary divisions. My understanding of Black feminist health-science studies is that it creates the space for cooperative theorizing. Black feminist health-science studies incorporates epistemic frames outside the West, particularly African diasporic understandings of health, the body, and healing that explode the already faltering binaries endemic in Western thought. By centering health, my alteration of feminist science studies attempts to reframe the discussion by focusing on the interplay between medical media and the well-being of people, not primarily the theoretical investment in challenging Western scientific practices.

Medical imagery asserts a healthy body that is visually conveyed in medical training and subsequently influences doctor-patient interactions.
The power of these images affects multiple marginalized populations and shows the need for an intersectional analysis of the medical system. Medicine holds a venerable position in the American cultural imagination, such that a doctor’s treatment of certain bodies informs societal treatment of those bodies as well. This is not a unidirectional exchange; societal ideas also hold sway over doctors. In order to change how we think about bodies, we need to change the way we represent them, particularly in the educational spaces of those sectors of our society that purport to treat us at our most vulnerable moments.

A more nuanced and impassioned theoretical position is possible with the fusion of the multiple theoretical perspectives that inflect feminist health-science studies. I imagine a field of study acknowledging the need for a cooperative and symbiotic relationship between multiple scholastic locations, united with an expanded understanding of how the biomedical model informs notions of “health” in society. What if we drew on multiple epistemic frames in discourse of the body? What if we did not privilege Western dualisms? We might create a community of scholars attuned to issues on the global and local levels, with the collaborative strength to push for the changes they wish to see. An efficacious coming to the table around biomedical hegemony would serve as a model of the productivity that an interdisciplinary approach can bring to scholarship.

Notes

1 This was the second such test, as Semenya had already been tested in South Africa in order to compete.

2 R. Kelly had a relationship with his protégé, Aaliyah. She was fifteen when they began their relationship and were married. The union was dissolved, but Kelly wrote and produced all the tracks on her debut album, ominously titled *Age Ain’t Nothin’ But a Number*. See Neal, 2001, p. 16.

3 In Sander Gilman’s *Seeing the Insane* (2014), he begins with the
statement, “We do not see the world, rather we are taught by representations of the world about us to conceive of it in a culturally acceptable manner.” This idea of mediating seeing works together with the medical connotation of seeing to create possibilities for useful metaphors.

References


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**Bio**

**Dr. Moya Bailey** is an assistant professor in the Department of Cultures, Societies, and Global Studies and the program in Women's, Gender, and Sexuality Studies at Northeastern University. Her work focuses on Black women's use of digital media to promote social justice as acts of self-affirmation and health promotion. She is interested in how race, gender, and sexuality are represented in media and medicine. She currently curates the #transformDH Tumblr initiative in Digital Humanities (DH). She is a monthly sustainer of the Allied Media Conference, through which she is able to bridge her passion for social justice and her work in DH.