THE NOT-SO-TYPICAL PATIENT:

GYNECOLOGICAL TEACHING ASSOCIATES AND THE STRUGGLE TO QUEER MEDICINE

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CERTIFICATION OF APPROVAL

I certify that I have read The Not-So-Typical Patient: Gynecological Teaching Associates and the Struggle to Queer Medicine by Bex MacFife, and that in my opinion this work meets the criteria for approving a thesis submitted in partial fulfillment of the requirement for the degree Master of Arts in Sexuality Studies at San Francisco State University.

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Medical education is a site for the reproduction of social inequalities: without emphasis otherwise, healthcare students rely on a default cultural imaginary of a "typical" patient, "average" person, and "normal" concerns. Within that normative imaginary, the unanticipated patient becomes a special case, someone to be treated differently and likely to face discrimination. Gynecological Teaching Associates (GTAs) attempt to interrupt the reproduction of social inequalities as they teach pelvic and breast exams within healthcare schools. In this project, I interviewed GTAs—all of whom act as both instructors and models in their teaching practice, identify as queer, and bring to established feminist GTA practice a patient advocacy that insists on the inclusion of queer and other marginalized identities. Driven by their own queer experiences in conventional health care, participants incorporate routinely left-out patients by incorporating into their instruction examples of othered behaviors, identities, and bodies. As they challenge the categories and assumptions that pervade systems of medical education, GTAs engage in a form of social change activism and further efforts to queer medicine. However, even as the GTA job description affords opportunities for queer activism, it also restricts GTAs' queerness. I examine the neoliberal, self-advocating patient typography that GTAs may unintentionally emphasize and explore how queer activism might become more transformative in GTA teaching, medical education, patient-provider interactions, and other pedagogical settings.

I certify that the Abstract is a correct representation of the content of this thesis.

Chair, Thesis Committee

20 May 19
Date

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This project is dedicated to the educators of The Applied Practice Collective, past and present, who have built this purpose-driven community over years of collective emotional and physical labor. To my colleagues, friends, and accomplices, I am humbled by your willingness to share your brilliant ways with me and the world.

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INTRODUCTION

In our society the standard person, the blank person, the template person, is hetero[sexual], right? Cis[gendered], middle-class--presumed to be middle-class, presumed to be stably housed, presumed to not engage in sex work or kink practices, presumed to have really low sexual risk and presumed to be thin and able-bodied. And so, it's like, well, maybe our organization, especially because of the diversity of educators we have who don't fit that--and purposefully don't fit that--can reinforce the importance of knowing how to be flexible and adaptable and mindful about the things that occur outside of that blank person.

-Danielle, Gynecological Teaching Associate

In medical education, students encounter lessons that anticipate the patients they should expect to meet over the course of their careers. Without explicit description of that patient or the normative assumptions guiding visions of ordinary people's medical concerns, students readily rely on a default cultural imaginary of a "typical" patient, "average" person, and "normal" concerns. As Danielle describes in the epigraph above, the imagined "typical patient" easily comes to embody dominant understandings of "good sexuality" (Rubin, 1984). A heteronormative model easily prevails—one that extends beyond sexual preference to include sexual practice, gender identity, gender expression, gender roles, relationship style, size, ability, class, and race (Warner, 1991). This hegemonic cultural imaginary of a typical patient excludes many bodies, identities, and health behaviors, and these "othered" people come to seem irrelevant to medicine. Medical providers are unprepared to receive and care for stigmatized patients; health disparities are left unchallenged, if not exacerbated (Robertson, 2017).

In the following pages, I explore how some Gynecological Teaching Associates (GTAs) try to interrupt understandings of this default heteronormative

"typical" patient. GTAs are educators who teach pelvic and breast exams within healthcare schools by acting as both instructors and models (Kretzshmar, 1978). After addressing interpersonal aspects of the exam and patient interview and walking through the technical steps involved in an exam and interview, GTAs undress and invite students to practice those lessons on the GTAs' bodies and with the GTAs' guidance. Sessions are usually small, with three to five students per GTA, and last between two and four hours to allow for individualized feedback. GTAs have an unusual role in medical education: they are not themselves medical providers or faculty, and their expertise comes from embodied knowledge of their own anatomy and trainings by more experienced GTAs (Underman, 2011). Their dual role as educators and as exam recipients afford them a special position in medical pedagogy and special opportunities to discuss sensitive topics that may not otherwise be addressed.

My focus is educators working with the GTA organization, The Applied Practice Collective[1]. Driven by their own queer experiences in conventional health care, Applied Practice educators incorporate left-out populations by including examples of othered behaviors, identities, and bodies in their interactions with healthcare students. Applied Practice GTAs advocate for excluded populations, including lesbian, gay, bisexual, and transgender people, gender non-conforming (GNC) and non-binary people, sex workers, non-monogamous, kink-practicing, houseless, disabled, people of color, and post-menopausal people.

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[1] The Applied Practice Collective, and all GTA names, are pseudonyms assigned to protect confidentiality.

GTAs' challenge to the categories and assumptions that pervade systems of medical education constitute a form of social change activism and an effort to queer medicine. Though gender and sexual identities are central to Applied Practice's work, "queer" functions as more than an identity category in GTA work. "Queer" is also a verb in this context—a theoretical opposition to categories at large and a political orientation as much as a sexual one (Cohen, 1997). Expanding the category of typical gynecological patient—and of "woman" in general—allows space for more fluidity and movement in sexuality and gender. Queer, trans, and GNC patients may more obviously be relevant to a gynecology-specific training, but overlooked patients who could benefit from a queer re-examination of inclusivity in medicine extend beyond LBTQ+ acronyms to include other marginalized patients. As Cathy Cohen explains, "in addition to highlighting the instability of sexual categories and sexual subjects, queer activists also directly challenge the multiple practices and vehicles of power which render them invisible and at risk" (1997, p. 439). GTAs resist the power of the medical institution and its history of categorizing and marginalizing people like them. And, as I will demonstrate, they also concede some of their queerness to do so.

To queer medicine is to address real-life health disparities. Mounting evidence indicates that queer people face stigma in healthcare settings, resulting in stress, distrust of medicine, and poor health outcomes (Daniel and Butkus, 2015; Graham et al., 2011; Lambda Legal, 2010; U.S. Department of Health and Human Services, 2012). The 2011 National Transgender Discrimination Survey found that trans and gender non-conforming people postpone or avoid medical care due to discrimination, with 28% of respondents indicating that they delay care, 19% reporting having been

denied care, and 50% of respondents stating that they have had to teach their providers about their own healthcare needs (Grant et al., 2011). Hanssmann, Morrison, and Russian found that increasing provider awareness and education around trans and GNC etiquette and needs is instrumental to addressing issues specific to those demographics (2008). Women who have sex with women also receive unequal treatment in medicine. For example, the erroneous assumption that lesbian sex does not carry STI risk leads to lower testing rates (Bauer and Welles, 2001). Several professional associations have put forth reports about these LGBTQ+ health inequalities and guidelines for addressing them.

Medical education is a site for the reproduction of social inequalities. In an ethnographic study of allopathic (MD) medical schools, Marie Murphy found that heteronormativity, or the default presumption of heterosexuality and normative behavior, is pervasive: sexual minorities are largely absent in the limited sex education that medical students receive (2016). Juno Obedin-Malever and colleagues found that one third of medical schools include *no* clinical training for addressing lesbian, gay, or bisexual health needs and that overall, sexual minorities are addressed for a median of five hours over an MD's education (2011). With mixed results, LGBT-specific education often takes the form of cultural competency trainings, following a model originally designed to combat racial and ethnic health disparities (Betancourt, 2006). Trans-specific competency trainings can provide opportunities for trans-spectrum individuals to advocate for themselves and their communities; however, they may unintentionally tokenize marginalized people or give the attending medical providers the impression that they leave the trainings with an understanding of the entirety of

trans experiences—experiences that are in fact diverse (Hanssmann, Morrison, and Russian, 2008).

"Patient-centered care" offers a framework developed to improve patient experiences, and it is a touchstone of GTAs' inclusive practices. The goal of the patient-centered care movement is to focus on patient-provider communication and to engage patients in their own healthcare (Capko, 2014). The term and movement provides GTAs grounds on which to match their goals with those of the medical education system. "Patient-centered" becomes the means for bringing diverse patients into the conversation, allowing GTAs to further their medical authority and join a conversation that healthcare students are already having. By teaching healthcare students that anticipates and prioritizes a variety of patients with a variety of identities and behaviors, GTAs provide healthcare students them tools for patient-centered care.

Another primary goal in patient-centered care, however, is to manage—that is, reduce—healthcare costs. In the name of purportedly magnanimous economic priorities, neoliberal patient-centered care invokes a self-reliant, self-advocating, and empowered patient who wants to collaborate with medical providers (Elliott, 2014; Murphy, 2012). This patient has a long history. As Michelle Murphy argues, the regular pap smear was both a feminist advance and a means of medical surveillance, construing the (female) patient as a pre-diseased subject responsible for regularly availing themselves to the medical system (2012). Consistently, the neoliberal patient-figure assumes someone willing and able to collaborate with medical providers despite a structural difference in power and with real consequences for provider preparation. In a recent study, Joanna Brooks illustrates the challenges medical residents face when

they face real patients who would rather default to provider expertise and not participate in meaningful processes of informed consent and mutually decision making (2019). As they participate in the logic of patient-centered care, GTAs also risk reproducing the neoliberal model of the engaged patient who articulates their desires.[2]

It is an ironic risk to note, given that GTA advocacy emerged in the late sixties as a feminist intervention into medical education (Beckmann et al., 1988; Kapsalis, 1996; Underman, 2011, 2015). The Women's Health Movement emphasized women's experiences as patients and challenged doctors' gatekeeping of medical knowledge. Activists started independent women's health clinics run by trained laypeople, and in this context medical schools started collaborating with trained laypeople to teach pelvic examination skills to students (Kline, 2010). The roots of social justice persist in GTA work decades later; Kelly Underman found in recent interviews with GTAs that many consider their work to be a form of activism (2015). However, Underman also found that, in the Chicagoland area, the political nature of the work shifted somewhat to the benefit of the institution and away from its radical roots. For example, GTA sessions cater to the wellbeing of healthcare students (decreasing student anxiety becomes the priority) more than to the benefit of gynecological patients (not allowing GTAs to teach while menstruating defends students against the messy reality of natural biology but also leaves menstruating people with fewer prepared health care providers). Underman interviewed two trans-spectrum GTAs in

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[2] [2] However, the role-play patient interview scenarios some GTAs present may address the inevitability of patients who resist expectations of responsible intervention-seeking patients. Jordan, for instance, will sometimes "play someone who doesn't want STI testing and gets kind of pissed if they push it. 'Cause sometimes the students get really confused if someone declines testing and I want to kind of drive the point home that patients get to make their own decisions." These role-plays are not a focus of this paper but are the likely focus of other publications.

other locales, but within Chicagoland noted a "culture that emphasizes stricter (heterosexual) gender presentation" (2015, p.24). While this shows that gender identity of GTAs does vary across the country, no academic research has tracked GTA demographics or action around LGBTQ+ identities.

The queerness of Applied Practice's GTAs is unlike the unquestioned cisnormativity of Chicagoland GTAs. The educators interviewed for this project all identified as queer, and they bring to the established feminist GTA practice a patient advocacy that insists on the inclusion of queer and other marginalized identities. The GTA position itself queers gynecology as it challenges medical provider's authority over Assigned Female at Birth (AFAB) bodies and bypasses gender roles by semi-publicly uncovering "private" body parts. Queer GTAs further challenge the constraints of professionalism when they insist on bringing their (often visually) non-normative queer bodies to the (exam) table. Yet to maintain access to medical education institutions they need to maintain their invitation, and so they also in some ways assimilate. Ultimately, I find that these GTAs pursue a version of "institutional activism," as they work within the system (Santoro and McQuire, 1997). Rather than dismantling oppressive systems, GTAs make small changes within an existing structure. Their activism satisfies a job description penned by the medical education institution they resist. The GTA pelvic and breast instruction sessions they provide are fleeting moments in multi-year medical education; the potential for change-making is limited. Although they sometimes describe the political nature of their work as "sneaky," "under-the-radar," or "stealth," the GTAs of Applied Practice Collective do not—perhaps cannot—reach far beyond what medical schools ask them to accomplish.

Like diversity practitioners in higher education, GTAs risk becoming professionalized and co-opted by institutions and feeling skeptical about institutions' capacity and willingness to change (Kirton, Greene, and Dean 2007).

My analysis of GTAs' activist potential unfolds in six chapters. First, I track the GTAs' accounts of their own uncomfortable experiences in healthcare as queer patients—experiences that compel their GTA work. Second, I follow their impressions of the job as a site of change-making, focusing on their understandings of the GTA position as an opportunity to shift healthcare on behalf of marginalized populations. In Chapters 3, 4, and 5, I document the GTAs' strategies for including and integrating othered populations into gynecological exam training: by offering their non-normative bodies as representations of diverse patients, by arranging exam language to account for a wider variety of gender identities, and by pointing out and providing alternatives to default hegemonic assumptions about sexuality. In the sixth chapter, the Critique, I address the neoliberal, self-advocating patient typography that GTAs may unintentionally emphasize and point to the limits of their role: as the GTA job description provides opportunities for queer activism, it also restricts GTAs' queerness. In the conclusion, I point to future directions for research and praxis. Ultimately, I explore how queer activism can be more transformative in GTA teaching, medical education, patient-provider interactions, and other pedagogical settings.

STUDY DESIGN AND PROCEDURES

I conducted open-ended qualitative interviews with five GTAs actively working with The Applied Practice Collective (referred to simply as "Applied Practice"), a GTA organization based on the U.S. West Coast (Esterberg, 2002). I have been a GTA with Applied Practice for the last five years (active except for during the production of this thesis), and this personal connection eased my access to the group (Underman, 2015). Before data collection began, I spoke openly about my research with colleagues during on-site lunch breaks and received permission from the lead administrator to use the listserv for recruitment. I also sent individual emails to follow up about in-person expressions of interest in the months before research began.

I met with each educator in person and in a location of their choosing—homes, a conference room at an office building, or a coffee shop. The interviews began with an informed consent protocol and with my giving them a $10 gift card. Interviews lasted between 50 minutes and 2 hours, which I recorded using a video program and an audio app. The interview guide consisted of a six-question protocol that provided a guide from which the educators and I diverged as necessary to allow the educators' control over the interview (Kvale, 1996). Questions on the interview guide covered initial and current experiences as GTAs, their perceptions of the job and GTAs' role in medical education, and their strategies for addressing gender and sexuality while in GTA sessions. At the close of the interviews, educators completed a questionnaire in which they indicated their age, race/ethnicity, years of experience with the GTA group, other employment, highest level of education, sexual orientation, and gender identity.

I transcribed the interviews and removed non-relevant identifying information. Drawing on principles of grounded theory (Strauss and Corbin, 1998), I conducted open coding to note developing themes such as gender and sexuality lessons, impressions of the medical institution, professional performativity, and addressing student anxiety (Esterberg, 2002). I isolated and grouped interview segments using a word processing program, by cutting transcripts into thematic excerpts, and by rearranging them on the floor in an axial coding arrangement (Strauss and Corbin, 1998). Throughout data collection and analysis, I pursued an iterative process of writing field notes and notes-on-notes (Kleinman and Copp, 1993), generating analytic memos (Strauss and Corbin, 1998), and completing reflexive freewriting exercises (Luttrell, 2010).

Participants' median age was 32 years old. One respondent identified as Black, two as mixed race (Black and unspecified), and two as white. One educator had been working as a GTA for close to a decade, one had started within the last year, and the rest averaged four years in the position. Some had additional responsibilities within the organization: administrative leadership, curriculum development committee membership, and training staff were also represented in the sample. No respondents were employed in any one full-time position—not surprising considering the seasonal and often all-day nature of GTA work. All had at least two other jobs in healthcare, childcare, teaching, wellness, or the arts. Each respondent had attended at least some college, and two held graduate degrees. All five reported their sexual orientation as "queer," and often expanded on what that term meant to them in the interviews—there seemed to be a community element, as many spoke of queer friends, trans partners,

and queer as political orientation. Three identified as cisgender (not-trans) women, and two as genderqueer/non-binary. The words some chose to describe their gender identities—including "gender-mixed bearded woman" and "woman/femme"—reflect a gender fluidity and creative terminology shown to be common in millennial generations (Troia, 2019). The GTAs' pronouns varied and included "she and they" pronouns, exclusively "she" pronouns, and "he or she" pronouns. To protect confidentiality, and in accordance with the range of gender identities, I will be using the singular "they" pronoun when referring to every educator.

Like many others pursuing non-medical academic research on GTA work, I came to my interest in these educators through my own experiences working as a GTA (Hall, 2012; Kapsalis, 1996; Underman, 2015). I identify with the GTAs' experiences and their perspectives and consider myself a group insider (Islam, 2000). I knew every educator before the interview. While all GTA sessions occur solo, being colleagues means taking lunch breaks, sharing transportation, attending organization-wide meetings, and traveling together for distant contracts. I had also attended some social interactions with my colleagues outside of the professional setting: for example, studying together in coffee shops and celebrating birthdays. To ensure some critical distance during my critical analysis of GTAs' work, I ran thoughts past academic writing groups, and I ceased active employment during the duration of this project.

As with every educator I spoke to, I have had negative experiences in healthcare interactions due to my marginalized identities, and these experiences shape my work as a GTA. I describe my sexuality as queer (like each of the five educators I interviewed), and my gender identity is genderqueer/non-binary (like two of the

interviewees). Two years into the job, I stopped removing the dark hairs on my chin and upper lip. I did not plan to mention it during instructional sessions, sticking to the organization's policy of avoiding personal disclosure. However, not long after the first session I led after allowing my hair to grow, Applied Practice received a lengthy negative evaluation in which a student complained about the educator (that is, me) "not disclosing that she was on hormones." My first reaction to reading the evaluation was shame; I also feared I would be asked to shave if not severely reprimanded. To my surprise, however, the organization saw the evaluation as a call to incorporate body diversity into my curriculum.

I now address the presence of facial hair to my students and use it to discuss how to determine clinical relevance (What pathology could it suggest? What gender diversity or normal and healthy variation might it indicate?) and how to approach (ab)normal findings (if you determine the finding is relevant, ask directly and without judgment.) I do all of this without actually disclosing why there is hair on my face. This experience led me to wonder if my GTA colleagues experienced similar discomforts-turned-opportunities, how they approach their own identities in the context of this job, and how it all fits into healthcare, institutional dynamics, and sociology. That is, my experiences as a GTA are integral to my research questions as well as the collection and analysis of data in this study.

ADAPTING MEDICINE TO THE QUEER EXPERIENCE

Gynecological Teaching Associates highlight the space between medical providers and patients. They speak from the authority of people trained in science and

biology who can speak to medical practices. They know how such objective understanding translates to their own specific embodied experience, down to the location of their ovaries and the position of their uterus. They simulate exemplary patients in order to provide healthcare students with authentic embodied experiences, and yet once they become GTAs they are no longer actually a typical patient. As the educators of Applied Practice have queer lived experience, their medical knowledge veers queer, too. In the following breakdown I track their presence in this liminal space of both patient and provider, both limited and furthered by their positionalities, and both institutional insider and outside (Pettinicchio, 2012).

Chapter 1: Negative Personal Experiences in Healthcare

All of the educators I interviewed described moving from layperson—one who had experienced discomfort in medical settings—to GTA—someone invested in improving a system that had treated them poorly. Jordan describes uncomfortable encounters in gynecology as the driving force in their decision to pursue not only a position within the GTA group but also a career in healthcare: "So, I had some shitty experiences with gynecological care when I was younger and got it in my head that my life goal was to do some non-shitty gynecology." In response to these experiences, Jordan became determined to provide a better and more comfortable alternative.

Alex, who wears a beard and is a visibly gender non-conforming person, describes similarly troubling experiences. However, theirs occurred in obstetrics:

> Being a queer person who has given birth, and so, a queer person who has interacted with the women's medical health system in this intense and deep way--I don't just go for my once every three years pap smear, like . . . this health system has been a major part of my life, and I've had personal experiences of this health system being challenging.

GTAs' troubling experiences as patients constitute a significant component of their expertise. Pregnancy has increased the amount of time Alex has spent with the health system, and that means they have had more chances to be treated poorly: "It did take me a few tries... to find a doctor who would listen to me." Alex now emphasizes patient-centered care ("No, really, listen to your patients!") as their primary lesson for students. Alex considers gender part of the issue: "Women are largely overlooked and ignored and mistreated, let alone how folks who are not women get treated in women's health care scenarios. In general, or in how they don't access these systems because of how folks are getting treated." Alex includes a particularly dire consequence risk of queer inequality: trans and gender non-conforming folks do not seek medical care so as to avoid mistreatment. The educators' awareness of healthcare disparities is in line with research that show significant delays in seeking treatment (Grant et al., 2011). GTAs respond to the categorization that sweeps all people with vaginas into "women's health care" in several ways.

Each educator spoke both to individual and community-wide experiences with healthcare, and the "queer community" to which they refer includes fellow queer GTAs. In addition to referencing their own negative personal experiences as a patient, Carla conceptualizes how other GTAs share in the perception of problematic healthcare: "Many of us have our own backgrounds of not having patient-centered care. Because of our orientation because of our gender identity etc. —because of our

race." The educators' individual experiences with dissatisfactory healthcare contributes to a group ethos. They contribute their negative experiences to systemic issues and providers being unprepared to work with patients' identities—gender, sexuality, and intersections with race.[3]

Educators also describe ubiquitous negative healthcare encounters among their non-GTA peers. Danielle maps their own experiences onto accounts from and imaginings of wider patient communities:

> I've felt what it feels like to be either disrespected or dismissed. And I know that that can happen in a number of ways for so many people. I think about people in my community and the ways that they share [that] those [things] happen to them and I try to bring that into the sessions.

Danielle pivots from thinking about their own experience to those of their community and innumerable others. Danielle does not specify what exactly they mean by community; it could be gender and sexual nonconformists, racialized groups, economically disadvantaged people, or any other number of categories. The ambiguity serves to foreclose personal disclosure and leaves "community" subject to interpretation—much like the word "queer" itself. The quotation also represents the systems-wide thinking of many educators--while they may start with personal experiences, they frequently referenced how common negative experiences are in their communities and beyond. The GTA position becomes an opportunity to intervene, and Danielle assumes the task of representing and advocating for minoritized populations.

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[3] Consistent in the educators' accounts of their negative experiences in healthcare is a lack of specific detail, which I attribute in part to professional group norms (like the policy to avoid personal disclosure) extending into the interview settings. I did not inquire further, likely because I did not recognize the theoretical importance of pre-GTA experiences until my later analysis of the interviews. As a queer with my own negative experiences in medicine, I accepted discomfort as an ordinary part of healthcare. This could be one instance in which being an insider obscured a finding.

Chapter 2: Becoming GTA as Intervention

Educators' shared experiences of dissatisfaction in healthcare helped them come to see themselves as working together to, as Alex describes, "nudge the system in the right direction" and, as Jordan says, "reduc[e] shitty encounters for future patients." Carla describes first learning about an available GTA position over ten years ago:

> I had an interview, and then I was like, "This seems like it fits with my politics." I don't think I had had any really, really horrible pelvic exams at that time, but I had some that could have been better. And I definitely felt like I'd heard a lot of horror stories from my friends. So, I was like, "Oh yeah, this fits. I wanna make the world better for vagina-having folks at pelvic exams, and, using my body as an educational tool, y'know, that seems fine."

Carla highlights the political potential of the work before they describe the embodied physical nature of the work. Other queer GTAs noted similar priorities when they emphasized social change and social justice over pay and physical vulnerability. Carla notes a collective sense of social justice when they describe the group as a whole:

> We are… coming with this queer filter meaning that many of us have our own backgrounds of not having patient-centered care. Because of our orientation because of our gender identity etc.--because of our race--so that it changes how we understand what patient-centered means.

Carla lists orientation, gender identity, and race together as identities the GTAs have been marginalized for, and they credit those experiences with shaping their commitment to securing respect in healthcare. By putting race, orientation, and gender identity in the same category, Carla nods to an intersectional queerness. A common-

sense notion of "patient-centered" shifts to tend to othered identities, and queers become integral to the work of being a GTA.

Alex and Marie both considered dedicating themselves to healthcare careers in order to affect change in the field. Ultimately, however, both chose to pursue education and arts—alternative paths that allow for them to be available for GTA work. Alex recalls, "I've gone through a lot of 'Do I wanna be a doctor? Do I wanna be a midwife?' … I don't think I actually want to enter that system in that way, but I get to touch the system in this way." In the description of being close to but not entirely within the medical institution, Alex's statements resemble how some women in the feminist health movement described becoming licensed healthcare providers as going into the belly of the beast; the ambivalence early GTAs experienced around the politics of the job, of the tension between being invited to change a system and exploited by the system, persist in this population (Kline, 2010). GTAs simultaneously see themselves as separate from and part of the medical system, an ambivalence that allows them to maintain their activist opposition but still gain access.

Some educators describe GTA work as entering the system, but as interlocutors doing radical work "under the radar." Jordan describes how they think of Applied Practice as a group: "Sometimes I think of it as a bunch of radical queers who are doing stealth work in very conventional industries, like sneaking in and pushing a radical queer agenda. But gently, and in business drag." Jordan describes a gentleness to the ways GTAs anticipate students who are anxious about gynecological pelvic examinations. Through non-evaluative demeanors and subtle interventions, GTAs "gently" advance an agenda; they work within a system, in some ways complying with

its normative demands. By "business drag" Jordan is referring to the business casual, button down shirts and slacks dress code of the organization. In calling this compliance "business drag," Jordan emphasizes a queer positionality, as it is a derivative of drag performance—originally gay men dressing and performing as women. It is an ironic use of the term considering that in this case drag is being used as an acquiescence to professionalism where it is often framed as a subversive resistance, such as in Judith Butler's seminal book *Gender Trouble* (1999).

Jordan's description of healthcare and medical education as "very conventional industries" that they infiltrate suggests an ambivalent and adversarial relationship with those industries. Jordan foregrounds the political nature of GTA work when they describe that relationship:

> I wanna say something about activism. Like, it feels like harm reduction. [Be]cause I still think the medical system is shitty… I think there's a lot of damage done in those settings… So this work feels like reducing shitty encounters for future patients, like I'm making a shitty system a little bit less shitty for folks with vulvas.

Jordan uses the public health term "harm reduction" to describe their intervention into the medical system. In this scenario, it is the conventional medical system itself that actively perpetrates harm. Jordan pursues incremental change, "reducing" uncomfortable encounters and making the system "a little bit less shitty."

Carla discusses the indirect nature of the interventions: "I consider it political work in the sense of—we're talking way stealth. I'm hoping this lands in a way they're not really even conscious of." Carla's incantation of the interventions being "way stealth" not only, through military imagery, speaks to subversion within an inhospitable system but also nods to the queer use of *stealth* to describe "the non-

disclosure of one's trans identity," or passing unnoticed as cis-gender—and indeed some of the GTAs are not cisgendered (Edelman, 2009 p. 165). Some of the GTAs' political work is so "stealth" that it may "land in a way they're not really even conscious of." While this messaging may be more effective because of how pervasive and not in-your-face it is, it also may be so subtle as to pass unnoticed or not make a difference. Marie similarly describes her sense of institutional progress as "small and sometimes it feels like chipping at an iceberg with a toothpick." Institutional activism by GTAs is tempered by their sense of the institution as large and immovable, much like diversity practitioners who describe institutions as "brick walls" (Ahmed, 2012, p. 27). GTAs hope to change the institution, and despite uncertainty about the impact of their efforts, they proceed.

The GTAs' perception of potential effects of the work is informed by their experiences moving through the world and, in particular, medical institutions as queer people. They simultaneously acknowledge the limits of their roles and of teaching a short workshop in a years-long, notoriously dense medical education process and maintain hope for the possibilities of their work. Part of the potential is what they teach, and another part is who they are; as the next section elaborates, GTAs physically wear their queerness into the exam rooms.

Chapter 3: Representing Diverse Bodies

GTAs must enact strategies for establishing and maintaining professionalism and authority inside the professionalized and medicalized system they navigate in their pursuit of social change (Underman, 2015). Even as the educators of this project

concede the importance of professional standards (Jordan says that "I feel like the [students] treat me with more authority if I have the button[down shirt] on"), they simultaneously resist them. Non-traditional style choices and gender non-conforming bodies support the educators as they challenge the typical textbook image of a gynecological patient. By exposing people to a greater diversity of the human form and to some of the human variation they will encounter in practice, GTAs teach students to adapt when necessary. Some of the variation is imparted verbally; other times, the information is shared silently through the GTAs' embodied presence. As Alex explains, "I'm just there being like, 'Your patients might look like me. FYI: you might not have seen me before or people like me, but your patients might look like me and now you know.'" Alex, who wears a beard, recognizes that their bodily expression may not be expected in the medical education context—that the imaginary typical woman patient does not have facial hair—and considers their very presence a lesson for the students. Encountering a non-normative person in a position of relative power, someone with skills to teach them, provides students with an opportunity to question their expectations about who can teach them and who will need them to provide medical attention and care.

When Carla describes Applied Practice educators, they focus on unconventional hairstyles and body modifications:

> We still have folks [with] all kinds of crazy color[ed hair], and undercuts and many, many facial piercings, and I feel like that's fine. If we got to the point where it was like you couldn't have facial piercings or your hair had to be a color found in nature, I'd be like, "That's a little weird," but I do think it makes sense for us to look as professional as possible.

Carla deems the "crazy color[ed] hair and undercuts" "fine"—in other words, not too unprofessional. However, Carla also concedes that some modifications and ornamentations might fall into the category of unprofessional. Questions of where Carla and their colleagues draw the line between professional and unprofessional remain unresolved. Like clothing, about which the organization does have a policy, hairstyles and body modifications reflect a person's discretion and agency. Carla does not object to the requirements of "button-down shirts and not-denim pants," but, a call for educators to minimize or change hairstyles or body modifications would represent too great a demand for Carla.

As to an educator's body, body modifications and hairstyles are central to a queer politic (Pitts, 2000). Carla uses their body modifications as an example of how to incorporate bodily differences—and thus queerness—into the lesson. During breast examination trainings, Carla "use[s] my nipple piercings to talk about how you would palpate with a body mod." Carla points to piercings as a tool for learning a wider range of skills, not as unexpected or unacceptable. By incorporating them into the lesson without fanfare they are presented as a positive opportunity and not a negative obstacle to overcome.

Alex also describes the experience of inhabiting a non-normative body inside the medical setting. Alex elaborates their decision not to remove facial hair:

> One of the reasons I choose to actually wear my beard instead of having a hidden beard is, like—it's just a small daily activism, that it sort of levels it up when I'm doing it in, like, a particular setting where it really matters.

Alex explicitly connects practicing non-normative gender expression to activism. The presence of different kinds of bodies in medical contexts "really matters" because it

exposes students to and prepares them for a diversity of patients. Alex is "aware of all the systemic issues about like queer and gender variant folks in this [medical] system" and presents their own queer body as an unspoken challenge to medical expectations of what constitutes a normal and healthy "woman." By calling facial hair that has been removed a "hidden beard," Alex places the onus on those who adhere to gender norms by removing or "hiding" facial hair and not on those who do nothing but let it grow out. This approach normalizes the presence of facial hair on AFAB bodies as it also de-naturalizes the social pressure to erase it. In accordance with the job requirement to center future patients (not educators) and to avoid personal disclosure, Alex does not bring attention to the beard during the lesson. Alex claims students usually follow their lead and do not remark on it: "most of the time it does not come up." Through this omission Alex normalizes feminine facial hair and suggests its presence does not diminish their authority as a GTA.

When students do ask about the beard, Alex provides specific tips for addressing it. Like how Carla uses their nipple piercings to teach palpation skills, Alex uses their beard to teach respectful information-gathering:

> I do tell them in the interview [that] in general, phrases like "I'm noticing" and "I wonder" can be the sort of neutral introductions to say "I'm noticing that you have a beard on your face, I'm wondering if there's anything I should know about that" so that they've got at least a little bit of language to work with that could be useful for them in lots of things.

Alex recommends that the students, should they deem it necessary, ask about body differences directly and non-judgmentally. By offering phrases like "I'm noticing" and "I wonder," Alex is making the challenge of nonnormative bodies not simply one of facial hair or gender expression, but rather anything non-normative a medical provider

might want to address in session. The GTAs identify and teach a skill that is generalizable to other situations. Additionally, in using "I" statements, a provider emphasizes their own observation instead of pressuring the patient to defend themselves. By making open-ended statements, the provider avoids making assumptions about hormone use or pathology. All together, these approaches challenge assumptions that facial hair on gynecological patients are medical or interactive problems. A healthcare provider doesn't have to change their entire approach when someone with a beard shows up in an exam room.

By not addressing it unless the students ask, however, Alex risks the beard becoming an evaded lesson (Fields, 2008). Their approach implies that those who respect gender nonconformity also do not consider facial hair a medical issue; however, sometimes body hair *is* a sign of something worth investigating medically: Hirsutism, or "excess terminal hair growth on a female" could be due to hormonal imbalance like Polycystic Ovarian Syndrome, a tumor on a hormone-producing gland, or an intersex condition (Sornalingam & Cooper, 2014). GTAs strive to prevent the trope of a trans person seeking care for a sore throat who ends up answering irrelevant questions about their genitalia or receiving unnecessary pelvic exams (Lambda Legal, 2010). One risk of their aversion to pathologizing gender nonnormative people and bodies is that some educators may naturalize hirsutism.

Educators frequently describe Applied Practice as a diverse group—a characteristic reflected in my interviewees: three of the five educators identified as not (exclusively) white. Not all of these racialized differences are explicitly articulated in GTA sessions, and the silence about race—like Alex's silence about their beard—may

generate its own message. Alex describes the (unspoken) thought process behind representation: "I'm there being like, 'Your patients might look like me. FYI.'" While unspoken—and often unnamed in the interviews—people of color occupying the position of GTA challenge the whitewashed normativity of the imagined typical patient and of the typical professional expert. When describing the activism inherent in the work, Danielle, who has a leadership role within Applied Practice, explains that "as a person of color, as a queer. . . it is not unpolitical for someone like me to be in such an impactful and powerful position in the health care field." Race appears consistently through the presence of racialized bodies, not as stated lessons about racial inequality.[4]

The educators' bodies invoke features that are unexpected in gynecology, a field whose practitioners typically assume heteronormative and racialized presentations of "womanhood." In so doing, they push the boundaries not only of what gynecological patients might look like, but also of who can represent gynecological patients and who gets to teach exam skills to healthcare students. Whether they use those physical differences as educational tools or leave them unacknowledged, the GTAs normalize manifestations of difference in healthcare settings and provide students with opportunities to enact the inclusion of a range of people instead of one static typical patient.

Chapter 4: Arranging Language to Be More Inclusive

[4] Marie has innovated a way to bring in a critical conversation about race despite its ostensible topical irrelevance, which I discuss in the Critique.

The educators teach and model queer and trans awareness by adopting language that accounts for gender variance. In doing so, they represent a diversity of identities and behaviors doctors might encounter during gynecological care; the understanding of a typical patient thus expands. Inside GTAs' queer imaginings, the possibility that some gynecological patients will not identify as women becomes an inevitability.

Anticipating this inevitability, Applied Practice insists that all instructors use what they call "gender-neutral language" and thus model this communicative practice for their students. Danielle describes a recent title change and medical schools' response to this change:

> We don't call these sessions a "female pelvic exam training" anymore. . . It's something that often slips by unnoticed for the administrators or the faculty. And saying, "These are the reasons why, and we're making a move toward gender-neutral language and we will do this in our sessions as well; we encourage you to think about this too."

Instead of "female pelvic exams," the organization now refers to them as "pelvic exams"; the gender-laden word has been removed. The term has weathered the loss of the gendered specification; administrators and faculty do not seem to notice the omission. "Female" appears unnecessary to the phrase's function in the healthcare or instructional setting.

Just as "female pelvic exam" became "pelvic exam," the GTAs have shifted their talk in breast exam sessions to accommodate alternative gendered language. "One change that I got really excited about," Jordan explains, "is [on the] laminated sheets we use as a teaching outline: the breast exam is no longer a breast exam, it's a 'breast or chest exam.'" "Breast" is a gendered word; the more masculine term "chest"

anticipates and accommodates patients who prefer such terminology as well as patients who would describe themselves as having breasts. Alex explains how to implement the term in practice:

> You can follow your patient's particular language for what they use for parts of their body if they're using different terms, or like the breast/chest exam so I'll talk about, "It says here 'breast/chest,' if your patient's calling it 'breast' you call it 'breast,' if your patient is calling it 'chest' you call it 'chest.'"

Alex's counsel illustrates "patient-centered care" by encouraging providers to follow the patient's lead and highlighting alternative medical terminology and variations in patient preference.

Applied Practice has a policy of practicing gender-neutral language, and educators encourage students to get in the habit of practicing that language. Carla describes presenting gender-neutral language to her students when, early in the teaching session, they review guidelines with students:

> As part of my guidelines I say you know "I'm gonna be using gender-neutral language, I will be talking about patients, people with this anatomy, folks who have uteruses, folks who have cervixes, etc., etc. There's many reasons for that, only one of which is that everyone"—and I used to say—"everyone who has this anatomy does not identify as a woman." And now I say, "Everyone who has this anatomy is not a woman."

When Carla says everyone who has this anatomy "*is* not a woman" as opposed to "does not *identify* as a woman," they validate gender non-conforming identities not as a choice to identify a certain way, but a naturalized part of them. By acknowledging gender variation early at the session's outset, educators establish a foundation that they reinforce every time they adhere to those guidelines. Carla encourages students to be specific in who they're referring to. If a provider invokes "folks who have uteruses," Carla gives them permission to be specific in naming body parts and embodied

experiences; the focus on the body part itself allows providers to not even ask about the person's identity.

GTAs use a laminated outline that presents pre-packaged scripted phrases in italics, which indicates that the words have already been carefully and intentionally selected. Teaching comprehensive pelvic exams involves walking students through a patient interview, for instance, wherein they require the students read the words directly from the outline. Alex explains how all-gender language appears in the interview script:

> In the interview questions, I usually point out that the phrasing is specifically set up to include folks of all sexualities and orientations and behaviors. And I point out that questions like, you know, "Are you planning a pregnancy?" is replacing the question "Are you sexually active with men women or both?" There are a lot of assumptions built into the prior, or sort of the old versions of these questions. Sometimes students will ask follow-up questions, and then I'll get into specifics of, like, "This assumes that you know the male partner makes sperm. [What about] people with trans women partners who make sperm and how about if there are people who have other genders?"

The question, "Are you sexually active with men women or both?" improved upon the previous tendency to assume heteronormativity. Otherwise, the provider may have asked simply "are you sexually active" and then taken the answer of "yes" to mean the patient was in a monogamous heterosexual relationship with normative sexual behavior; or providers may have taken marital status listed on a history chart to reliably predict sexual preference or behavior. However, "Are you sexually active with men women or both?" remains problematic. The phrasing assumes, first, that "sexually active" is clearly defined and understood and, second, that determining the genders of sexual partners will provide meaningful and useful information about pregnancy and STI risk. Despite its clinical tone, "sexual activity" remains vague and

does not necessarily indicate what body parts or fluids go where--the primary concern for determining sexual health needs. As Alex points out, someone who has sex with women may still be at risk of pregnancy if their partner is trans or intersex and produces sperm. With the specific question, "Are you planning a pregnancy?" the provider elides assumptions that same-sex partners have no interest in having children. The construction "men, women, or both" affirms that there are only two genders and obscures non-binary or many-gendered people. By removing gender and asking a less socially-loaded and more clinical question, the GTA interview protocol makes room for gender and sexual diversity that includes—but also reaches beyond—the experiences of straight and cis patients.

All of these language arrangements encourage students to imagine and recognize several possible gender and sexuality arrangements. Instead of "gender-neutral language," which presumes gender can be removed and rendered neutral, I offer it as "all-gender language:" it opens the language to fit many more genders, making it in a way more (multi-)gendered than ever. Students do not have to guess or ask about a patient's gender because the wording is already set up to work for everyone. This approach is more inclusive than teaching feminized language as the default unless a patient comes along who clearly does not fit into the category of woman. When that happens, the unanticipated patient becomes a special case, someone to be treated differently and likely to face discrimination. Educators also give students permission to ask more specifically about clinical relevance as a way to avoid—or at least reduce—false equivalences about patients' identities and practices, hoping to result in future patients experiencing less stigma.

Chapter 5: Pointing to Assumptions about Sexuality

Educators intervene in the (hetero)normative assumptions healthcare providers and students make about gynecological patients. Within heteronormative framings, sexual activity is primarily presumed to mean conventional penis-in-vagina intercourse; couplings are presumed to be heterosexual, monogamous, and procreative; and gender is presumed to be binary and inextricably linked to biological sex (Schilt and Westbrook, 2009). By pointing to assumptions that may otherwise pass unnoticed, GTAs stretch possibilities for not just who a patient might be, but also what health-related behaviors they may pursue and what they might want and need from the encounter with a health care provider.

Queer people are marginalized in medicine when medical providers think only of heterosexuality and are unprepared to address non-heterosexual behavior. Several educators described experiences with this as patients and as GTAs. Jordan, for instance, recalls "clinical situations I'd been in where providers didn't know how to ask about the sex I'm having." Not knowing how to ask about or broach different kinds of sex places the onus on the patient to explain themselves, which some people are more comfortable doing than others and takes time away from more pressing healthcare needs. Danielle draws from similar experiences of ill-prepared providers when they explain that their emphasis on patient-centered care:

> stems honestly from some of my own experiences. Some of my own experiences with providers either being blatantly judgmental in commentary, or… having absolutely no helpful information that's relevant to my sexual practices. Or providers not being interested in figuring out the answer with me.

The concerns here include disrespect, lack of relevant knowledge, and the absence of humility. "Not being interested in figuring out the answer with me" stems from not taking either the question or the patient seriously. Danielle mirrors how their personal experiences reflect those that continue to riddle the healthcare student populations:

> So many times, students are just like "I've never thought about how to do harm reduction for a patient who has sex with other women. Never thought about it. And I have no ideas. I have no harm reduction things to offer because I think condoms and that's it."

Danielle points not to students either intentionally avoiding or overlooking sex practices to the point of simply not knowing. Ignorance regarding the health effects of lesbian sex may be in part due to the relatively low chances of STI transmission as compared to heterosexual sex (Bauer & Welles, 2001) and the (presumed) absence of unintentional pregnancy risk--or it could be due to phallocentrism. GTAs frequently note such gaps in medical education because of their experiences being on the other side of it.

While GTAs' status as laypeople limits their medical knowledge and role, they provide a container for thinking about how to interact with many kinds of patients. For example, Danielle uses the moment of confusion around a "patient who has sex with other women" to lead what they describe as

> a discussion of, "OK, how do we do harm reduction counseling for people of various sexualities or people with different practices?" And sometimes it's just reminding students that it's not necessarily about the patient's identity, it's just about what body parts are touching where, and what STIs are typically transmitted via those routes, and then how we can reduce the time or amount of exposure.

Such discussion rests on collaborative pedagogy. Danielle has adapted a framework to account for a variety of people instead of offering medical answers outside the GTAs'

purview. The GTA focus on body parts and not identity specifies that the counseling providers offer should be based only on clinical relevance. However, pursuing details about specific body parts and sexual acts may not be comfortable for all students, and being asked such questions may not be comfortable for all patients. Again, a limit of the queer GTA approach is that it presumes self-responsible and confident parties.

GTAs confront heteronormative assumptions of the nuclear family. Carla explains that "because someone says she's a lesbian doesn't mean we're gonna skip the question about pregnancy." Lesbians may be as interested in planning pregnancy or at risk of accidental pregnancy as straight women are. Alex, who has experienced childbirth as a queer person, goes into more detail:

> We can spend a little while on me explaining why lesbians might be interested in information about preventing or achieving pregnancy, and why, like, somebody not having sex is not the same as them not planning a pregnancy. . . "I should point out to you that, you know, sperm banks are a thing; non-sex pregnancy is a thing."

While penis-in-vagina sex is the most common way to achieve pregnancy, it is not the only method. Sperm banks may be separate from gynecological clinics, and at-home artificial insemination may occur in the home. Nevertheless, the process of pregnancy is medical in nature—if medical providers deem it important to inquire about some pregnancy, they should be aware of all the ways it may occur. The fact that someone identifies as a lesbian does not necessarily say everything about what kind of sex they are engaging in or what medical intervention they may need. By challenging the health implications of certain sexual orientations, the GTAs are challenging the clinical relevance of such categories more widely.

Heteronormativity presumes monogamous relationship structures that do not engage in BDSM and other non-normative practices. Jordan explores the influence of their own kinky identity by challenging the logic that bruising is a sure sign of intimate partner violence. Jordan explains how they incorporate it into the lessons:

> I bring up kink in most of my sessions just briefly. We talk about, like, what they might be looking for during a physical exam, and I bring up bruises—sometimes they bring up bruises before I get to it—and they say something like "signs of abuse" and I'm like, "Cool, let's talk about bruises. They might be a sign of abuse or they might be the sign of consensual sexual activity or the [patient] might have gone horseback riding. There are a lot of ways bodies can get marked. How might you address that?" And then they all kind of panic, and we talk through like how to ask if the patient knows where they got a mark and, like, how to interpret—like how to see embarrassment versus nervousness versus like, "You are going to learn to listen to your patient's words and also read their body language."

Jordan points out several possible explanations for bruising: abuse, which is often the students' first thought, the tamely worded "consensual sexual activity" (which is also vague, and may be why some of this conversation "passes over the students' heads"), and the non-sexual and mundane "horseback riding" example. Jordan encourages the students to directly address the bruises by exploring whether "the patient knows where they got a mark" instead of suspecting criminal activity. In combating some assumptions, though, other inferences come up—that students can accurately assess patients' body language or are willing to speak frankly about body markings.

These assumption-challenging lessons all come with similar solutions: instead of generalizing about identity, students can ask directly about what is clinically relevant. It simplifies the students' job, as it means medical providers are not expected to know everything about all populations. According to cultural competency trainings, a provider must anticipate cultural differences in order to adequately serve

marginalized populations (Betancourt, 2006). GTAs may portray the message that identity does not matter, or they may be saying that it matters so much as to not be worth guessing about or erroneously bringing up. In either case they are preparing students to think outside of the heteronormative box.

CRITIQUE: Queer Limitations

As queer as the GTAs' ambitions may be, their activism is limited by their location in and relationship to medical education. Healthcare frameworks and institutional regulations restrict the radical potential of sexuality and gender inclusion, and in doing so they prove an unwelcoming audience for the most fulsome implications of the educators' queerness. The GTAs' integration and inclusion of queerness has an unintended consequence—the production of a new typical patient imaginary—and in that outcome may lie a new normative.

The GTAs bring queer perspectives, but professional norms prevent them from being out to their students or discussing their (personal) queer experiences. "You can't share personal stories," Marie explains, "like, I can't tell my students 'I had this amazing experience where people that this organization trained were part of a care team for my trans partner, and it was like really life changing for both of us.'" Marie's personal account, though potentially humanizing, would violate Applied Practice's policy against personal disclosure. This restriction supports the GTAs' task of representing and teaching skills that are translatable to a variety of possible patients; as, Marie puts it "you're trying to be the every-patient." Speaking to their own experiences would contradict that premise. While the invitation to advocate and stand

in for wide range of patients affords GTAs space to include queerness, it also stops them from being explicit in that goal, so in some ways compromises their queerness. GTAs are limited in how queer they can be because they must also represent heteronormative women. To navigate these obstacles, GTAs see themselves as subtly subversive and working under the radar. Maybe students can tell they are queer without a coming out moment, maybe not—the ambiguity is both powerful and limiting.

As the GTAs resist some categorizations, they unintentionally reproduce other categories. They may avoid the heteronormative defaults of a typical patient through their deployment of the strategies I outline above. However, through their enactment of the exemplary patient as one characterized by self-advocacy and self-awareness, they also affirm a neoliberal idea of a "good" typical patient (Murphy, 2012). GTAs advocate for themselves during instructional sessions: the practice is a requirement for the job, if they are to ensure the students do not physically hurt them. They also portray patients consistently and thoughtfully engaged with their healthcare. As GTAs challenge students to replace the question "Are you sexually active with men, women, or both?" with more specific inquiries about what kinds of sex the patients are engaging in (to determine STI and pregnancy risk and help coach a patient through decisions), they prepare students for patients who will be willing to share explicit sexual details with providers. By offering the question "Would you like an STI test today?" GTAs prepare students for either patients who are already educated about STIs and know whether they want to be screened or not, or patients who are willing to ask for counseling.

The GTAs may also—albeit unintentionally—create a queer patient paradigm. Just as trans competency trainings risk creating a superficial sense of what trans-ness is, so too might the queer GTAs be depicting their kind of queer as the only kind of queer (Hanssmann, 2012). The queer GTAs benefit from collaborating with similarly non-normative educators. Jordan depicted Applied Practice as "a bunch of radical queers"; Marie described Applied Practice as having "a great demographic… with a lot of queers"; and Carla called it "very queer on the GTA front." When everyone expresses non-normativity, non-normativity may itself become a norm. As techniques for queer inclusivity circulate between educators, so too might a similar, co-constructed depiction of queerness. In the effort to resist a *heteronormative* typical patient, they may unintentionally create a *queer* typical patient—one who has facial piercings, is sensitive to pronoun use and aware of systemic oppression, is young and educated, who can address unorthodox or kinky sexual activity, and who performs the neoliberal responsibility of actively seeking STI testing, pregnancy or birth control resources, and regular pap smear check-ups.

Medical categorizations are also limiting. GTAs can only do so much to minimize gendered language considering their location in gynecology: the subfield is predicated on a separation of sexes that presumes binary anatomy. Feminine gender connotations permeate even supposedly objective biological words like "cervix" or "uterus." By referring to AFAB patients as "people with uteruses," the language may accommodate more gender identities, but it also erases some intersex people or people who have had hysterectomies. Not all patients may welcome such a medicalized framing; "people with uteruses" may seem awkward to a patient who is used to

hearing "woman," and it also risks reducing a whole person to a body part--what the women's health movement was trying to alleviate by referring to the field as "women's health" (Kline, 2010). While "people with uteruses" is meant to more fully reflect a variety of gender identities, it shifts the focus away from a patient's wholeness and toward a body part tied to reproduction and motherhood or what medicine has historically considered the entirety of a woman's purpose—what the women's health movement was trying to counter.

The GTAs expand (and queer) categories to accommodate more differences, and yet they cannot truly be every patient. In order to work in medical institutions, GTAs must have enough intellectual and social capital to communicate in medicalized language and maintain authority in hierarchical spaces. They must show enough self-advocacy, awareness, regulation, and confidence to teach, which sets them up to embody that neoliberal model of a "good patient." They must have baseline normal and healthy reproductive anatomy, so could be not intersex, have had a hysterectomy or have conditions that greatly affect reproductive organs; this also means that while they can show gender variation, there are limits to whether a GTA can have medically transitioned. Additionally, post-menopausal people may find multiple pelvic exams in a day physiologically challenging. As Carla states, "I don't know if this is my last year, y'know 'cause I'm getting older, I'm in perimenopause; the skin down there gets thinner." This may foreclose older GTAs from participating or prevent GTAs from continuing to work as they age. The absence of older GTAs may contribute to ageism the first time a student does come across an aging or elderly patient. While they may represent queerness through their bodies and advocate for gender and sexual

minorities, there are many more marginalized populations GTAs are not bringing into the conversation.

Queer pursuits of social change are fundamentally dynamic; their strength lies in a constant practice of critique and hope (Muñoz 2009). Perhaps, then, the queer potential of GTAs' efforts lies in a persistent vigilance about their mission and an impatience with their limitations. Marie models this when they describe their efforts to account for those bodies queered by race (Cohen 1997). Though there is little room reserved in GTA trainings for explicit conversations about race, Marie inserts race under the heading of medical ethics:

> I also talk a little bit about medical ethics although it's outside of the scope of the class. Why a particular demographics of people might have more a lineage of cultural trauma regarding this particular exam and then I often refer for them to read *Medical Apartheid* by Harriet Washington [(2006)].

By pointing out that they are going "outside the scope of the class," Marie emphasizes the class's borders. Though they and other GTAs are limited by time constraints and have institutional pressure to teach only about gender and sexuality-related diversity, they can also claim time to address race as it intersects with gynecology and sexual health.

The book recommendation goes beyond the constraints of immediate relevancy. In addition to addressing the racialized roots of gynecology as a medical field, Harriett Washington draws attention to the recent medical abuse of an entire population and the mistrust that remains. By drawing attention to Black people's critique of and resistance to the medical institution, *Medical Apartheid* highlights for readers not only the racialized dynamics that infiltrate a pelvic exam, but also the presence of politicized patients who avail themselves of pelvic exams and resist

conventional medical authority. Through their bodily presence, knowledge, advocacy, and book recommendations, GTAs recognize the longstanding history of abuse in health care and, simultaneously, insist that a queer interruption is possible.

GTAs must conform to the medical systems they work in even as they resist, challenge, and subvert them (Ahmed, 2012). Despite frustrations with the medical system at large, the GTAs express overall high work satisfaction. A sense of community with fellow GTAs and a feeling of being on the same side of a fight to address inequality contribute to the meaning they derive from the job: Marie calls it "the most social justice-forward work I've ever done," and Carla attests that "I love my job. I feel like we're part of doing something that's changing the face of medicine, slowly but surely." The subversive act of advocating for themselves and their communities in a system that has mistreated them contributes to the meaning they derive from the job, and they persist through the pushback of the institution.

CONCLUSION

GTAs take the opportunity of instructing healthcare students to queer the typical imaginary patient, expand categories to account for a larger diversity of possible patients, and ultimately represent themselves, their communities, and other marginalized people. The potential to effect change is significant and sustained. However, GTAs' queerness, and therefore their queer activism, is limited by the institution they participate in.

When asked if they think they are making a difference in medicine, Jordan declares "I hope that I am; I don't know that I am." Accordingly, as queer inclusion in

the GTA session has not yet been explored, the impact on healthcare students has also not been measured. Researching students' learning outcomes may be challenging due to variability between educators, but doing so may reveal the large-scale potential of queer GTAs as an intervention of inequality. As opposed to competency trainings, the fact that GTAs are first hired to teach breast and pelvic exams and secondarily include queer activism may lead to more integrated and effective outcomes that minimally tokenize already marginalized people. Having queers in positions of authority where they can provide practical advice, immediately invite students to apply what they learn, and provide individual feedback could be an instrumental step in preparing providers to encounter queerness. Additionally, the GTA position is already established and has been in motion for fifty years—what if it could be mobilized to do more and re-politicized to improve healthcare for queers just as it was once politicized to improve healthcare for women?

The queering techniques outlined in this paper may be easily taken up by other GTA programs across the country (if they are not already in play) and yet there may be structural limits to its generalizability. In contrast to many GTA programs, the Applied Practice Collective is an independent organization that participates in a contractual relationship with the medical establishment; others are designed by and through the health sciences schools themselves, so may be more beholden to the restrictions of large bureaucratic institutions. A combination of this autonomy, along with a decades-long reputation and their liberal-reputation west coast setting, may allow GTA activism around non-normativity to occur as much as it does.

By becoming professionals and entering the medical institution that has oppressed them, the Gynecological Teaching Associates of The Applied Practice Collective are advocating for themselves, their communities, and other people queered by marginalization. Their practices of including and integrating queerness into a heteronormative system provides a model for how categories can be expanded and challenged in order to accommodate more people. More than that, though, they are questioning whether categories are necessary at all for providing good health care, and they are combating medicine's role in pathologizing non-normativity. Gynecological education as a cite of queerness can complement LGBTQ+ competency trainings and address health disparities; having queer and trans people in the institution at many levels and in several roles shows the range of experience and expression and can mitigate the risk of oversimplifying the identities. I encourage GTAs to locate all the places social justice can play a role in the exam room, and to notice when emphasizing one way of being obscures other ways of being. I encourage medical education institutions to see queers and their perspectives as essential to an ecosystem of diversity, progress, and equity—some things can only be brought into view through the agency and experience of non-normative individuals.

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