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“Okay so remember, this is a drape – not a sheet”: A critical autoethnography of (per)forming the practice(d) body of a Gynecological Teaching Associate

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Health and Rehabilitation Sciences

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“OKAY SO REMEMBER, THIS IS A *DRAPE* – NOT A SHEET”: A CRITICAL
AUTOETHNOGRAPHY OF (PER)FORMING THE PRACTICE(D) BODY OF A
GYNECOLOGICAL TEACHING ASSOCIATE

Spine title:

(“Okay so remember, this is a *drape* – not a sheet”)

(Thesis format: Monograph)

by

Jodi C. Hall

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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**“Okay so remember, this is a *drape* – not a sheet”: A critical autoethnography of
(per)forming the practice(d) body of a Gynecological Teaching Associate**

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requirements for the degree of
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Abstract

In this autoethnographic study, I utilized my past experiences as a Gynecological Teaching Associate (GTA), along with data collected within a particular pelvic teaching module, to critically explore the ‘silences’ and taken-for-granted assumptions embedded within the performances of pelvic teaching. Theoretically informed by (post)critical feminist theories, I considered how the ‘culture’ of pelvic teaching, as enacted within this specific setting, simultaneously (re)produced and resisted particular normative discourses about women, and how the performances of GTAs, medical students and program administrators were reflective of larger social-political and biomedical discourses. Data collection methods included participant observation, field notes, reflexive journaling, and individual interviews with GTAs, students and administrators. A focus group with GTAs was also conducted wherein my own storied reflections as a former GTA were shared to create points of connection and departure, providing us with a unique starting point to explore the varied experiences of GTAs, and to re-visit the meanings I had made out of my own performances as a GTA. I utilized thematic analysis informed by the “multiple lens” approach developed by McCormack (2000) to interpret participants’ data. Interpretation of research findings demonstrate how GTAs (re)performing the practice(d) body reified normative discourse about women, particularly by focusing on how to (not) talk the body, and acceptable ways to ‘be’ the/a body. GTAs were motivated to perform their roles due to a myriad of, at times, competing interests – complicating their ‘willingness’ to depart from the script when faced with disconcerting situations. While GTAs framed their work as fundamentally self-affirming, their sense of ‘self’ in this

context was interwoven with assisting students to achieve their goals, and their desire to improve examination experiences for women in the broader community. However, by placing ‘lay’ people in the position of instructor and ‘knower’, the GTA performance potentially destabilized biomedical practices. The multiple roles that GTAs (re)performed are particularly relevant for programs utilizing GTAs. Additionally, interpretations offer significant considerations for pedagogical practices and curriculum development in medical education more generally by taking into account how normative discourses related to gender inform the assumptions underpinning performances enacted within teaching spaces.

Keywords: Gynecological Teaching Associates, pelvic examination teaching, clinical skills, medical curriculum, normative discourse, autoethnography

Implicit in the role of the [gynecology teaching associate] is a fundamental contradiction. On the one hand, she is an educator, more knowledgeable than medical students about pelvic and breast exams although she holds no medical degree. . . . On the other hand, the [gynecology teaching associate] is bound to a traditionally vulnerable and powerless lithotomy position: lying on her back, heels in footrests.

- Terri Kapsalis, *Public privates: Performing gynecology from both ends of the speculum*, 1997, p.76

The view that gender is performative sought to show that what we take to be an internal essence of gender is manufactured through a sustained set of acts, posited through the gendered stylization of the body.

- Judith Butler, *Gender trouble*, 1990, p.xv

Dedication

This thesis is dedicated to my mom and dad, whose profound and tireless support of all endeavors, academic or otherwise, has made all that I have accomplished, possible. Mom, you wished for years that I would dance a solo to “Wind beneath my wings”; however, that dream was never realized. So mom and dad, *this* ‘dance’ is for you,

It might have appeared to go unnoticed,

but I've got it all here in my heart.

I want you to know I know the truth, of course I know it.

I would be nothing without you.

Did you ever know that you're my hero?

You're everything I wish I could be.

I could fly higher than an eagle,

'cause you are the wind beneath my wings.

- Bette Midler, “Wind beneath my wings”

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brilliant, giving, and always-present presence, your commitment to helping me reach this particular ending, will never be forgotten.

I would like to thank my children who have reminded me time and again, that the most important and joyous experiences in life will likely not make it onto the pages of my curriculum vitae. Malcolm, ‘your silly git’ lights my world, Malik your hugs sustain me, and Maya your capacity for effortlessly navigating any space with self-assuredness inspires me. I wish to thank my dearest friends Amanda Saunders and Nanette Bowen-Smith who each contribute to my life in indescribable ways. Thank you to Trevor Hinds for your enduring support, pushing me to apply to graduate school – believing that it was indeed possible. To Chris Wall, my partner, personal computer technician and ‘home base’, I am deeply appreciative of your patience, support, and yes, even your sense of humour. Jacob and Michael Wall, you have helped me become a better person, and I am grateful for the life lessons you have taught me. Darlene Durand and Amber Sipila, my childcare providers, you mothered my children as your own, and I will be forever indebted to you both for the care you provided. Lastly, I would like to thank the various research participants who shared their time, their space, and their stories with me. I am particularly grateful to the GTAs. Together, you astounded and inspired me daily with your collective capacity and willingness to work toward better pelvic examination experiences for women by putting your ‘selves’ ‘on the line’. *Thank you.*

In memory of my cousin beautiful cousin Terrielyn Kluge

Table of Contents

Certificate of examination.....	ii
Abstract.....	iii
Dedication.....	vi
Acknowledgements.....	vii
Table of contents.....	ix
List of tables.....	xii
List of images.....	xiii
List of appendices.....	xiv
A note on performance texts.....	xv
Preface: The doorknob twists.....	xvii
Chapter One: (Ir)rational choices.....	1
Background.....	2
Review of the literature.....	4
Women’s experiences of pelvic examinations.....	4
Pelvic examination interventions at the practice level.....	6
Socio-political approaches.....	12
Strengths and limitations of current research literature on pelvic examinations ...	16
The inception of pelvic teaching programs utilizing Gynecological Teaching Associates within medical examinations.....	19
Program administrators’ perspectives.....	22
Medical students’ perspectives.....	24
The perspectives of Gynecological Teaching Associates.....	28
Strengths and limitations of current research literature on Gynecological Teaching Associates.....	34
Chapter Two: Asking different questions, <i>differently</i>	36
Crafting my research study.....	38
My research questions.....	38
Intentions of my research.....	39
Ontological considerations.....	40
Epistemology.....	41
Theoretical influences.....	42
Methodology.....	49
She left me breathless: My first autoethnographic encounter.....	50
Research writing as practice.....	52
Tensions.....	60
Methods.....	63
Interpretation.....	70
Reflexivity.....	73

Theoretical and methodological specific criteria for evaluating trustworthiness	75
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Chapter Three: Methods in motion: Nomadic identities, hybrid spaces & (re)writing the stories of intimate others	78
(Re)entering the space	79
Research participants	81
Positioning participants	84
Partial perspectives	91
Composite characters	92
Amanda	94
Caroline	95
Rosemary	95
Drew	97
Gloria	97
Suzanne	98
Anna	99
Cultural artifacts: Pelvic teaching module's 'prop' participants	100
Chapter Four: A 'typical' day	105
Interlude: It was funnier from behind	110
A 'typical' day	110
Chapter Five: Training day	142
The (in)formal training process(es) in becoming a Gynecological Teaching Associate	145
"You understand more what the students are going through"	147
"I have to look at her?"	148
"I didn't know what the training was"	150
"But I don't feel ready to teach it yet. Not at all"	151
"It's easier to just lie down"	155
Allegiance to your role	157
Interlude: An (un)standardized approach	158
"It's the pot of gold at the end of the rainbow": Situated understandings of the purpose(s) of the pelvic teaching program	160
"There are a lot of different balls to juggle": Program coordinators negotiate competing priorities	166
"But there is a wide range of comfort levels. And that wasn't addressed ever": Medical students and pelvic teaching	169
"...disgraceful, disrespectful & misogynist": When a student dare speak the silences	170
"I have the upmost confidence in my abilities"	173
"I've had a bunch and then I have done one, and watched a couple": Medical students' preparations for conducting pelvic examinations	174
"Make sure you don't say these words": Medical students' perceptions of the role of the Gynecological Teaching Associate	176

Chapter Six: (Per)forming the practice(d) body	180
Getting ready for (body) work	181
“They are owed a clean body”: GTAs and the work of becoming ‘the body’	182
“Okay, so just repeat after me”: How to (not) talk the ‘body’	190
Positioning	192
The “gold standard”	196
‘Other’ women	198
“I’m sorry. I’m broken”	201
Chapter Seven: (Silent) space(s)	203
First love: A reflection	204
My‘self’ is stolen	205
Unspoken	206
Sexual violence in the lives of women	207
“Wilful’ discomfort.....	208
Dropping the drape	210
“Everything that’s required of me is making me stay”	211
“You need that balance between like freaking them out, but they’re like going to hurt you”	217
“Taking one for the team”	220
Discursive (re)constructions in history-taking.....	222
“You do <i>what?!?</i> ”	225
Compensation	227
Chapter Eight: Lost(<i>ness</i>).....	233
Breath(e)	236
(Re)creating spaces	238
Discourses pertaining to women’s genitalia	239
‘Discourses-in-use’	241
Words that (re)wound	242
‘Right’ kind of woman.....	244
(Non)sexual.....	245
Enacting resistance to biomedical discourse.....	247
Healing space	248
Bodies that matter	250
Request for the space(s) that went missing.....	255
“The unseen guest”: Methodological considerations.....	257
Intentions of my research.....	263
Sharing my work with others	266
Closure	267
Possibilities	269
Afterward	270
References.....	272
Appendix.....	289
Curriculum vitae	314

List of Tables

Table 1: Legend	xv
Table 2: Timeline of data collected according to participant	83
Table 3: How to (not) talk the body.....	192

List of Images

Image 1: Wanted: Women needed for teaching medical students.....	xvi
Image 2: Opening(s)	xvii
Image 3: Subjectivities.....	84
Image 4: Partial perspectives	91
Image 5: Time to end pelvic examinations without consent.....	107
Image 6: Views	110
Image 7: First day of high school	204
Image 8: Wandering.....	234

List of Appendices

Appendix A: Letter of information and consent for GTAs	290
Appendix B: Ethics approval	295
Appendix C: Revised ethics approval.....	296
Appendix D: Focus group questions.....	297
Appendix E: Semi-structured interview guide GTA	298
Appendix F: Demographic questionnaire	300
Appendix G: Semi-structured interview guide students	301
Appendix H: Letter of information and consent for students	303
Appendix I: Semi structured interview guide program administrators.....	307
Appendix J: Letter of information and consent for program administrators	308
Appendix K: Concept map medical students.....	312
Appendix L: Field note	313

A note on performance texts

Performance texts are situated in complex systems of discourse, where traditional, everyday, and avant-garde meanings of theater, film, video, ethnography, cinema, performance, text, and audience all circulate and inform one another ... the meanings of lived experience are inscribed and made visible in these performances (Denzin, 2003, p.x).

Within my thesis I have utilized various fonts to represent the numerous data sources collected, interpreted, and performed in the sharing of my research. My longer reflective writing pieces are displayed in two columns. These fonts and textual arrangements serve as visual cues that a different ‘voice’ is speaking, or a particular type of staging is at play. In this way, the text itself participates in the generation of meanings, which invites the audience to read my thesis as a performance in and of itself – opening up possibilities for multiple (re)interpretations. I have included a ‘Legend’ to the fonts that explain which font is being utilized. Additionally, photos have been included to punctuate the written text. These photos played a central role in my reflective process, and occasionally are paired with a poem creating a unique type of movement for the reader as one moves between the photo and the poem.

Table 1: Legend

Myself as researcher

My ‘in the moment’ field notes

My reflective writing

Data represented as a scripted performance between 2 or more participants

Email correspondence, and newspaper advertisement

**WANTED
WOMEN NEEDED FOR TEACHING MEDICAL STUDENTS**

To ensure optimal gynecological health, early detection and management of health problems, women have to undergo regular gynecological examinations with a qualified, competent professional.

Yet, research indicates that many medical students lack the opportunity to obtain appropriate clinical experience in this area prior to graduation. This was confirmed in a recent study which found that many students had performed as few as two pelvic examinations during their obstetrics and gynecology course.

Therefore, it is hardly surprising that this lack of experience will contribute to graduates lacking confidence in their ability to detect abnormality, which will increase the discomfort experienced by women during the examination. This may prevent women from obtaining this vital examination in the future.

As a coping mechanism, health care professionals may become hardened to the sensitivity required to perform pelvic examinations' or feel reluctant to perform pelvic examinations. Professionals may even shy away from offering routine examinations.

Therefore, we are inviting all healthy women who live in the area to consider scheduling an interview for employment as a teaching associate in an innovative, educational program. The program is aimed at providing medical students, nurses, and sometimes midwives, with sufficient knowledge and practice to develop the confidence and competence needed to perform a sensitive and accurate speculum examination of the vagina and palpation of the uterus and ovaries with the assistance of teaching associates.

All interested parties would need to attend an interview and training session. You are expected to be involved in the pelvic teaching program two to three times a week during a four-week time block. Remuneration will be discussed at the interview.

FOR MORE INFORMATION, OR TO BOOK AN INTERVIEW PLEASE
CONTACT THE PROGRAM COORDINATOR AT: (xxx) xxx-xxxx¹

Image 1: Women Needed

¹ Adapted from Carr, S. (1999). Women needed for teaching clinics in WA. *Australian Nursing Journal*, 6(11), 34.

Preface

The doorknob twists



Image 2: Opening(s)

The tour

Picture your typical hospital clinic room. You know the ones – with the paper- towel, sheet-on-a roll ‘bed covering’. Basketball sized mirror attached to the wall on a moveable arm. Tongue depressors and cotton- balls lined up next to the small metal sink in glass canisters. Windowless. Charts of ulcers and lung cancer adorn the walls.

One stool placed at the foot of the table for the medical student, and a side tray with lube, a variety of speculums and boxes of assorted sized non-latex gloves sit atop the tray waiting to be animated.

By the time the two members of the ‘pelvic teaching squad’, upwards of three medical students, and a possible observer, wedge themselves into the room, it will be stuffy.

The ‘exam’ is about to begin.

I’m worried because this male medical student seems like a ‘Jacques Cousteau’ – a

little too confident, a little too eager. But then I hear the relaxing, steady voice of my teaching partner chime in, “Hello Jodi, ready to begin?” a quick head nod from me and she continues on, “I know you saw in the video that this exam could be performed with the patient upright, but for the sake of time we will conduct it with the patient lying down. Remember to re-drape whenever you’re not actively examining the patient. Please be sure to follow my directions step by step – don’t rush ahead.” Here we go. The student steps to the foot of the table, and says confidently, “Jodi, please slide your buttocks down until you reach the back of my hand”. Good, just like they’ve been instructed – he parrots back my teaching partners’ phrasing word for word. According to ‘best practice’, I am now offered a mirror to watch the exam – I politely decline. While slightly curious, watching some stranger’s hand insert itself into my vagina was not something I was interested in viewing, and I know I’m likely to be overly critical about the appearance of my

vagina – having birthed a child and all. Next, he assists my legs into the stirrups – I’m glad I left my socks on – I feel less exposed. I am handed the middle of the drape to be deployed should I experience any discomfort. For the students’ benefit, I am reminded that I can stop the exam at any time – really I think? I needed the money – my vagina needed to work for me. I needed to just (un)focus. No, this all just works best for me when I look up at the ceiling tiles and count the ‘specs’. I like to distance myself as far as possible; I hum in my head, and just nod a yes or no to requests to continue on ... I hear my ‘pelvic’ partner’s voice off in the distance, “Okay, first you’ll look for any lumps, lesions, discolorations, and/or lice. You can see the labium majora, labium minora. Being careful, really careful not to touch the clitoris, gently separate the ‘lips’ of the vagina and insert your index finger in up to about the first joint, about 1 inch. Next give a squeeze with the index finger and thumb, at ‘5 and 7’ checking for any tenderness in the glands. There should be none. Before removing your finger, make a beckoning motion upwards under the urethra, what the video called “milking”, while watching the urethra for any discharge. Inform your patient what you are going to do before you do it”. I’m slightly more relaxed now that the exam is underway; however, I can feel that my cheeks have flushed warm and red in embarrassment.

One section of the exam over with, two more to go ... I’m working hard to keep ‘grounded’. Breathe, think happy thoughts ... the humming is getting louder in my head. I hate the speculum, with its duck-bills, cold and edgy blades. No amount of lube makes that thing bite less. And my vagina apparently requires the ‘big one’, the Graves (how appropriately named), because I’ve been informed that I have flab/lax vaginal walls. No Kegels done here. The speculum is guided in, pressure, not pain is what I feel. I

hear the clicking of the speculum as the nut is being locked into place. Then the light is swiveled down, and he glares inside me. “Eye to speculum”, my partner warns, “you are looking for the pink donut - that’s the cervix.” she informs. I just want him to get out of there, his head back from my crotch ... I can feel the warmth of his breath against my vagina- It’s unexpectedly arousing - fuck that’s weird, isn’t it? Now the other student is peering over his shoulder, anxious to get a peak. “You will be able to see better when it is your turn”, she reassures. I hope he sees it, come on already, I silently urge. I don’t want him to have to re-insert the darn speculum, as sometimes happens.

And then I hear the excitement in his voice, “I got it! ... There it is. Cool”. I feel his sense of accomplishment right alongside him. My body has cooperated. This really is the ‘holy grail’ of the exam – visualizing the cervix. But in his enthusiasm he becomes distracted from the task of removing the speculum safely – I wince at the searing pain as the speculum bills snaps closed on the tip of my cervix. I feel a wave of nausea, combined with humiliation, I feel tears pooling in my eyes. I feel sorry for the student who now looks horrified; I’ve let him down. This experience now marred by this (in)significant oversight produced as a consequence of his momentary exuberance. I attempt to reassure him that everything is okay, “Things like this happen all the time. I’ll be fine”. My partner walks him through what happened, how he needed to keep his thumb pressed slightly on the lever while unlocking the speculum, and then ever so slightly withdrawing before allowing the walls of the vagina to collapse the bills. I take some slow, deep breaths.

Onto the bi-manual portion of the exam now, and I feel his fingers inserting as far as possible inside me, until his knuckles are right down against my perineum. His non-

dominant hand pushes too hard on my abdomen, my partner steps in, “ease up a bit.” I’m grateful for her close supervision. I need to now guide him to find my ovaries. They are very tender now, ovulation time. I am a little anxious of his touch, and of my flinching – my reflex to recoil from him. I remind myself that I am being paid to allow this exam to happen. I applied, was trained, and I’m being compensated. I wanted to get over it. I needed to get over it.

With all three portions of the exam now complete, he lifts me by my elbow back to a sitting position. “Now you show her where the tissues are, and offer her one, but you won’t need to tell her what it’s for – she’ll know, and remind her that some discharge or slight bleeding is normal after a pelvic exam”, my partner instructs. They file out of the room, leaving me to ‘wipe down’ and prepare for the next exam. Wiping the discharge mixed with too much lube reminds me of cum and the ‘cleaning-up’ process that ensues after ‘unprotected’ intercourse. I note just some slight bleeding on the tissue. Next up is a woman student, I feel comforted by this.

I lie back down, hear the doorknob twist, and we begin again. “Hello Jodi...”

I've made some flippant choices, apparently. Some say it's because I'm a risk-taker and I enjoy the 'rush'. Some say it's because I was 'wounded'. I'll admit it - I've run with arms outstretched to embrace situations where potential harms loomed in the shadows, while peers and families watched with bated breath. Maybe I wouldn't have without a 'history' – maybe I would've been more mindful of the potential emotional, physical and mental consequences of such actions.

I would have made decidedly different choices.

Possibly.

'I' may have mattered (differently).

Possibly.

Becoming a gynecological teaching associate (GTA)² was one such choice:

Gynecological Teaching Associates [GTAs] are women who are specifically trained to teach, assess, and provide feedback to learners about accurate pelvic, rectal, and/or breast examination techniques. They also address the communication skills needed to provide a comfortable exam in a standardized manner, while using their bodies as teaching tools in a supportive, non-threatening environment (Association of Standardized Patient Educators [ASPE], 2010)

GTAs are a specific type of standardized patient (SP), but unlike SPs, GTAs are not role-playing a specific ailment or 'afflicted' patient. Rather, GTAs are trained to teach pelvic examinations to medical students, usually working in pairs with one performing as the patient and the other as the instructor (Pickard, Baraister, Rymer, & Piper, 2003; Siwe, Wijma, & Berterö, 2006). Pelvic teaching is usually but one aspect of larger Clinical Skills Teaching Programs or Patient-Centred Clinical Methods Programs.

² Within the research literature, several different terms are used to refer to women employed in pelvic teaching: patient instructors, professional patients, gynecological teaching assistants and/or gynecological educators. I am using the term being advocated by the Association of Standardized Patient Educators.

Typically, women who become GTAs are recruited by word of mouth from their community. Potential GTAs usually complete an initial ‘screening’ interview with the program coordinator, and sometimes a physical examination to determine their suitability to perform as a GTA. Once accepted into the program, training for GTAs may vary according to the design of the program. Generally GTAs undergo at least a half-day training program to learn how to provide basic instruction to medical students, occasionally to nurses, nurse practitioners and midwives, on how to conduct a pelvic examination using *their own* bodies as the site of instruction (Underman, 2011). One of the most celebrated aspects of the program is that during teaching sessions with medical students, and with the absence of a ‘legitimized’ medical professional, the GTA assumes the position of instructor – sending a powerful message that a lay-person has specific knowledge to be valued about a medical procedure, in this case the pelvic examination (Underman, 2011). I performed as a GTA within a pelvic teaching program from 2001-2003; however it would be almost five years later before I would deconstruct, in any particularly meaningful or critical way, my employment as a GTA. It was not until I was a graduate student in the field of Health Professional Education taking a course on epistemologies of health care practice. It was through the act of (re)presenting my experiences as a GTA for the purpose of a course paper that I came to see how complex and nuanced that particular space for/of pelvic teaching and learning was for me. I began to see threads that wove throughout my past experiences of trauma, my time as a midwifery student and birth assistant (doula), counselor for women who were experiencing abuse, volunteer outreach worker for a harm-reduction program with sex workers, a health professional educator, and my performance as a GTA. Curious about

these threads, I began asking questions

Chapter One, entitled *(Ir)rational choices*, is a survey of the research literature related to pelvic examination generally, and studies more specifically addressing attempts made at the practice level to improve women's experiences of pelvic examinations. Reviewing the literature was a place for me to begin asking question, and served as a basis for explicating the rationale for (re)focusing our attention on pelvic teaching within medical education curriculum. Chapter Two, *Asking different questions, differently* provides an overview of the theoretical work that informed my research, the methodology and methods utilized for data collection and interpretation, and the criteria for trustworthiness specific to autoethnography. In Chapter Three, *Nomadic identities*, I introduce 'myself', and how I entered the field to conduct this research. I also provide an in-depth discussion regarding issues of representation, and introduce the research participants to the audience via fictional composite characters crafted using 'non-fictional data'. The development of composite characters was a representational technique I utilized in order to enhance the anonymity of participants. Chapter Four, *A 'typical' day*, walks the reader through a representation of one 'typical day' within the pelvic teaching module in order to set the stage for the interpretations that follow in subsequent chapters. Chapter Five, *Training day*, explores the nuances of training to become a GTA, while Chapter Six, *The practice(d) body*, demonstrates how normative discourse shaped the (per)forming of GTAs. In Chapter Seven, *(Silent) space(s)* I further problematize what went (un)said, producing 'telling' silence(s). I conclude my thesis with Chapter Eight, *Lostness* wherein I draw parallels between the expectations and obligations of my participants performing as GTAs, and my role as a researcher. In bricolage fashion, I

introduce theories of action through a performative lens to consider examples of disconnects between what was said, and what was done in pelvic teaching. I conclude by considering acts of resistance to biomedical and cultural discourses in how GTAs utilized their (per)formed body.

Chapter One
(Ir)rational choices

Background

There is growing body of work critically examining the (re)shaping of women's bodies through biomedical practice and education (see Grosz, 1994; Lippman, 1999; Sawicki, 1991; Shildrick, 1997; Weir, 2006). The utilization of GTAs in pelvic teaching is situated within this broader work, and contributes to on-going discussions related to the (re)production and reification of normative discourses in the education of biomedical health professionals. There is a rich body of feminist literature addressing the history of biomedicine's role in constructing and representing the female body in very particular, objectified, disembodied ways that have normalized how we collectively make meaning, and experience the female body (Grosz, 1994; Shildrick, 1997).

Drawing upon my own experiences as a GTA, the purpose of my research was to explore the 'silences' and taken-for-granted assumptions embedded within the performance of pelvic teaching utilizing GTAs. This purpose involved considering how the 'culture' of pelvic teaching potentially (re)produced, while simultaneously resisted, particular normative understandings about women through the transmission of various pedagogical practices, and as such, to consider how these understandings were reified practices of larger social-political and biomedical discourses. I considered what newer understandings might be gained by critically examining the broader context in which pelvic teaching was taking place. Such understandings were developed through an examination of my experiences as a GTA, and consideration of how similar and/or divergent the experiences of other GTAs were from my own. The unique role GTAs played in both reifying traditional medical educational practices and resisting them should be of particular interest to those charged with the responsibility for developing,

implementing and/or coordinating gynecological teaching curriculum and methods, and for those concerned with shifting the landscape of gynecological educational discourse and practice toward a more nuanced and contextual understanding of women's 'choices' in relation to gynecological examination. While the teaching of pelvic exams has important implications for medical students' future practices, the (re)positioning of women in pelvic teaching also says something to us about the (re)positioning of women in a more general context – moving us beyond narrowly defined, normalized conceptualizations of women that eradicate paradoxes and contradictions in search of overly simplistic explanations of women's experiences and 'choices'.

I was also interested in how medical students made sense of this learning experience and how their sense-making was subsequently enacted within the teaching space. And, what were the goals and responsibilities of the program administrators? Did they align with the rhetoric that imbued the context of pelvic teaching? My critical autoethnographic study explored these issues by considering the following research questions:

- How did the various participants position themselves within the teaching context?
- How did the various participants conceptualize the purpose of the pelvic teaching program, and their role within it?
- How did the various participants interact with one another within the pelvic teaching space to accomplish the goals of the program?, and
- How did various discourses manifest themselves within the pelvic teaching program?

However, before I proceed with presenting my research design more fully (see Chapter

Two), I will provide a review of research literature relevant to my research.

Review of the literature

My review of the literature focused on published literature related to women's experiences of pelvic examinations, the evolution of pelvic teaching methods within formal medical education, including the implementation of programs utilizing GTAs, and program evaluation from the perspective of GTAs, medical students' and program coordinators. A search of the CINAHL, PubMed, PsycInfo, Contemporary Women's Issues, and Gender Studies databases was conducted using the following search phrases: pelvic exams, pelvic teaching, pelvic exam + women, standardized patients + women, vagina, pelvic examination, professional patients, gynecological teaching associates, and Pap smear. All searches were limited to English, and due to the scant amount of research specific to the area of pelvic teaching, the review drew on literature from as early as 1965, when pelvic teaching programs utilizing GTAs began to flourish. Reference lists of articles were consulted for additional relevant publications from journals, conferences, government sources, online materials, and/or media releases.

Women's experiences of pelvic examinations

Pelvic examinations involving the insertion of a speculum are one of the most routine medical procedures performed on women, and play a vital role in the prevention and detection of gynecological disorders, such as abnormal uterine bleeding, and the screening and treatment of cervical and uterine cancers (O'Brien, Mill, & Wilson, 2009; Wright, Fenwick, Stephson, & Monterosso, 2004). The pelvic examination generally includes a visual inspection of the "external genitalia, urethra, and introitus; speculum examination of the vagina and cervix; and bimanual examination of the uterus, cervix,

adnexa, and ovaries. If indicated, a rectovaginal examination is performed as part of the exam” (The American College of Obstetricians and Gynecologists [ACOG], 2009).

Routine pelvic examination is recommended annually as a preventative health care measure for all women 21 years of age and older, or within three years of becoming sexually active. It may or may not be combined with cervical cytology screening, such as Pap screening/smear (ACOG, 2009). While it is outside the scope of my doctoral research to explore more fully, I would like to note that there is much ongoing debate regarding the utility of routine pelvic examinations, the role of such examinations with Pap screening (Stewart & Thistlethwaite, 2006), and the standard practice of requiring a pelvic examination prior to dispensing oral contraceptives (Scott & Glasier, 2004).

Despite the presumed mundane and routine nature of pelvic exams, for many women the examination remains a source of considerable anxiety. Women may experience a multitude of feelings in relation to obtaining a pelvic examination, including embarrassment, shame, fear of discovering a pathological condition, worries about vaginal odour, and physical and/or emotional discomfort and distress – all of which are said to contribute to the relatively low rates of women obtaining pelvic examination (O’Brien, Mill, & Wilson, 2009; Seehusen et al., 2006; Yanikkerem, Özdemir, Bingol, Tater, & Karadeniz, 2009). Indeed, many women do not seek or receive regular ‘screening’, particularly older women (van-Til, MacQuarrie, & Herbert, 2003), poorer women, criminalized women (Sered & Norton-Hawk, 2008), indigenous, and visible minority women (Ackerson, Pohl, & Low, 2008; O’Brien, Mill, & Wilson, 2009). Therefore, to improve individual women’s experiences of pelvic examination, and in turn increase screening rates, attempts have been directed almost exclusively toward

decreasing physical and psychological distress at the practice level. The assumption that making improvements at the individual practice level will improve clinical experiences, and therefore increase screening rates and gynecological care, provides the impetus for pelvic teaching programs utilizing GTAs.

Pelvic examination interventions at the practice level

Various attempts have been made at the practice level to improve individual women's experiences by decreasing physical and psychological distress. This body of research collectively frames the problem of low rates of engagement in pelvic examinations as one of women's anxiety and hesitancy. This, it is argued, results in resistance and reluctance toward pelvic examination, and/or a lack of understanding about the importance of the exam itself. These understandings have resulted in investigations of medical procedures and/or practices that could address such 'problems' within clinical practice, such as adapting the examination gown, offering a chaperon, the option of self-insertion, (re)positioning the patient, and considerations of gender. A sampling of research from each of these practice-based approaches will now be examined.

Adapting the examination gown. In the early 1990's, Williams, Park, and Kline (1992) set out to address women's discomfort and to minimize reluctance toward having future pelvic examinations by investigating women's preferences regarding the gown(s) worn during the pelvic examination. In the study, a newly designed 'one-size-fits-all' gown was intended to hang to the mid-calf, was short-sleeved and opened in the back. The bottom of the gown served as the drape during the pelvic examination. These researchers hypothesized that patients wearing the new experimental gown would express

greater overall satisfaction with the exam procedure and less anxiety following the examination compared to women using the standard clinic gown. In this study, they also hypothesized that women with previous examination experience would report greater overall comfort with the exam *regardless of experiment conditions* presuming that previous experience would be associated with an improved coping and satisfaction with the procedure. Based on their finds, the authors reported that women wearing the experimental gown experienced significantly greater emotional and physical comfort than control “subjects”, however there were no significant differences in their overall attitudes towards the examination itself. Additionally, this study also found a significant correlation between the number of pelvic exams with fewer desired changes in exam procedures, and greater overall physical and emotional comfort during the examination. A strength of this study is the researchers’ focus on changing a particular aspect of the pelvic examination context (the gown), rather than the patient. However, the underlying causes of women’s ‘distress’ were neither explicated nor addressed, nor how repeated examinations contributed to an increase in comfort. Stopping short of such an analysis fails to problematize the conditions that produce women’s distress, and insights into what contributed to the decrease in distress over time are lost – what exactly did the authors mean by the statement that women had adapted ‘coping skills’? What were they coping with, and how? What *produces* feelings of “distress”?

Offering a chaperone. Also focusing on the issue of women’s distress in relation to pelvic examination, Fiddes, Scott, Fletcher, and Glasier (2003) investigated the desirability of having a chaperone present during pelvic examination as a means of decreasing women’s discomfort. Opinions about pelvic examinations and chaperones

were obtained from 687 women attending a family-planning clinic in Scotland. Overall, regardless of whether a chaperone was present or not, many of the women (41%) felt troubled during the examination. When the health care provider was female, most women did not want a chaperone present during the examination. One third of women (34%) actively objected to a chaperone (more often younger women), however 62% preferred having a chaperone present if the health care provider was male. Younger women also reported feeling less likely to request a chaperone if one had not been offered, yet two thirds of the sample overall felt unable to request a chaperone. Researchers concluded that chaperones should be universally offered but not made mandatory for all women obtaining pelvic examination. This conclusion is premised on their findings that women felt unable to request the presence of a chaperone even if they so desired. However, the researchers stop short of considering what precludes women from making such a request. This shortcoming resonates with scholars who draw attention to the ways in which women experience their positions within medical discourse, research and practice as liminal and invisible, particularly rural and older women (Kermode-Scott, 2004), all the while being inundated with client/patient/women-centered practice discourse which merely creates the illusion of choice in the absence of actual choice (Cheek, 2004).

The option of self-insertion. Wright, Fenwich, Stephenson, and Monterosso (2004) concluded from their research that allowing women to insert their own speculum was an innovative, simple and cost-neutral change that improved women's comfort and satisfaction with the examination. Sampling close to 200 participants attending a family planning clinic in Australia, Wright et al. found that self-insertion was acceptable to most women, but that satisfaction with self-insertion declined with age. However, 75% of their

study population was under the age of 30, and there was no mention of cultural or ethnic diversity in the sample, thus raising important questions as to the applicability of their claims for women across a range of cultural or ethnic populations. Perhaps even more problematic, almost 90% of the sample was comprised of women who used tampons during every period: this is not a worldwide phenomenon as many women lack access to any form of menstrual hygiene products (Tjon A Ten, 2007). While speculum self-insertion may be a desirable option for younger women with little prior experience with pelvic examination, for older women and women of varying cultural backgrounds, taboos related to women touching their own genitals may very well preclude self-insertion as suitable or attainable option (Gollub, 2000).

Moreover, participants in this study received additional support and instruction on how to self-insert the speculum, raising critical questions about whether or not it was the experience of self-insertion that women found so positive, or whether it was the time and information that providers took with participants that led to improved experiences. As one participant commented, “Everything was very well explained to me ... so I understood. I was more involved in the process; it took the mystery out of it for me” (Wright, Fenwich, Stephenson, & Monterosso, 2004, p. 1106). Subsequent research has demonstrated that women’s access to information regarding the purpose of the exam, the components of the exam, and the meaning of the examination results factored into women’s decisions to obtain pelvic examination and in evaluating their experiences as positive, particularly for younger women, aboriginal women and women undergoing a pelvic examination for the first time (Oscarsson, Benzein, & Wijma, 2007).

(Re)positioning. Research conducted in the United States by Seehusen et al.

(2006) investigated whether the standardized method of leg positioning without stirrups reduced women's physical discomfort and feelings of vulnerability and increased their sense of control. They employed a randomized clinical trial methodology in a family medicine outpatient clinic recruiting 197 adult women undergoing routine gynecological examination and Pap smear. Women were randomly assigned to either a "no stirrup" or "stirrup" group, with women in the control group being examined with their heels placed in uncovered metal stirrups at 30-45° angles to the examination table, while the women in the intervention group were examined with their feet placed on the corners of a fully deployed table extension. Based on their findings, the authors suggest that while physical discomfort and sense of vulnerability decreased in the women examined without stirrups, women's sense of control did not increase significantly.

While the researchers collected data related to race, they did not report whether or not there were significant differences between the women who identified as white, black and Hispanic. Such differences would be important to note as compared to white women, the incidence rate of invasive vaginal squamous cell carcinoma (SCC) among black women and Hispanic women is substantially higher. Additionally, black, Hispanic, and older women were more likely to be diagnosed with late stage disease, and lower five-year relative survival rates than their white, non-Hispanic, and younger counterparts (Wu et al., 2008). Additionally, among women, both lower education and higher poverty appeared to be associated with increased rates of HPV-associated cervical and vaginal cancers (Watson et al. 2008). In order to understand how changes to examination practices (such as re-positioning), may increase women's comfort during the exam, encouraging women to return for future screening, reporting on differences, if any,

between women who are differently situated across a range of social and economic locations is essential. Furthermore, the average age of participants was 37, again raising questions concerning the suitability and desirability of this approach for older women who have unique concerns and apprehensions related to pelvic examination, physical comfort and positioning (van Til et al., 2003).

Considering gender. Other researchers have focused on questioning how the examiner's gender may impact women's overall experiences. Moettus, Sklar, and Tandberg (1999) used a convenience sample of female emergency department patients undergoing pelvic examination as part of their assessment to determine whether the physician's gender effected women's perceived pain and embarrassment during pelvic examinations. Quantitative data was collected from a total of 167 women, with an average age of 25. The authors concluded that women seen in emergency room visits who required a pelvic examination experienced significantly higher levels of embarrassment when the examination was performed by male health care-providers, resulting in their recommendation that where feasible, women be offered a choice between or male and female examiner.

Such concerns about the potentially problematized role of men in particular practice locations, prompted Johnson, Schnatz, Kelsey, and Ohannessian (2005) to investigate whether or not men should be encouraged to enter the medical specialty of obstetrics and gynecology. They distributed self-administered surveys to patients in 13 obstetrics waiting rooms in Connecticut. Findings from the 264 women who participated suggest that "although a small percentage of survey respondents did indicate a gender preference, it rarely influenced physician selection and was only a minor consideration

when compared with other desirable physician attributes” (p. 369). These findings, however, were derived from a sample in which the majority of the participants were white, married with children, had college education or above, were currently employed earning greater than \$50,000 USD, had health insurance, and were either Catholic or Protestant. Regarding race, the researchers stated that “white respondents were more likely to have no gender preference in comparison with Black and Hispanic women” (Johnson et al, 2005, p. 376) who tended to prefer female caregivers. Age was also significantly related to perceived comfort and preference for a female caregiver as older women (mean age 42.8) preferred male gynecologists, and younger women (mean age 33.7) preferred female gynecologists. This is consistent with earlier research conducted by Schmittiel, Selby, Grumbach and Quesenberry (1999), which explored women's preferences regarding the gender of the provider of basic gynecological service. They reported that for women of colour and of lower income, there was a strong preference for a female care provider. While both studies note race, income level, and age as significant factors in their preference for female caregivers, the researchers fail to theorize as to why this was so. Researchers who take into account the socio-political context of women's lives offer an alternative perspective on how the experiences with (not) obtaining pelvic examinations could be theorized. Such an approach considers, among other things, the lived context of women's lives, such as poverty, systemic racism, and the heteronormativity of medical encounters.

Socio-political approaches

Considering the lived context

Instead of concentrating on clinically focused solutions, other researchers have

expanded their focus on women's 'reluctance' to include a consideration of how broader contextual barriers inhibited access to and information about, pelvic examination. Recruiting women using information from a cytology database and population registry, van-Til, MacQuarrie and Herbert (2003) conducted a study to better understand the barriers to screening. Epidemiology staff then contacted potential participations who had not been screened over a five-year period, and out of the 32% who met this criterion, 60 women were randomly selected to participate in the focus group research. Authors utilized thematic analysis informed by the population health model. After analyzing the data from the five focus groups with women between the ages of 45-70, van-Til, MacQuarrie and Herbert argued strongly for the recognition that women who were 'avoiding' routine examination were "falling between the cracks created by a complex interaction between personal experiences and the health system's approach to Pap screening" (2003, p. 1116). Among these experiences that contributed to their 'avoidance', were painful examinations, being sexually assaulted during an examination by a health care provider, and histories of childhood sexual abuse. Participants also indicated that placing the responsibility onto the patient to ask for the screening was a major barrier. They felt embarrassed asking for the test, which is indicative in and of itself, of the context within which women receive their health care – context that makes even *requesting* a routine procedure problematic and disconcerting.

The authors' attention to the interplay of personal and structural barriers is consistent with the work of Oscarsson, Wijma, and Benzein (2008), who were also interested in understanding why women chose not to obtain routine cervical screening. A purposeful sample of 14 women who had not attended cervical cancer screening within

the previous five years participated in an individual interview. Based on their interpretations, the authors of this study also suggested that the reasons women refrained from obtaining routine Pap screening were complicated and nuanced, influenced by both their present day situations, and their past lived experiences. For instance, they noted that childhood physical and/or sexual abuse, poor self-esteem and poor body image were pivotal factors that influenced women's decisions to avoid examination. Consistent with early research findings, they noted that just one bad experience could delay or deter a woman from seeking further screening (Wright et al, 2004).

Viewing these findings through a critical feminist lens, what is understood in the research literature as 'women's problematic reluctance' and avoidance, is repositioned as strategies women employ to protect themselves from unnecessary triggers, feelings of judgment, humiliation, and further physical/emotional trauma. Therefore, the focus of the intervention moves from addressing women's reluctance, towards an analysis of the social and cultural conditions of women's lives that makes obtaining an exam, seen as so crucial to the detection of a host of health issues, so problematic.

Heteronormativity in medical encounters

Other researchers have considered lesbian women's experiences of pelvic examinations. Women who identify as lesbians have often been rendered invisible through the almost exclusive focus on heterosexual reproduction in health education, research and practice (Aaron et al., 2001; Bunting, 1993). The limited research into lesbian women's health has been fragmented and pathologizing, as understandings about their sexuality are rooted in heterosexist, normative conceptualizations about women's sexuality (Bunting, 1993). The studies that do exist, suggest that lesbian women face

unique challenges related to accessing appropriate care provision, including: physicians' attitudes, greater mistrust of the health care system, lack of coverage under a partner's health insurance benefits, and ignorance leading to inappropriate recommendations, prescribing for example, birth control (Aaron et al., 2001; Bradford & Ryan, 1998).

Matthews, Brandenburg, Johnson, and Hughes (2004) conducted a multisite survey study of cervical cancer risk factors, screening patterns, and predictors of screening adherence in demographically similar samples of lesbian (N = 550) and heterosexual women (N = 279) living in the United States. Although their results indicated that lesbian and heterosexual women were equally likely to have ever had a Pap test, lesbians were less likely to report annual or routine testing, and that this could be attributed to numerous factors, including health care providers' misconceptions about lower risk factors for cervical cancer and sexually transmitted infection in lesbian women, in turn leading to fewer recommendations for pelvic examination. The researchers point out that many lesbians have a history of intercourse with men and that there is often a long interval between contracting a sexually transmitted infection and the onset of symptoms, but health care providers lack even a basic education in lesbian health matters (Buenting, 1993; Matthews et al., 2004).

These new(er) approaches to understanding women's 'reluctance', as attempts to avoid gynecological experiences that (re)produced racial, classist, fragmented and pathologizing health 'care' that is rooted in heterosexist, normative conceptualizations about women, and women's relationship to their bodies, informed my research. I sought out spaces within pelvic teaching that attempted to articulate a critical awareness of the role context(s) played in the 'decision' to obtain, or not obtain a pelvic examination. I

paid attention to conversations between various participants and examined teaching materials for examples of such insights.

Strengths and limitations of the current research literature on pelvic examination

Collectively, practice-based intervention studies highlight the relative ease and cost-effectiveness of seemingly simple changes that could be made within a practice context to improve the experiences of some groups of women with obtaining a pelvic examination. These attempts in isolation however, do little to address the structural barriers and inequalities that contribute to women's 'decisions' to refrain from obtaining pelvic examination. Nor does it deepen our understanding about what it is about the examination itself that produces women's reluctance. For instance, why was it that some women were concerned about the odours of their vaginas? The intervention-based research related to pelvic examinations is focused on 'technical' solutions. In doing so, it adheres to a larger biomedical discourse wherein the question of 'why' is it that women experience pelvic examinations in the ways that they do is largely overlooked. It is as though reluctance, shame, embarrassment are 'givens' – inevitable, and yet these feelings are likely produced within, and reproduce, normative discourses that govern the interactions between women and their health care providers.

Moreover, in critiquing this literature, it becomes apparent that there are key differences in obtaining pelvic examinations for women; differences that are rooted in expressions of gender, ethnicity, age and class locations, which reflects the complexity and multiplicity of women's experiences (McMullin, 2010). As such, gender, while an important variable, intersects in a myriad of ways with other contextual factors, including the context of the exam itself (scheduled/routine versus an emergency, first examination

versus a subsequent examination). Such a perspective helps researchers understand the limitations of *de*-contextualized approaches to enhancing practice, characterized by a '*If we can just adjust this particular aspect of the exam, then women will experience less discomfort*' mentality – and that the factors that collectively coalesce to shape women's experience of the pelvic exam do so in a complex, nuanced and intersecting manner. Such recognition resonates with Crenshaw's (1991) work on the development of an *intersectional* understanding of violence against women, which has been particularly influential in questioning the ways in which the categories of race, gender, class, sexual orientation, age and colour intersect to engender complex patterns of subordination. Such an analytic perspective reminds researchers that women's lives, and indeed, women's pelvic examinations, are experienced within situated intersections with complex relationships manifesting between their various social locations.

The propensity within the existing research literature to address women's low rates of obtaining pelvic examinations from a clinical practice perspective leaves many important questions unanswered. That is, while researchers identified the pelvic examination as a (di)stressful event in the lives of women, they fall short of holding up to question: (1) what it is about this *particular* examination that breeds such feelings of embarrassment, shamed and humiliation?; (2) why it is that women felt unable to ask for what they needed (e.g. requesting a chaperone)?; (3) why was it that women needed to develop coping mechanisms at all?; and (4) how might the assumptions and understandings of what produces women's feelings about the pelvic examination at the practice level be implicated within the pedagogical approaches in the *education* of health care professionals?

Therefore, the vast amount of research literature related to pelvic examination aligns with a dominant biomedical discourse, which reinforces the ideology that: (1) women lack the awareness of the benefits of pelvic examination, (2) women misperceive their susceptibility to sexually transmitted infections and cervical cancers, and (3) women undervalue their own health needs. These assumptions have previously been highlighted as factors leading to many women never obtaining a pelvic examination (Wong, Wong, Low, Khoo, & Shuib, 2008). It is evident through a critical exploration of the intervention based literature that as a discourse, this research foregrounds a particular understanding about women's experiences of pelvic examination, and as such, what is needed to enhance screening rates. These perspectives narrowly framed as either ignorance or apathy, submerges alternative realities in which women consciously and actively choose not to obtain pelvic examination for a host of complex and highly nuanced reasons, including self-preservation.

When reconsidered through a socio-political lens, what appears at the surface as being an irrational choice, not to obtain routine pelvic examination or gynecological care, can be seen as a rational 'choice' in light of potential harms that await women throughout the process of obtaining gynecological care. Furthermore, the notion of 'choice', so dominant in the rhetoric of biomedicine, must be troubled and problematized as such a concept cannot exist without social justice:

For example, Canadian public health policy now recommends mammograms for all women who are over 50 years of age, and the costs of the screening exams are covered by women federal health insurance programs. However, this does not mean these exams can be 'chosen' by all women. Women face important barriers other than cost that tend to be overlooked (Lippman, 1999, p. 283).

Too easily forgotten are the specific populations that have experienced human

rights violations during gynecological ‘encounters’ at the hands of health care providers. For example, the forced sterilization within Aboriginal, African American, and disability communities (Meekosha, 1998; Randall, 1996), and the relentless targeting of sterilization programs toward poorer women, black women and women involved in criminalized or other ‘morally ambiguous’ activity (e.g. substance use) (Grekul, 2008; Price & Darity, 2010).

So while the pelvic examination is (re)presented as a “safe” and relatively simple procedure, a critical (re)reading of the space of pelvic examination highlights deeply entrenched and highly ideological practices which have perpetuated violence onto the bodies and into the lives, of women. However, a key aspect of the collective response by medical education programs in Westernized contexts regarding low routine pelvic examination rates and negative experiences with gynecological care more generally, has been to implement pelvic teaching programs utilizing GTAs in medical education as an ‘intervention’ in education – attempting to (re)script the pelvic examination space as one that is not hostile to/toward women.

The inception of pelvic teaching programs utilizing Gynecological Teaching Associates within medical education

Historically, medical education of clinical methods has relied heavily upon a combination of teaching methods and simulation techniques, including plastic pelvic models, manikins, practicing on fellow students, the use of cadavers, and most controversial, anesthetized women who often were unknowingly, and without providing informed consent, subjected to pelvic examinations by students (Coldicott, Pope, & Roberts, 2003; Hendrickx et al., 2006; Kapsalis, 1997). Noting the significant drawbacks, for example, no ‘actual’ feedback from a patient could be provided to the student, and

ethical tensions of these various teaching methods (Coldicott, Pope, & Roberts, 2003; Ubel, Jepson, & Silver-Isenstadt, 2003), new programs were developed in the late 60's - early 70s utilizing live women who were not patients.

Initially, some educational programs hired women who were predominantly prostitutes, as it was presumed that no other 'type' of woman would subject herself to such immodesty (Kapsalis, 1997); others placed ads in local papers. The hiring of prostitutes complicated the assertion that pelvic teaching was devoid of sexual undertones and a role suitable for any woman with the 'right' skills to perform (Kapsalis, 1997). The initial backlash against the use of women in pelvic teaching came in the form of pejorative comments directed toward the women themselves who were pathologized as exhibitionists in need/want of financial and/or sexual rewards (Kapsalis, 1997).

Dr. Robert M. Kretzschmar, a former assistant professor of obstetrics and gynecology at the University of Iowa, is often credited with the advent of the modern day GTA program (Kelly, 1998; Underman, 2011). At first he utilized a nurse hired to perform as the patient; however at the request of the nurse, a drape was erected between herself and her students precluding communication between the respective parties. Only her pelvic region remained visible, presumably because "... 'only a whore gets paid' for a non-diagnostic exam ..." (Kapsalis, 1997, p.69). This version of the program was replaced by Kretzschmar in 1972 as he wanted the patient and student to be able to interact, and staffed with women recruited from the larger community. With minor adjustments, this remains the dominant model for pelvic teaching in medical education in the United States, and growing in prevalence across, Australia, Sweden, Great Britain and Canada (Beckmann et al. 1988; Kapsalis, 1997; Siwe, Wijma, & Berterö., 2006):

The traditional pelvic examination instruction methods were reviewed and found to be deficient ... [Throughout the 1970s], a new education specialist, the Gynecology Teaching Associate (GTA), has evolved to help improve the initial gynecology teaching experience ... The qualities she brings to the instructional system include sensitivity as a woman, educational skill in pelvic examination instruction, knowledge of female pelvic anatomy and physiology, and, most important, sophisticated interpersonal skills to help medical students learn in a nonthreatening environment (Kretzschmar, 1978, p. 367).

Today, GTA programs usually operate as distinct units umbrellaed under a larger standardized patient program that provides a broad range of clinical methods training to health professionals using hired 'laymen'. Such a model for teaching pelvic examination presumes to address the apparent inadequacies of other types of instructional methods. As a result of medical students being able to 'practice' on and receive instant verbal feedback from the GTAs, it is believed that using GTAs leads to improved skill acquisition and greater communication efficiency in practice, and thus to more competent care of women in the wider community (Lane & Rollnick, 2007; Robertson, Hegarty, O'Connor, & Gunn, 2003). With more competent and sensitive care for women in the community, then presumably there would be a greater screening rates and rates of routine gynecological care.

Interestingly, while GTAs are said to have become such an integral component of the pelvic examination teaching curriculum, research into the experiences and perspectives of GTAs employed in pelvic teaching programs remains virtually absent. The little research that does exist primarily documents the perspectives of the program administrators and of medical students with a primary focus on comparing the utility, validity, and effectiveness of GTAs with other types of simulators. Additionally, where literature about GTAs does exist, researchers have produced findings that do not take into serious consideration the broader context within which GTAs perform their work,

and therefore what pre/co-existing factors might contribute to GTAs' responses to program administrators and researchers. This review of the literature will now proceed with an analysis of the existing research concerning these three perspectives.

Program administrators' perspectives of the use of Gynecological Teaching Associates

Most prevalent in the literature on women's involvement as GTAs is research into program administrators' perspectives, particularly in terms of the perceived effectiveness of various types of teaching methods. Administrators have a vested interest in their students' history-taking skills, their ability to increase empathetic communication, cost effectiveness, and the extent to which various methods best simulate an 'actual' gynecological exam (Herbers, Wessel, El-Bayoumi, Hassan, & St. Onge, 2003; Lane & Rollnick, 2007). Consistently, this literature asserted that GTAs are more effective at teaching communication skills, providing feedback, giving direction, decreasing anxiety and improving students' confidence when compared to other methods such as role playing, peer examination, or faculty-led training (Kleinman, Hage, Hoole, & Kowlowitz, 1996; Siwe, Wijma, Stjernquist, & Wijma, 2007).

An example of such research was that conducted by Kleinman, Hage, Hoole, and Kowlowitz (1996), who evaluated the pelvic examination performances of medical students at two separate schools of medicine in North Carolina. Students were trained either by GTAs who served as both instructors and patient, or students were trained by attending physicians with the GTA serving only as a patient. Students at one school received a lecture on the pelvic examination by faculty, viewed an instructional video, then divided into groups of four to attend a three hour training course with the GTA. GTAs led a discussion around interpersonal skills, sexual history taking, and

examination techniques before the students performed the examination. Students at the other school received a lecture from faculty, viewed the instructional video, and then were divided into groups where the examination was performed first by the attending physician. Each student group was evaluated by the GTA using a 35-item scale that included both technical and interpersonal skills. Their results indicated that students who were trained by the GTA exclusively scored significantly better on interpersonal skills than the physician-trained students. These interpersonal skills included knocking on the door before entering the room, introducing oneself to the patient, offering the patient a mirror to watch, offering the patient a chance to view the cervix and avoiding language with sexual or violent overtones. There were no noted differences on technical items. The authors conclude that standardized patients ought to be incorporated into the teaching of pelvic examinations as interpersonal skills taught by GTAs could have a lasting effect after clinical clerkships. While these findings suggest that students who were trained with a GTA seem to gain better interpersonal skills, the authors fail to take into consideration how the items on a Western-biased tool (e.g. student made eye contact with the 'patient', the student offered a mirror to the 'patient') limit the applicability of the findings to women across a range of social and cultural locations.

A more recent prospective, longitudinal study carried out in Sweden by Siwe, Wijma, Stjernquist and Wjjma (2007) compared the outcomes in terms of stress and relevant clinical skills (e.g. palpating the uterus) between a GTA and a clinical patient model (i.e., a 'real' patient). The Gynaecologic Examination Distress Questionnaire was designed to measure different aspects of the exam which were believed to create distress, such as inserting the speculum, and was administered on four separate occasions: prior to

the course beginning, just before the examination, just after the examination was complete, and at the end of the semester. In the clinical patient model, students attended a lecture and watched a seven-minute video before performing a pelvic examination on a manikin ‘Gynnie’ (!) under the direction of a gynecologist. The students then viewed the video again and received handouts before individual students performed their first examination on a clinical patient during a routine consultation supervised by the gynecologist. In the GTA model, the students watched a 36-minute video and were given pamphlets with detailed descriptions and illustrations about how to perform a pelvic examination. Prior to beginning the exam, everyone sat down for introductions and space was created for students to verbalize their feelings. The GTA then shared their reasons for participating in the training and along with the gynecologist, made suggestions about how to approach the women in the pelvic examination context. Afterwards, students were provided with individual feedback. Their results indicated that students who learned with a GTA were much less distressed after the learning session and more skillful than students who had learned with a clinical model. Students trained by GTAs reported receiving more guidance and reported that the learning session had been more useful in a clinical context than students trained in the clinical model.

Medical students’ perspectives on pelvic teaching utilizing Gynecological Teaching Associates

Rather than focusing on issues of effectiveness, some researchers have focused more exclusively on understanding the experience of the students during the course of the training. Buckwald (1979) for example, who, in the course of 10 years, worked with roughly 700 students assigned (for the first time) to obstetrics and gynecology, found that students had several fears related to conducting pelvic examinations. These

included: (1) fear of hurting the patients due to clumsiness and a lack of awareness of female genitalia; (2) fear of being judged as inept (noting that the first pelvic examination became a kind of initiation rite with clear sexual undercurrents and that male students could be judged as lacking the essential skills needed to accomplish their tasks under the watchful gaze of their male superiors); (3) fear that they would be unable to recognize pathology and would therefore be responsible for a patient's death; (4) fear (on the part of both male and female students) of becoming sexually aroused; (5) fear of finding aspects of female genitalia unpleasant; and (6) fear of disturbance in their relationships with their patients through counter-transference, i.e. if the patient reminds them of their sister or mother.

In the twenty-some years subsequent to Buckwald's (1979) article being published, students' perspectives on learning how to perform a pelvic examination utilizing GTAs have not been well documented in the research literature (Hendrickx et al., 2006). Generally, students have not been asked to provide feedback on how they felt about different aspects of the program, nor how they may or may not have benefited from the instructions provided by standardized patients. To address this gap in the literature, Hendrickx et al. (2006) used a variety of data collection methods including questionnaires, written reflections, and round-table conferences to assess the perceptions of 71 medical students involved in the implementation of a pelvic teaching program utilizing GTAs for intimate examinations in Belgium (which also included intimate examinations performed on male standardized patients, i.e., to practice prostate exams). The research found that the gynecological examination was considered by both male and female students to be the more invasive and intimate than prostate exams. In any case,

students articulated anxiety and concern related to the GTAs. For instance, one student questioned, “What kind of person would volunteer for this program?” (Hendrickx et al., 2006, p.50). Seeming to prefer providing a descriptive account only, rather than a critical account of their findings, the researchers did not problematize where students’ perceptions or attitudes toward the GTAs were stemming from.

At about the same time, Theroux and Pearce (2006) explored graduate nurse practitioner students’ perceptions about their experiences when learning to perform pelvic examinations and then in subsequent clinical rotations. One group of students was instructed by faculty and subsequently practiced on classmates, while the other two groups were taught by GTAs. A Likert scale survey assessed students’ levels of anxiety, embarrassment and their confidence level prior to the first examination in the learning environment. In addition, four open-ended questions asked about their experiences and opinion. Results indicated concerns from all students over potentially hurting a patient, making an error during an examination, and feeling embarrassed. However, after they completed the pelvic examination, students taught by the GTAs rated the experience more positively and had a better understanding of exam techniques than the students who conducted the examination on classmates. Students paired with GTAs appreciated the immediate feedback and the comfortable atmosphere that had been created. Although researchers’ interpretations were based on a conceptually flawed design, because one would assume practicing pelvic examinations on fellow classmates under the direction of faculty would result in higher levels of embarrassment and anxiety, their findings of greater satisfaction with GTAs’ teaching was consistent with earlier research by Robertson, Hegarty, O’Connor, and Gunn (2003).

In 2007, Siwe, Wijma, Silen and Berterö conducted a study exclusively with female medical students. Their stated objective was to gain a deeper understanding of female students' experiences of performing their first pelvic examination on a 'patient'. As the researchers were also the program administrators, they felt at times as though mixed-gendered groups prevented students from expressing their feelings openly. Using in-depth interviews, the researchers collected data after students conducted a pelvic examination with GTAs and a gynecologist as supervisor. Using constant comparative analysis, their analysis yielded two categories that fell under the larger umbrella of "transcending unspoken boundaries and taboos, a prerequisite for learning" (p. 55): (1) a didactic teaching design facilitated the transition from woman to examiner, and (2) interactive support facilitates creative learning of both interpersonal and palpation skills. With respect to the main theme (transcending taboos), the authors noted:

The students reported that their fear of experiencing the situation as strange and provocative was diminished by the natural attitude the [professional patients] had to their bodies and to being naked. This enabled students to gradually dare to look at the exposed genitals at eye level and overcome their feeling of intruding (Siwe et al., 2007, p. 58).

While the authors note significant discomforts among the female students, they stop short of addressing why in fact these fears are prevalent and why it was experienced as so "daring" for the female medical students to look at the genitals of another woman:

As observers, the students said that a special feeling of trespassing had to be overcome when looking at a [professional patient's] vulva while another student was examining her and especially when the examiner inserted fingers in to the [professional patient's] vagina. Initially the student said they wanted to look away but the will to gain knowledge prevailed (Siwe et al., 2007, p. 58).

Important assumptions remain unpacked, and difficult questions remain unanswered: what was it about the specific act of inserting fingers into the vagina that was so

potentially threatening and destabilizing for the female medical students to confront?
 How is gender being constructed and understood? How is the medical discourse interacting with gender performance?

The perspectives of Gynecological Teaching Associates

“A stronger, clearer perception of self”. Siwe, Wijma, and Berterö (2006) educators and program administrators of a pelvic teaching program, were interested in whether or not pelvic teaching programs ‘exploited’ the women who participated in this mode of teaching. According to the researchers, their main objective was to identify and describe the experiences of GTAs with teaching the pelvic examinations (Siwe et al., 2006). They conducted an interpretive phenomenological study using semi-structured interviews with thirteen female GTAs who taught pelvic examinations to medical students and midwives in Sweden. Their sample included six nurses, three teachers, two trained social workers, one occupational therapist, and one secretary.

Based on their interpretations of the data, there were five main themes that lead to an overall sense that participating as a GTA contributed to a stronger and clearer perception of self: embodied knowledge, promoting a proper approach for conducting pelvic examination, redrawing personal boundaries, feeling confident and doing something meaningful. The authors concluded that participating in the pelvic teaching program allowed the women to ‘get their bodies back’, and to increase their knowledge regarding their own bodies. Women found that looking at the genitals of other women, and at their own in a mirror, assisted them to learn the anatomy of the vagina. In addition, the occasional Pap smear that was required as part of the program reassured the women that their bodies were healthy and normal. The authors stated that according to

the GTAs, the teaching situations were never sexually charged, but were experienced as relaxed and comfortable: no embarrassment was felt by the GTA during the teaching situations as they “mentally transformed the examination into a teaching situation so as to be able to perform” (Siwe et al., 2006, p. 893). Sometimes this meant that their comfort became secondary to the students’ learning needs, as the authors noted “occasionally the women felt some discomfort during an examination but tolerated it so as to assist a student to succeed” (p. 892). The authors concluded that the positive feedback GTAs received from the students promoted feelings of being valuable and significant, increasing their pride in being a woman. The authors noted that the women could never have imagined the positive outcome of their participation.

While this research lends important insights into the positive experiences of GTAs, and how their participation in the program was personally instructive and meaningful, within their interpretations are several poignant comments that provoke critical exploration. Consider again some of the GTAs’ words/sentiments: they were able to “get their bodies back,” “feel less vulnerable,” “learn the anatomy of their vagina,” and “tolerate discomfort”. Such comments demand rigorous questioning and problematization: *how is it* that they lost their bodies in the first place?; felt vulnerable in the first place?; didn’t know the anatomy of their own vagina?; felt they could/should tolerate discomfort? Moreover, what the authors fail to theorize are how the attributes that characterize this study group may have shaped their experiences: all the women were professionals of at least middle class, and all were part of and familiar with the health care context. That these findings might be thought to apply to women with fewer choices and less social status and resources demands scrutiny, and given my own experiences as a

GTA, I felt it was important to ‘return’ to this teaching space to ask such critical questions.

GTAs as glorified “dummies”. Silverman, Araujo and Nicholson (2012) utilized stories of GTAs’ in teaching scenarios with medical students to illuminate the problematic communication that can occur during women’s health exams and how the use of GTAs can improve students’ competency. In their article, entitled “Including Gynecological Teaching Associates’ Perspectives in Women’s Health Exams: Lessons for Improved Communication Practices”, they describe an encounter between a medical student and a GTA. According to the authors, his treatment of her was that of a “glorified dummy” instead of a person with their own unique lived experience. For instance, the male medical student pushed the GTA’s knees apart before she had the chance to move them herself, and he began the exam without her consent. When he finished the exam, the student looked back at the GTA and said, “You have a lot of lube”. He grabbed paper towels from the counter, and then proceeded to lift her gown without her permission. He then wiped the lubrication from her vagina, dropped the dirty paper towels onto her belly and abruptly left the room.

The authors use this encounter to demonstrate how GTAs were required as part of their performance, to negotiate not only physical discomforts but emotional discomfort. As the authors state, “from the providers’ perspective, the encounter is a learning experience; from the GTA perspective, real life is repeatedly articulated and intimate discomforts regularly experienced” (Silverman, Araujo, & Nicholson, 2012, p.724). The authors present compelling ‘evidence’ that indeed the use of GTAs in women’s health teaching could illuminate potential communication problems occurring in practice. They

offer several suggestions to improve providers' competency during pelvic examinations based on the lessons learned from the GTAs in pelvic teaching, such as the need for providers to be aware of their physical environment, the importance of eye contact, and avoiding phrases that may contain sexual undertones. They emphasize the importance of recognizing that there could never be a standard script or recipe for good communication, but with the inclusion of GTA programs, educators are demonstrating an attempt to enhance better communication between caregiver and patient in health care settings.

While reminding health care providers about the importance of 'good communication' in encounters with patients is useful, that which is considered to be good communication must be understood as situated in particular cultural-linguistic frameworks within specific sociocultural and historical locations. Language, and thus communication itself, is a cultural product enacted and 'read' differently depending on a myriad of factors (Bucholtz & Hall 2005; Chun, 2011). Furthermore, the title suggests that the perspectives of GTAs ought to inform communication between patient and health provider during women's health exams. However, the article presented the perspectives of the GTAs only insofar as the teaching scenarios used as exemplars of poor communication involved the deplorable treatment of a GTA, and the incompetency of students during various role-plays scenarios involving GTAs. GTA perspectives were not included, except when spoken for on behalf of the authors.

Moreover, the authors do not provide information on how the stories were gathered, for instance, did the authors become aware of these teaching encounters during de-briefing with GTAs – were the authors their program coordinators or fellow GTAs?,

or were they gathered during the course of a research study? Who were the authors in relation to the participants? How did the GTA who was treated so callously in the aforementioned teaching scenario feel about the treatment she received, and what does this encounter with the medical student potentially reveal about the positioning of women's body in medical education and beyond? What was the follow-up with the student? If his performance was left unchallenged by the teaching program or his supervisors, what then? As the article veers away from their title to argue instead, for the legitimacy of utilizing GTAs in women's health teaching, as a reader, I am left with these lingering questions, wondering what exactly were the perspectives of the GTAs?

“Embodied labour”. An additional study conducted by Underman (2011), entitled “‘It’s the knowledge that puts you in control’ – The embodied labour of Gynecological Educators, the author, a former GTA herself, conducted semi-structured interviews with 18 current or former GTAs in the United States recruited through the author’s own informal network. Of the 18 participants interviewed, 16 self-identified as Caucasian, one as African American, and one participant chose not to identify. All had, or were working toward at least a bachelor’s degree, although most were working toward graduate degrees. One participant identified as female genderqueer and one identified as genderqueer. Length of involvement in the program ranged from one year to 25 years. Age range of the participants was not provided.

The study was situated within the literature related to ‘body labor’. Based on data analysis, findings presented center around the themes of: (1) embodied labour, which involved an analysis of GTAs’ motivation and expertise; (2) negotiating the challenges of physical harm and intimacy, specifically physical harm to their bodies and the intimacy

created during the examination because of the association between the naked female body and sexuality; and (3) strategic dualism, enacting distancing techniques to reduce physical and psychic harms.

Similar to the conclusions drawn by Siwe et al. (2006), the author of this study stated that GTAs took great pride in their work, and were motivated to participate in pelvic teaching to improve the practices of medical students for the benefit of women in general. According to Underman, GTAs while trained in anatomy, language, and pelvic examination techniques, what is of most value to the students is the GTAs familiarity with their own bodies, and that this experiential knowledge "...makes the work of gynecological educators valued by future health care practitioners and to some extent legitimated by the medical educators who employ them" (Underman, 2011, p.440).

Unlike the assertions by Siwe et al. (2006) that the space of pelvic teaching was never sexually charged, according to Underman, participants reported incidents when there were momentary slippages in the efforts made to desexualize the space of pelvic teaching. There were times when GTAs:

... found themselves attracted to the students.... [However] in these situations, all of the women expressed the importance of maintaining their professional demeanor to avoid making the encounter intimate...[Yet] students introduce elements of sexuality and intimacy into the exchange in other ways. Gynecological educators may be able to control their own performances of gender in the workplace, but the students' performances of gender influence the interaction (p.441).

To (re)establish professional boundaries, GTAs developed distancing techniques, what Underman (2011) called "strategic dualism" to negotiate the way that GTA bodies were constructed as objects, while GTAs were simultaneously required to offer their subjective experiences to the medical students. Some of these strategies were taught during training,

such as the right to stop an exam and/or correct a physical behavior that was causing immediate harm. Other techniques were learned through repeated interactions with medical students, such as using the tone of their voices to command authority, and deploying medicalized language to assert control. This article offers significant contributions to the literature related to body labour and embodiment, demonstrating how GTAs' gendered performances can be enacted in ways that resist positioning the female body as passive and docile. This work raises several key issues related to the experience of performing as a GTA, notably the techniques employed to assert and maintain their authority in the teaching space, and strategies to negotiate the tension produced by the requirement to be both subject and object in the teaching encounter.

Strengths and limitations of existing research with Gynecological Teaching Associates

This review of the literature related to the perspectives of GTAs serves as a starting point to engage in a critical discussion regarding the usages of GTAs in medical education. Such a discussion is especially vital when such programs are premised on, and promote the assumption that they improve pelvic examination experiences for women in general by contributing to the development of more sensitive and competent health care professionals (Robertson et al., 2003; Siwe et al., 2007). Collectively, the above research draws our attention to the ways that GTAs make sense out of their experience of participating as a GTA, often along the normative lines of contributing to the development of future health care providers, and are willing to negotiate their own physical, and at times emotional, well-being to do so. Furthermore, as the authors suggest, GTAs employ various skills to manage the complexity of situations that arise within the teaching space; however, the authors do not theorize how embodying gender

norms in order to complete the requirements of their roles, may actually reflect larger normative discourses that produce the position of women as one naturally predisposed to self-sacrifice for the greater good. The virtually absent voices of GTAs from the research literature is also concerning, in addition to how the way that authors' interpretations of GTAs' performances themselves also (re)enact normative discourses. For example, authors' assertions that GTAs' motivations to help medical students succeed superseded their own discomfort, and that performing as a GTA helped to affirm their femininity (Siwe et al., 2006; Underman, 2011). Based on my appraisal of the literature, Chapter Two will argue not only do we need to start asking *different questions*, but also the questions must be *asked differently* to open up spaces for such discussions to occur.

Chapter Two

Asking different questions, *differently*.

Current methods do not resonate well with important reality enactments... with the fleeting—that which is here today and gone tomorrow, only to re-appear again the day after tomorrow... with the distributed—that is to be found here and there but not in-between—or that which slips and slides between one place and another ... with the multiple—that which takes different shapes in different places... with the non-causal, the chaotic, the complex. And such methods have difficulty dealing with the sensory—that which is subject to vision, sound, taste, smell; with the emotional—time-space compressed outbursts of anger, pain, rage, pleasure, desire, or the spiritual; and the kinesthetic—the pleasures and pains that follow the movement and displacement of people, objects, information and ideas (Law & Urry, 2004, p.403-404, emphasis in original).

‘Asking different questions, *differently*’ is about problematizing how previous researchers have sought to explore the uses of GTAs in pelvic teaching – the questions that have and have not been asked, and how they’ve been asked. It is about recognizing that methods “...are productive: they (help) to make social realities and social worlds, They do not simply describe the world as it is, but also enact it ... [Therefore], if social investigation makes worlds, then it can, in some measure, think about the worlds it want to help make” (Law & Urry, 2003, p. 1, emphasis in original). As I mentioned in the preface, I came to explore this topic further in a graduate course, but during my review of the literature I was astounded by the lack of research literature on the topic, and further by how narrow and uncritical was the existing published literature. Therefore, the body of published scholarly work was the provocation for my dissertation³. I felt different questions needed to be asked, and asked differently; otherwise, silences and taken-for-granted assumptions would continue to be propagated within/outside GTA programs. I felt strongly that my own story would have resonance with other women in the GTA program, and that our

³ In her public presentation entitled *Conceptualizing autoethnography as assemblage: Accounts of occupational therapy practice*, Western University, April 17, 2012, Dr. Sally Denshire shared that the provocation for her doctoral work was the absence of autoethnographic accounts of the experience of occupational therapists.

stories would say something critically important about the complexity of the experience of performing as a GTA, of performing pelvic examinations and being performed on, and on working intimately on the bodies of others for medical education. Where divergent opinions were found among us, the conversations would be all the richer for them.

Crafting my research study

Through my graduate studies, the practice(s) of locating oneself paradigmatically; articulating one's epistemological and ontological assumptions; and ensuring an adequate "fit" between theoretical lenses, methodology, and methods, was instilled in me as necessary in order to adequately assess one's knowledge claims and to maintain quality in qualitative research (Crotty, 2003). As such, in this chapter I will present my research questions, objectives, guiding epistemology and ontology, and method/ology.

My research questions

As introduced in Chapter One, I drew upon my own experiences as a GTA, to explore the 'silences' or taken-for-granted assumptions embedded within pelvic teaching with GTAs, to consider how the 'culture' of pelvic teaching potentially (re)produced while simultaneously resisted, particular normative understandings about women through the transmission of various pedagogical practices, and to consider how these understandings were imbedded within larger social-political and biomedical discourses. I considered what insights might be gained by exploring and critically examining the broader context in which pelvic teaching was taking place, through an examination of my experiences as a GTA, and to consider how similar or divergent the experiences of other GTAs were from my own. My critical autoethnographic study explored such issues by considering the following research questions:

- How did the various participants position themselves within the teaching context?
- How did the various participants conceptualize the purpose of the pelvic teaching program, and their role within it?
- How did the various participants interact with one another within the pelvic teaching space to accomplish the goals of the program?
- How did various discourses manifest themselves within the pelvic teaching program?

My own experiences as a GTA, along with the experiences of other GTAs were of primary importance to me in considering how this particular learning culture set out to accomplish the task of providing a teaching space for medical students to perform a pelvic examination. I will note that although I carried out my research with these key research questions in mind, I was also mindful that conducting qualitative research is an emergent endeavour, and that further questions, or more salient questions could/would arise as I interacted with participants and reflected on my interpretations. That is, I did not presume to have all the ‘right’ questions prior to data collection.

Intentions on my research

Through observation, in-depth interviews, and group interviews, the intentions of my research were to inquire critically into the performances of GTAs, medical students and program administrators involved in pelvic teaching, and bring new(er) insights into critical dialogue with my own experiences. I intended to explore the assumptions and knowledges of GTAs and students engaged in this learning method, as well as those of the program administrators responsible for the provision of the pelvic teaching module. I

set out to call attention to the various discourses that weaved themselves throughout the various subject performances impacting on the relationships within/outside the pelvic teaching module, and to consider the intersections between the individual narratives shared by the participants and larger social - cultural and bio-medical discourses. In the process, I intended to demonstrate how discourses, particularly related to ‘the body’, (re)constructed understandings about women in particular normative ways, and were manufactured and (re)produced in part, by dominant biomedical discourse enacted through gendered performances. This type of engagement asks us to question what were the potential consequences, and for whom?

Ontological considerations

Drawing on a definition provided by Crotty (2003), “ontology is the study of being. It is concerned with ‘what is’, with the nature of existence, with the structure of reality as such” (p.10). I understand our perceptions of reality to be situated, contextual, competing and contrasting. Consequently, I view one’s experience of reality to be historically located, and transient, wherein the intersections of gender, class, race, sexual orientation, and physical and mental ability traverse in multifarious ways to construct our particular view of reality. “We are seen to live in webs of multiple representations...[where] meanings vary even within one individual ... This focus on the fundamentally relational nature of identity results in the historically constituted and shifting self versus the static and essentialized self inherent in the concept of the free and self-determined individual” (Lather, 1991, p.118).

So while a “real” world may exist outside our consciousness, “It becomes a world of meaning only when meaning-making beings [attempt] to make sense of it” (Crotty,

2003, p. 10). I understand our perception(s) of reality to be constructed within “historically situated structures that are, in the absence of insight, as limiting and confirming as if they were real” (Guba & Lincoln, 2004, p. 27). Guba and Lincoln further suggest that there is a relationship between ontology and epistemology, such that, if there is an assumption of external “real” reality outside the knower, the stance of the knower [necessarily] becomes detached and value-free in order to capture how things “really” are (Crotty, 2003). However, upon further exploration we can imagine the coupling of ontological realism with a critical, relativist epistemology.

Epistemology

The epistemological advantage of women is that a sexist society puts them in contradictory social locations, constructing them as both subject and object. They have an “outsider within” advantage and can play on the location created by the gap between experience and the conceptual frameworks that are available to make sense of it (Sprague & Kobrynowicz, 2006, p. 38).

I contend that knowledge and truth(s) “can be understood only in relation to particular sets of cultural or social circumstances...Conditions of justification, criteria of truth and falsity, and standards of rationality are likewise relative: there is no universal, unchanging framework or scheme for rational adjudication among competing knowledge claims” (Code, 1991, p. 2). Taking this position does not mean that I embrace the idea that knowledge claims can be, or ought to be, indistinguishable from personal opinion or bias, an absolute subjectivism; however, I do contend that there are a myriad of ways of knowing, and coming to know, and that findings between researchers and their participants are inextricably linked to the situatedness of their particular context (Guba & Lincoln, 2004). Therefore a moderate relativist position that entails embracing the local, partial and situatedness of all knowledge claims, makes room for the valuing of a variety

of perspectives (Code, 1991), where the “specific, subjective ‘nature’ and circumstances of knowers – [are factored] into the conditions that bear on the nature, possibility, and/or justification of knowledge” (Code, 1991, p. 27). To this end, I embrace the post-structuralist proposition that language is ideology in action, and that language speaks to us, and that it is *through* language that ideology can be challenged (Belsey, 1980).

Theoretical Influences

The rise of medical education has been described over time as a “history of reform without change” (Bloom, 1989). To advance medical education as a field, medical educators are calling for researchers to clearly articulate the theoretical underpinnings informing their research studies (Rees & Monrouxe, 2010). The theoretical underpinnings that inform my research are influenced by a combination of personal, professional and academic endeavours. Moreover, as I reviewed the existing research literature, and collected my own data, different scholars and theories were brought into the conversation to contextualize my emerging interpretations. The work that informs my research is drawn from critical feminist literature, particularly Butler (1990, 1993, 1997) and Grosz (1994); sociology of body/work as per Wolkowitz (2006) and poststructuralist theorizations related to social (dis)order and discourse such as Foucault (1990, 1995).

Unpacking discourse

Discourses can be conceptualized as,

...ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern (Weedon, 1987, p. 108).

My work draws on Michel Foucault's conceptualization of discourse, particularly as this has been taken up by scholars in health studies. Discourses order reality in particular ways as "they both enable and constrain the production of knowledge, in that they allow for certain ways of thinking about reality while excluding others" (Cheek, 2004, p.1142). At any given point, there are a variety of possible discursive frames to draw on for thinking, speaking and writing about our experiences of reality, and operate as "... a form of power that circulates in the social field and can attach to strategies of domination as well as those of resistance" (Diamond & Quinby, 1988, p. 185).

However, some discourses are positioned as more legitimate than others due to the intricate operation of webs of power that facilitate certain types of knowledges to gain prominence over others (Cheek, 2004). The authority that is granted to the biomedical discourse, for instance, allows health care professionals to speak authoritatively about health and wellness, which in turn also affords the medical communities power to exclude or marginalize other knowledges from being taken up as legitimate (Bratich, Packer, & McCarthy, 2003; Cheek, 2004).

I argue that it is precisely because the women's genitalia is the site of so many conflictual discourses that the pelvic teaching program risks oversimplifying its role in the larger socio-political context. The vagina is (re)presented as: (1) an anatomical space separate from the woman herself (biomedical discourse), (2) the signifier of what a woman is, and what she is predetermined to become (biology is destiny), (3) something to be enjoyed by men for the purpose of men's pleasure only (compulsory heterosexuality) (4) something that can be commodified, packaged, bought and sold (pornography), (5) the space of temptation, and should be feared and engaged with only

to service reproductive purposes (religious discourse), and (6) when left to the discretion of its owner to decide its own boundaries – criminalized and/or pathologized (legal, moral discourse). These discourses do not operate in isolation, as discrete and tidy categories, but innervate one other to generate multiple and contesting ways of ‘knowing’ women. By (re)considering the discursive scaffolding that collectively shapes how women and health care practitioners enact, experience and frame the pelvic exam performance, possibilities for different understanding(s) of how particular discourses advantage particular groups, and simultaneously disadvantage others, emerge.

Critical feminist theories

The crafting of my research and the representation of the research findings were also informed by (post)critical and post-structuralist feminist theories. Today, critical feminist theorists recognize that it has become difficult, if not impossible, to locate oneself within a particular “feminism” (Lather, 1991); therefore, “weight [is given] to the lived experience and practical consciousness by situating research and researched as bearers of knowledge...” (Lather, 2001, p. 215). Critical feminist theory has become a contested site, but where all forms of feminisms unite in understanding the dire need for continued commitments to social justice agendas (Denzin, Lincoln, & Tuhiwai Smith, 2008). Generally speaking, critical feminist theories concern themselves with issues related to social justice, and how the economy, and matters of race, class, and gender intersect within multiple, hegemonic discourses (Kincheloe & McLaren, 2005). Critical theory argues for the recognition that reality is subjective and (re)constructed based on power, where Truths are many, and are (re)constituted within a system of socio-political

power. Rhetorical and political will embeds and shapes which forms of knowing will be granted discursive authority over others (Lather, 2006).

Within a research context, a critical researcher might ask: who is excluded from the research ‘room’? How does this affect what we think we know? (Fine, 2006, p. 95) In accordance with a critical feminist perspective, women’s experiences of their lives are conceptualized within larger historical and social discourses. In the context of gynecological practices, biomedical discourse has been dominant in constructing women’s bodies and particular practices. When viewed from a critical feminist perspective, biomedicine as a scientific practice operates from a paradigm that is laden with embedded assumptions. Among them are: (1) Western approaches to medicine are superior, (2) the physician is the (legitimized) expert that knows what is best for the “patient”, and (3) the use of invasive and expensive procedures and technologies should not be questioned but encouraged (Arroba, 2003). In effect, the medical gaze attempts to de-sexualize women’s bodies while simultaneously pathologizing them against the backdrop of a ‘heterosexual male norm’ as the biomedical gaze often focuses exclusively on the women’s reproductive processes (Elliot, 2003), “this misleading universal representation separates the body from the rest of the person, their emotions, their intellect, their spirit, [and may deny] women the opportunity to explore and understand their bodies in any way other than reproductive and heterosexual” (Elliot, 2003, p. 135).

Women’s bodies as sites for surveillance and regulation. Women’s bodies have become contested sites where powerful technologies of surveillance and regulation get (re)enacted. Medical experts, with all their technological apparatus positioned to diagnosis and (re)name/blame, are granted the authority to give meaning to women’s

bodies (Conrad, 1992). According to Foucault (1990), the emergence of the population as a unit of analysis in the eighteenth century was one of the most significant developments in the techniques of power. No longer was the focus strictly upon individual subjects, but upon the health of entire populations. Concerns such as birth and death rates, fertility and patterns of habitation became matters of the state where “[a]t the heart of this economic and political problem of population was sex” (p. 25). It was at this point that a significant shift occurred, and the population as a whole became “an object of analysis and a target of interventions” (p. 26). Of paramount importance was the state’s quest to *know* about the sexual habits of its citizens, and to ensure its proper usage amongst individuals, such that the sexual behaviours of persons became not something to solely repress, but rather provided an entry point for newer regimes of discourses to gain prominence. In fact, according to Foucault, there was an institutional incitement to speak about sex.

As Foucault contended, a shift occurred wherein the power of the sovereign no longer exerted itself as “the right to *take* life or *let* live” (p. 136, italics in original) through such measures as seizures: of bodies, property time and life, but aligned itself with a power to “ensure, maintain, or develop its life” (p. 136). This new form of power over life is what Foucault refers to as biopower, and what is at stake –the biological existence of the population. Foucault locates the birth of biopower within the emergence of the proliferating discourses and diversification of techniques “for achieving the subjugation of bodies and the control of populations” (p. 140). Two separate, yet connected strands of development shifted this power over life: (1) A focus on the body as a machine, connected to treatment aimed at optimizing its efficiency and exploiting its ‘productive’ capabilities – constituting an “*anatomo-politics of the human body*” (p. 139,

italics in original); and (2) The regulation at the population level through surveillance and “regulatory controls: a biopolitics of the population (p. 139).

Pelvic examinations perform as a part of this surveillance, making sure that women’s bodies are healthy for reproduction – reproduction being the ‘norm’ for women (Shildrick, 1997). Furthermore, positioning GTAs against normative gender roles perpetuates the validity of the question ‘what kind of woman’ would volunteer for such a thing? Such questioning determines and then polices the boundaries between ‘kinds’ of women, reproducing particular understandings of what a woman and her body are ‘good for’.

Performativity

...performers tend to foster the impression that their current performance of the routine and their relationship to their current audience have something special and unique about them. The routine character of the performance is obscured (the performer himself is typically unaware of just how routinized his performance really is) and the spontaneous aspects of the situation are stressed) (Goffman, 1959, p.31)

In my thesis, the notion of performativity refers to the capacity of speech acts and language specifically, as well as other non-verbal forms of self-expression, to (re)perform a type of socially constructed and sanctioned identity, and to elicit through discursive means, such performances in others. The early work of Irving Goffman, and the later work of Judith Butler informs my theorizing throughout my thesis, particularly as I attend to the issues of preparing to perform the role of a GTA, the directed performance between the students and the GTAs during the teaching, how GTAs attempted to managing the performances of others within the pelvic teaching encounter, and my performance as a researcher.

Irving Goffman’s *The Presentation of self in everyday life* (1959) is cited as the first

book to treat face-to-face interactions as a subject of serious sociological investigation. Goffman likens social interaction to that of a theatrical performance, where “actors” when in the presence of others, are front stage. Other aspects within the self that may be subject to scrutiny or judgment, are placed off-stage until one is alone or out of the immediate presence of others (Ritzer, 2004). The notion of ‘front stage’ self/ves is extended and re-conceptualized in the work of Judith Butler, demonstrating that,

The view that gender is performative sought to show that what we take to be an internal essence of gender is manufactured through a sustained set of acts, posited through the gendered stylization of the body. In this way, it showed that what we take to be an “internal” feature of ourselves is one that we anticipate and produce through certain bodily acts, at an extreme, an hallucinatory effect of naturalized gestures (Butler, 1990, p.xv-xvi).

Performativity has been defined by Butler as “...that reiterative power of discourse to produce the phenomena that it regulates and constrains.” (Butler, 1993, p.2). Butler (1993, p. xi) suggests that the way we perform ourselves perpetually (re)constitutes our identities – our bodies “only appear, only endure, only live within the productive constraints of certain highly gendered regulatory schemas.” She asks us to question what constraints act on the body, and also, how through the repetitious enactment of “violent circumscription of cultural intelligibility” is it that *some* bodies come to matter more than others? (1993, p.xii)

To this end, performing gender is not an innocent practice; rather, it is a performance of (disem)power(ment): “performativity must be understood not as a singular or deliberate ‘act,’ but, rather, as the reiterative and citational practice by which discourse produces the effects that it names ... to materialize sexual difference in the service of the consolidation of the heterosexual imperative” (Butler, 1993, p.2). By troubling gender through drawing attention to the performative nature of gender, Butler

calls into question what we think to be the reality of gender – “...this is the occasion in which we come to understand that what we take to be ‘real’, what we invoke as the naturalized knowledge of gender is, in fact, a changeable and revisable reality” (Butler, 1990, p.xxiii).

Within the context of this thesis, Butler’s notion of gender as performed offers space to consider how gender, as it is *now* performed during pelvic examinations, could be performed differently. The aim therefore, “...is to make visible the tenuousness of gender ‘reality’ in order to counter the violence performed by gender norms” (Butler, 1990, p. xxiv) and to (re)create the possibilities for something other, something more. By troubling the ways in which gender is (per)formed within the context of pelvic teaching, our attention is drawn to how such performances are situated within dominant discourses, leading us to consider how and why this matters..

Methodology

I crafted my study using an autoethnographic methodology, informed by the rich and multifaceted tradition of classical ethnography, and newer forms of performance ethnography emerging within the field of education studies. In response to positivist research practices based on prediction, experimentation, verification, and objectivity, and coupled with a growing dissatisfaction with the privileged status afforded to quantitative methods, there has been a surge of interest in conducting research within alternative paradigms utilizing qualitative approaches (Guba & Lincoln, 2004). In conjunction with this dissatisfaction, there has been a resurgence in the debate surrounding the philosophical traditions and accompanying assumptions of social science research (Kezar, 2004; Snape & Spencer, 2003). There is also growing attention in the qualitative

literature around such issues as power, (re)presentation, transparency, reciprocity and authority in the research process (Hewitt, 2007; Morrow, 2005). As Lather (2007) explains, “[t]his is about the “ruins” of methodology, the end of the transcendental claims and grand narratives: methodology under erasure. In such ruins, inquiry is seen as a social practice, and “what is at stake is not so much the nature of science as its effects” (p.2).

Against this backdrop, alternative methodologies embracing the tentative, situated nature of the research/researcher began to appear: where “a quiet methodological revolution has been occurring in the social sciences; a blurring of disciplinary boundaries is taking place” (Denzin, & Lincoln, 2005, p. ix). New methodologies for ethnography, such as performance ethnography and literary journalism (Denzin, 1997) developed in response to the call to trouble notions of “self-correction” through critical modes of (re)presentation and reflexivity (Lather, 2007). There was a need for newer ground, where (re)presentational texts could move us towards recognizing the absence of any and all transparent narratives (Lather, 2007). These perspectives informed the framing of my critical autoethnographic research design, and the writing of my thesis.

She left me breathless: My first autoethnographic encounter

She stands at the front of the classroom, short spiky hair – flushed cheeks. A recent medical school graduate without a residency. She seems vulnerable, her speech rapid. Over the course of the hour she presents a riveting account of her experiences as a “med student”. I sit mesmerized, captivated really, as she narrates slide after slide from her PowerPoint presentation of her grueling experiences in a large teaching hospital. She’s slowed her speech down, has found her groove – feels the safety of the space... Her words are like bullets raining out over us; only I don’t want to hide or shield myself. I want to hear more. I’m drawn in by the rawness of her emotions, but it’s her brilliant storytelling that holds me there – makes me lean forward in my lecture-hall chair. She stirs something in me. I’m excited. I am lulled by the power of her voice and the authenticity she projects. The story resonates strongly with my own experiences as a midwifery student - I want to jump out of my seat and yell, “you go girl!”

“She left me breathless” was my first autoethnographic ‘encounter’: it was an *awakening*. Hooked instantly, I started foraging around journal databases for references to other such work. Within days a professor (upon my request), emailed me a list of references. I scrolled down the page reviewing what she had sent: *Bochner and Ellis were the two to watch out for*. There was also a book called *The Ethnographic "I"* (Ellis, 2004), which I was told was *the* quintessential text on autoethnography. So I purchased a copy, devoured it within days, flagging passages for future reference with multi-coloured sticky notes. During my own literature review I came across Art Bochner’s (1997) *It’s about time: Narrative and the divided self*, and Jeanine Marie Minge’s heart-wrenching autoethnography of rape(s), *The Stained Body: A fusion of embodied art on rape and love* (2007). The volume of published autoethnographies was limited but the breadth of research topics was impressive: childhood sexual abuse (Ronai, 1995), the peer review process of manuscript submission (Holt, 2003), fathers and son (Bochner, 1997, 2008), mental health (Short, Grant & Clarke, 2007), professional and personal discursive constructions in practice (Kinsella, 2006), and an autoethnography on learning about autoethnography (Wall, 2006). Recently, there has been a proliferation of studies utilizing autoethnography, for example: the regulation of the bodies of elite athletes (McMahon & Dinan-Thompson, 2011), disability, masculinities and teaching (Mara, 2011), and an embodied account of the transition to mothering (Kuttai, 2009). Autoethnographic studies are still relatively rare within the health sciences, with a few notable exceptions, such as: autoethnographic accounts of occupational therapy practice (Denshire, 2010), the experiences of mental health nursing (Foster, McKallister, & O’Brian, 2005), and illness autoethnographies (Morella, 2008; Richards, 2008).

Despite the diversity of topics, styles and methods of (re)presentation, all autoethnographic writing foregrounds the researcher's own subjectivity as a/main participant in the text (Bochner & Ellis, 2002; Denzin, 2006; Ellis, 2004; Wall, 2006). The autoethnographic rubric developed by Ellis and Bochner (2000) includes personal narratives, narratives of the self, ethnographic short stories, memoirs, confessional tales, and a host of several other forms making an unambiguous definition and an explicit description of the methodology challenging. Autoethnography has been taken up in many different ways, drawing on a diverse range of epistemological and ontological assumptions (Wall, 2006). While various conceptualizations of the autoethnographic approaches circulate, the most useful for researchers like me, who use participant observation, focus groups, and in-depth interviews, are ways that view autoethnography as a means of making sense of one's and others' experiences within diverse 'cultural' settings (re)shaped by movement across varied context(s) (Berry & Warren, 2009; Ellis & Bochner, 2000; Pompper, 2010). Intentionally inviting 'other' participants to share their experiences with me, allowed my prior assumptions to be challenged, expanded upon and/or (re)affirmed.

Research writing as a practice

What does the ethnographer do – he writes (Geertz, 1973, p. 19).

It is no doubt strange, and maddening to some, to find a book that is not easily consumed to be "popular" according to academic standards. The surprise over this is perhaps attributed to the way we underestimate the reading public, its capacity and desire for reading complicated and challenging texts, when the complication is not gratuitous, when the challenge is in the service of calling taken-for-granted truths into question, when the taken for grantedness of those truths is, indeed, oppressive (Butler, 1990, p. xix).

Within health sciences, qualitative health researchers are beginning to resist dis-

embodied writing practices that “obscure the complexities of knowledge production ... [yielding] deceptively tidy accounts of research” (Ellingson, 2006, p. 298; Richards, 2008). Functioning as a naturalized norm, the absence of the researcher’s body from health science research continually reaffirms a masculine, Western cultural way of being, and “[w]hen health care researchers’ bodies remain unmarked – and hence naturalized as normative – they reinscribe the power of scholars to speak without reflexive consideration of their positionality, whereas others’ voices remain silent or marginalized by their marked status” (Ellingson, 2006, p. 301). By using an autoethnographic approach, I intended to make room for the body, my body, in the production of knowledge.

Not without criticism, autoethnography moves “ethnography away from the gaze of the distanced and detached observer and toward an embracement of intimate involvement, engagement, and embodied participation” (Ellis & Bochner, 2006, p. 434). As Jones (2005) states, "Autoethnography [as] a blurred genre...refus[es] categorization...believing that words matter and writing toward the moment when the point of creating autoethnographic texts is to change the world" (p.765). From beneath the shadows of the regimes of truths (Foucault, 1980) we begin “thinking thoughts we’re not supposed to think” (Bochner, 1997, p. 425), where we invite “[b]odies themselves [to] engage in theory making” (Gannon, 2006, p. 477), and where deferral and displacement in writing ‘oneself’ is located as a site of resistance. Autoethnography appears on the scene as “part of a corrective moment against colonizing ethnographic practices that erased the subjectivity of the research while granting him or her absolute authority for representing “the other” of the research” (Gannon, 2006, p. 475).

Authors writing in an autoethnographic style write in the first person making themselves both the subject and object of the research project (Ellis, 2004). Further, autoethnography,

... shows struggle, passion, embodied life ... Autoethnography wants people to care, to feel, to empathize, and to do something, to act. It needs the researcher to be vulnerable and intimate. Intimacy is a way of being, a mode of caring, and it shouldn't be used as a vehicle to produce distanced theorizing. What are we giving to the people with whom we are intimate, if our higher purpose is to use our joint experiences to produce theoretical abstractions published on the pages of scholarly journals? (Ellis & Bochner, 2006, p. 422).

In addition to the singular voice of the researcher, often there is on-going dialogue between other 'participants' in the text, such as research participants, as in autoethnography that includes interactive interviewing (Ellis, Kiesinger, & Tillmann-Healy, 1997), other texts (such as books and journal articles), and the reader (Ellis, 2004). This dialogue aims to foster an understanding that knowing is a relational practice that supports, and is supported within, spaces of trust, caring and mutuality. It requires autoethnographers to *risk* being uncomfortable, where the desire for predetermined outcomes evaporates (Brooks, 2006). In this enactment of dialogue, vulnerability and insight partner one another. Other participants may include the multiple voices of the researcher as they reflexively bend back on themselves from their various subject positions, locations in time and space. Working these different 'locations' sheds light on the plurality of the ethnographic identity. Working within this 'hybrid' reality, the identities of the researcher collide with the "larger cultural assumptions concerning race, ethnicity, nationality, gender, class, and age. As a certain and fixed identity is never possible; the ethnographer must always ask "not *who* am I?" but "*when, where, how* am I?" (Trinh, 1992, p.175).

An autoethnographer often discloses intimate aspects of one's personal life, and require the involvement and participation of writer, reader and text (Ellis, 2004). So rather than using academic discourse to create the illusion of a disembodied researcher (Ellingson, 2006), autoethnography *embraces* the voice of subjectivity as a source of insight. The task for the autoethnographer is to act from a space of courage: to take risks, aim to discover and speak from within their own voice(s). Without defensiveness or apology, autoethnographers hold their ground against the forceful current(s) of dominant academic discourse(s) that innervate the spaces where 'we' live and work (Bochner, 2008).

Autoethnographers recognize that we tell our stories as attempts to make order out of chaos, to make meaning out of the events in our lives and that "evidence, such as personal descriptions of life experiences, can serve to issue knowledge about neglected, but significant areas, of the human realm" (Polkinghorne, 2007, p. 472).

Autoethnographies are counter-narratives aiming to "disrupt and disturb discourse by exposing the complexities and contradictions that exist under official history" (Multua & Swadener, as quoted in Denzin & Lincoln, 2005 p. 946). The disruptive force of autoethnography is accomplished through writing that challenges "the distancing and alienating forms of self-expression that academic elitism encourage[s]" (Behar, 1995, p. 7), for when it comes "to communicating ethical consciousness, it is much more effective to tell a story than to give an abstract explanation or analysis" (Fachning & deChant, as cited in Ellis & Bochner, 2006, p. 439).

To encourage multi/polyvocal texts, various methods and styles of representation are employed by autoethnographers, carefully chosen with the intent to evoke an embodied

response in the reader. Autoethnographers often quilt, like a tapestry, various narrative genres together: poetry, personal diaries, field notes, visual imagery, theatrical performance, with theory drawn in from the disciplines of sociology, performance studies, philosophy, English, and art education (Bochner & Ellis, 2002).

Autoethnographies often represent a fusion of these texts (Minge, 2007) in an effort to engage the reader in thinking about the unexpected, the unexamined, the unexplored, the non-problematized, and to create spaces for a radical (re)visioning of our assumptions (Gannon, 2004, 2006). Autoethnography is *vulnerable* work. Evocative, provocative, and written well, autoethnography is authentic, and therapeutic; further, its style involves methods of telling that take the reader by the heart, break it, and create opportunities to heal it again (Ellis, 2004):

Autoethnography is a powerful way to “take back the night” from the potential violence of our unexamined projections and resist our own protestations that we are not biased. By telling a story *on* ourselves, we risk exposure to our peers, subject ourselves to scrutiny and ridicule, and relinquish some of our sense of control over our own narratives ... [however] a paradoxical effect occurs: By giving up the power that comes from being disembodied and disinterested observers, we can claim a new sense of empowerment ... Vulnerability is returned for strength (Allen & Piercy, 2005, p. 156, emphasis in original).

Such evocative writing requires one to become *vulnerable* – to the reader, to ourselves – our inner most thoughts, fears, desires are put out and held up for examination. And the writing process and product is integral to the methodology:

We want to satisfy our desire to not reproduce the old forms of representation, the ones that limit and constrain us. We realize that how a story is told shapes what the story can tell. Thus, our desire to tell new and different stories rests on our capacity to liberate ourselves from restrictive, conventional modes of telling (Bochner, 1994, 2002, as cited in Bochner 2008).

Writing from the first person requires one to engage in critical reflexivity: dialogue with/against oneself(ves), opening yourself up to the possibility of being unsettled – *of unsettling others*. The introspection critical reflexivity demands is (dis)comforting, jarring, and potentially (de)stabilizing to one's sense of his/her self (Finlay, 2002). Autoethnographic texts make space for such unsettling endeavors – through such reflexivity and problematizing of our own identities and assumptions – as terrifying as it is liberating.

As both process and product, autoethnography produces *messy texts*. A term coined by George Marcus, “messy texts” is used to describe new practices within ethnography that embrace partial and fluid epistemological assumptions, and writing styles that problematize modes of writing that present linear, authoritarian representations of ethnographic fieldwork (Lather, 2007). Messy does not mean in-congruent, or of poor rigor. It does imply a non-linearity and a non-conformity that is intended to agitate readers’ assumptions and displace an authorial voice by calling attention to issues such as: the transparency of language and the conventional staging and performance of science as a means to destabilizing “its own truth claims” (Ellis, 2004; Lather, 2007, p. 39; Gannon, 2004). My thesis is informed by a style of representation called a “layered account” first advocated by Ronai (1992):

A layered account is a postmodern ethnographic reporting technique ... a narrative form designed to loosely represent to, as well as produce, for the reader, a continuous dialectic of experience, emerging from the multitude of reflexive voices that simultaneously produce and interpret a text. ...this format enables ethnographers to “break out: of conventional form and expand the types of knowledge they are permitted to convey” (Ronai, 1995, 396).

Stacy Holman Jones (2005) in her article *Autoethnography: Making the personal political* discusses the act of balancing with respect to autoethnographic writing, that is,

the balance between: (1) telling versus showing - how much of ourselves do/should we include, and what should we leave out?; and (2) writing about, and holding together the/a self and culture in a world that is constantly in flux. I found myself struggling with this task of balancing, of weighing how much of myself to explicitly make visible with how much to maintain tucked away. I also wrestled with these challenges because of the context in which I was writing – that is as a doctoral candidate and an emerging researcher. As this is my doctoral thesis, I felt a heightened sense of urgency and vulnerability to negotiate a suitable balance.

Yet I was also aware that there were other voices in the ‘room’, those who discount the postmodern and post-structural versions of qualitative research, equating it with political correctness, with radical relativism, narratives of the self, and armchair commentary (Guba & Lincoln, 2004). And I also cannot fail to mention the communities whose voices have been, and continue to be, left out of the conversation, or worse still - spoken for. People(s) whose interests and needs have been submerged, marginalized, silenced – colonized throughout the history of quantitative and qualitative research (Denzin & Lincoln, 2005). There is the potential to (re)commit such eradication with/in the philosophies of the ‘post’ (Hill Collins, 2000). Numerous critical, feminist and post-colonial researchers have raised poignant concerns over the “death of the subject” put forth by post-structuralists at a time when women and people from lower socioeconomic classes and racialized minorities were just starting to challenge the authority of the Western white male elite from their particular standpoints (Hill Collins, 2000; Lather, 1991).

But does such a radical, splintering proliferation of grand narratives *necessarily* undermine the emancipatory efforts of critical researchers? What if instead, subjects in the “post” (which are positioned as fluid, ambivalent, and in constant flux) become viewed as agents of resistance, refusing categorization and compartmentalization? What if instead of being taken-up merely as a theory (solely) utilized by intellectual ‘elites’ within academia, decentering practices were used strategically as modes of / for sites of resistance? (Hill Collins, 2000) Patti Lather (2006) argues that “working discontinuous interruptions that aggregate in excess of intending subjects and tidy categories or purposes [lead us] toward a transvaluation of disciplinary formations” (p. 43).

Consequently, this work must remain mindful that “while discursive categories are clearly central sites of political contestation, they must be grounded in and informed by the material politics of everyday life, especially the daily life struggles for survival of poor people – those written out of history” (Mohanty, 2004, p. 53). As such, I troubled the representations of GTAs that precluded an analysis of how material conditions participated in the motivations for participating in pelvic teaching – however uncomfortable, or rife with tensions, such conversations might be. Women’s bodies are being deployed in pelvic teaching, which have real material effects in/on their bodies, which demands a critical analysis of the circumstances that produce such realities.

A trickster moving within hybrid spaces. So I remind myself that the calling here is to remain a ‘trickster’ prowling across and between the various, seemingly competing and contesting ‘zones’, never forgetting that any really “loving” political practice must fall prey to its own critique ...[yet] we can pull together [what might appear at first glance to be disparate theories] even if we bring each other to crisis (Spivak &

Harasym, 1990, p. 111). This is work that happens at the boundaries of ourselves, denying and defying the performances of authority, and congruency, wherein postmodern /poststructuralist discourses become (potentially) libratory in and through the problematizing of “knowledge and engagement in potent ways” (Lather, 1991, p. 14).

Autoethnographic work is positioned in what has become conceptualized as a *hybrid space*: where texts enact double(d) agendas becoming radically fractured “within a critical deconstructive suspicion of hegemonic practices and a simultaneous reinstallment of the referent in the service of resistant struggles” (Lather, 2006, p. 41). Displacement and radical proliferation, rather than confrontation and closure (Lather, 1991), are embedded notions within autoethnographic methodology (Gannon, 2006). The texts as they are staged allow for and encourage alternative, multiple readings. They are purposely left open to a plethora of interpretations (Ellis & Bochner, 2000). The position of the autoethnographer is self-conscious. Recognizing the limits of knowing oneself, the autoethnographer willingly places themselves, and their assumptions, on the table for closer examination and skeptical consumption (Gannon, 2006; Kincheloe, & McLaren, 2005). Feminism has been credited with assisting in the autoethnographic movement by working to legitimize the voice of the autoethnographer (Ellis, 2004), urging researchers to operate under “an ethic of care, solidarity, community, mutuality, and civic transformation” (Denzin, as cited in Ellis, 2004, pg. 149).

Tensions

Autoethnography, by beginning inwards and moving outwards (and back again, and around again), traverses the boundaries between self and culture, arguing for the recognition that the ‘local’ is grounded in the politics, circumstances, and economies of a

particular moment, a particular time and place, a particular set of problems, struggles, and desires. Within the local, resistance and possibility are embedded (Denzin, Lincoln, & Tuhiwai-Smith, 2008). Within each of us are the seeds of radical cultural change.

But there is a charge that the work is self-involved navel gazing. Carolyn Ellis (2004) responds to this critique by stating conversely:

...it's self-absorbed to pretend that you are somehow outside of what you study and are not impacted by the same forces as others...To write about the self is to write about social experiences...If culture circulates through all of us, then how can autoethnography not connect to a world beyond the self? (p. 34).

Those who critique autoethnography as a narrative focused solely on the self, and thus inherently limited, fail to consider that each individual speaks within societal frameworks and it is within these frames that meanings are (co/re)negotiated (Delamont, 2009). So rather than being a hindrance, the reliance on, or privileging of, personal experience strengthens autoethnography: "Who would make a better subject than a researcher consumed by wanting to figure it all out?" (Ellis, 1991, p. 30).

Convergence and departure: Re-constituting 'the field' in autoethnographic work

Like classical ethnography, critical autoethnography shares an interest in understanding culture; however, critical autoethnography has been conceptualized as alternative or disruptive in that it is poised as openly ideological and interested in identifying how oppressive situations are reproduced and reified within the cultures they study (Koro-Ljungberg & Greckhamer, 2005). Critical autoethnographers shift how culture is conceptualized; shifting from culture as static and 'there' prior to the researcher arriving/engaging, toward more dynamic/multiple/socially situated notions of culture, thus recognizing the researcher's role in contributing to the naming of what it

(re)constitutes – unfixing received notions of boundaries within any given ‘culture’.

Unlike classical ethnography, critical auto/ethnographers locate themselves as a central participant in the research, recognizing the multiple ways we all engage in knowledge production, and utilize various theoretical lenses (often held in tension) to work in hybrid spaces that disrupt “the cycle of unreflexive reproduction” (Koro-Ljungberg & Greckhamer, 2005, p. 293). The researcher’s epistemological and ontological beliefs are understood to influence and construct their relationship with participants; therefore, they are implicated in the production of data, and not ‘just’ in the collection and analysis of data (Koro-Ljungberg & Greckhamer, 2005).

In traditional anthropology the aim of the ethnographer was to articulate a deep and credible birds-eye-view of a culture that he or she had deeply immersed himself or herself within. For example, the photographs at the beginning of Malinowski's *Argonauts of the Western Pacific* depict the ethnographer's tent set up amongst Trobirand dwellings. Malinowski claimed a kind of panopticism in which rites, rituals, spells and cures "took place under my very eyes, at my own doorstep, so to speak" (Malinowski, 1922:, p.8). Results were not directed toward being applicable across cultures and other research projects, but in bridging the distance between the ‘self’ and ‘other’, and to celebrate the *extraordinary* in the mundane, taken-for-granted aspects of the human experience. A central tenet of anthropological ethnographic work was to 'make the familiar strange and the strange familiar, exemplified in seminal works such as Geertz's *The Interpretation of Cultures* (1973).

Critical autoethnographers maintain these goals with the exception of foregrounding their subjectivity throughout the research process (Koro-Ljungberg &

Greckhamer, 2005), viewing one's position(s) in the text not as a weakness, but an inherent source of insight. Autoethnography celebrates the tensions between the 'self' in relation to culture – a 'self' which emerges within and against culture, and foregrounds the struggle to find representational practices that can account for the messiness of life.

Within the 'culture' of pelvic teaching, I understand that realities are many, knowledges are situated, and the 'self' is (re)produced in relation to and within, larger socio-political-historical contexts making particular discourses available for describing, for indeed enacting our 'selves', (im)possible. This understanding means that I conceptualize the 'culture' of pelvic teaching to be contingent, in flux, and (in)formed and (re)constituted by elements outside my capacity to 'capture'. I recognize that the participants come together, united, perhaps only momentarily, under the common goal of attempting to accomplish the task(s) associated with pelvic teaching.

Methods of data collection

The methods for my study were chosen in conjunction with the purpose and nature of my research questions, and according to my theoretical and methodological framework. For researchers working with(in) critical perspectives and using feminist theory, there are no prescriptive set of methods to be used (Jayarante & Stewart as cited in Berman, 1996). However methods are generally chosen based on their capacity to engage with participants in critical dialogue, a valuing of the research study as a process (i.e. not just a means to an end), an embracement of researcher reflexivity, and the researchers' willingness to hold their own assumptions up as tentative and situated (Fonow & Cook, 1991).

My autoethnographic ‘field work’ took place in a clinical skills teaching lab that is housed within a Faculty of Medicine. In addition to the data of my storied experiences performing as a GTA, I chose four primary data collection methods: (1) participant observation, including field notes and reflective journaling; (2) focus groups with GTAs; (3) semi-structured interviews; and (4) document review. A letter of information outlining each method of data collection was given to each participant prior to data collection, and written informed consent was obtained. Institutional ethics approval was obtained prior to data collection (see Appendices A, B and C).

Participant observation

Participant observation holds the potential to establish greater rapport and better access to research participants than other data collection methods. Participant observation is believed to enhance the researcher’s understanding of how thoughts and behaviours are (re)created within any given context (Dewalt & Dewalt, 2002). The field for this study was identified as the clinical teaching lab in which the various participants engaged in activities related to learning about the pelvic teaching program, and carrying out the activities associated with performing the pelvic examination. The field included the clinical teaching rooms in which the pelvic examinations were conducted, and the group room GTAs would gather before and after the teaching sessions. Participant observation took place just before, during and after each pelvic teaching module for the duration of the program. The pelvic teaching program ran from Tuesdays through Fridays, 8:30am to 11:30am for a four-week block of time.

Interactions between and among myself, medical students, GTA and program administrators before, during and after the pelvic teaching module were captured in field

notes taken by hand during the sessions, and separate field notes were digitally recorded after each session had ended, generally within an hour of leaving the research location.

During the pelvic teaching sessions, I observed the interaction between the medical students and the GTA, and the interaction between the two GTAs (the one acting as the 'model/patient' and the one facilitating the session). Observations enabled me to document patterns in actions and performances, to note the ways in which, and 'which', discourses were enacted, and to reflect on where and how resistance manifested within the teaching space. Before and after the training sessions I also participated in the preparation for teaching, and the informal de-briefing that took place after the teaching sessions that occurred between the GTAs and the medical students, as well as amongst the group of GTAs.

Focus groups

Focus groups were conducted with GTAs during the second week of the module. At the start of the focus group interviews, the intention of my research and of the focus group was explained. How I explained the purpose of the focus group is discussed further in Chapter Three. Issues of unique importance to focus groups were covered, such as the limits of confidentiality and anonymity. I also reminded participants that the goal of the focus group was not to reach consensus, but to share opinions and experiences performing as a GTA (Kruger & Casey, 2008). The focus group sessions were intended to establish that all of the participants shared something(s) in common (e.g. training to become a GTA, how many students they typically worked with), and I began by inviting each participant to share how long they had worked as a GTA and their motivation for becoming a GTA. After introductions, the remaining questions were designed to

encourage participants to reflect on their experiences performing as GTAs, beginning with the process of training to become a GTA (see Appendix D).

The decision to conduct a focus group was also informed by feminist research(er) practices which position focus groups as a strategic method of data collection, utilized to circulate power more equitably amongst researcher and participants – something more challenging to accomplish within most one-on-one interview settings. Using focus groups to generate a sense of shared experience had been an important intention within feminist research (Hesse-Biber & Yaiser, 2003), and unlike more traditional approaches to focus groups, feminist researchers theoretically ground their choice of focus groups within an action framework intentionally used to generate the conditions necessary for critical group reflection and action (Kamberelis & Dimitriadis, 2005). As Morgan (1998) stated, “[T]he hallmark of focus groups is *the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group*” (emphasis in original, as cited in Wilkinson, 1998, p. 112). For instance, the researcher’s power and influence can become reduced as there are more participants than researcher(s) present, and the interview guide tends to be less restrictive than in one-on-one interviews (Wilkinson, 1998), and as the participants utilize one another’s responses to stimulate reflection and narration of insights. Prior to asking my research questions, I attempted to articulate, as transparently as possible, my theoretical positioning and the intention of my specific research design. In subsequent chapters I describe how I introduced my research participants to my theoretical positioning, the discussion that ensued afterward, and in hindsight, my personal reflections on making this choice. Additionally, prior to ending each focus group session, I shared a reflective account with

the GTAs of teaching experiences (re)written as a performance piece (*The tour*). This was a deliberate and mindful strategy to open up spaces for dialogue, and as a strategy to support researcher and participant reflexivity. Sharing some my own experiences was meant to create rapport, demonstrate we shared some common ground, to lessen the space between researcher and researched, and as an opening to talk about potentially ‘forbidden’ topics, such as sexuality or less positive experiences with one another and with medical students. My written reflections also served as data to be interpreted. In addition to participant observation and focus groups, in-depth interviews were conducted with the GTAs.

Semi-structured Interviews with Gynecological Teaching Associates

I conducted semi-structured interviews with the GTAs during the latter portion of my time in the field so that I had the opportunity to develop trust and rapport with participants, and to refine my interview guide based on participant observation. Prior to the interview, participants were reminded of their right to refuse to answer any questions, to withdraw participation from the interview at any time without consequence, and verbal consent was obtained. The interviews were conducted in a dialogic manner wherein participants were asked open-ended questions designed to address each of the study objectives and research questions (see Appendix E). The interviews took place in a location that was chosen by the participants based on convenience and comfort. Demographic data, including age, ethnicity, education, employment history, length of time involved with the program and marital status, were gathered in order to describe the study sample (see Appendix F).

Probes that encouraged further reflection and dialogue were used with flexibility as appropriate. Each interview lasted approximately one to two hours, was digitally recorded with participant's permission, and transcribed verbatim. During data collection and interpretation, all digital recordings, transcriptions, and field notes were stored in a locked filing cabinet within a locked office at the Western University, London, Ontario.

Semi-structured interviews with medical students

Brief, semi-structured interviews were conducted before and after the medical students' training sessions (see Appendix G). For feasibility, the semi-structured interviews were conducted in groups of two as this was how they were paired off for the training session. Each interview was expected to last approximately 15 minutes as I assumed students would have other time commitments, particularly as they would not be aware that my research was taking place until they arrived for their teaching session. Information about the study was explained before they watched the training video and prior to meeting with the GTAs. Written consent was obtained prior to the teaching session with the GTAs, and with participants' permission, interviews were digitally recorded and transcribed verbatim. The purpose of these brief interviews was to capture the medical students' immediate thoughts and feelings before and after their first experience learning how to do a pelvic examination. Furthermore, my intention was to understand their perspectives on the pelvic teaching performance, how normative discourses were taken up or resisted) by students in ways they spoke about their expectations and assumptions. Students were also offered the opportunity to meet with me for a separate interview, which allowed for greater anonymity and confidentiality; however, no students contacted me for an individual interview time.

Semi-structured interviews with program coordinators

Semi-structured interviews were conducted with program coordinators at various times throughout the pelvic teaching module (see Appendix H). Each interview lasted approximately 90 minutes, was digitally recorded with participant's permission, and transcribed verbatim. The purpose of these interviews was to gain an understanding about the experience of coordinating the pelvic teaching program – the challenges and successes, as well as their espoused beliefs about the benefits of the program. Moreover, as all female program administrators occasionally participated as GTAs when scheduling conflicts arose and there were not enough GTAs to 'go around', this dual subject position, of both program administrator *and* occasional GTA was of interest to me. Additionally, within the previously mentioned literature on pelvic teaching, this aspect was not documented as a component of coordinating the pelvic teaching program. Interviews with program administrators also allowed me to identify and collect key documents, such as training manuals.

Document Review

I reviewed the training materials that were used for teaching pelvic examination with medical students within the training module. These materials included the DVD used during training for both GTAs and medical students, the photocopied chapter from a gynecology text that was provided to GTAs, and the Clinical Skills Teaching Gynecology Handbook provided by the department of OB/GYN to the GTAs. This handbook provided detailed information regarding the history-taking portion of the module, and included a brief paragraph about their specific role as a GTA. While reviewing the materials, I made reflexive notes, highlighting particular words or phrases that resonated

with my research questions. As data collection continued, I referred back to these teaching materials to assist me in analysing aspects of the scripted performances of GTAs.

Interpretation

The anthropologist... does not find things; s/he makes them. And makes them up.

-Trinh T. Minh-ha, 1989, p.141

Man is an animal suspended in webs of significance he himself has spun... I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretative one in search of meaning. It is explication I am after...

- Clifford Geertz, 1973, p 4-5

The ways in which a researcher goes about interpreting their data will depend on the researcher's paradigmatic location and theoretical perspectives. I am aware that the standpoint from which I begin my research shapes what I look for, what and how I see, and how I will interpret the participants' stories (Charmaz, 2004). Therefore, while a certain identity is never possible, when conducting an autoethnography, I challenged myself to ask not only who I was, but when, where and how I was in my research (Trinh, as quoted in Denzin, & Lincoln, 2005).

As such I analyzed my participants' data through the "multiple lens" approach developed by McCormack (2000). This approach to analyzing text values change at the individual level, respects the contexts of people's lives, the individual's subjectivity and the researcher's voice(s), and recognizes that no single lens can bring into focus the individual and the complex elements of one's life in relation to others (McCormack, 2000). Viewing interview data through multiple lenses involved approaching the data from several angles: (1) immersing oneself in the transcript through active listening, such

as thinking about (problematizing) where I was positioned as a researcher; (2) listening to the narrative process, such as stories and/or argumentation, that the participant utilized; (3) questioning the features of the language of the transcript that may impact on interpretation, for instance, words that the participants used to describe themselves, their relationships and their environment; (4) considering contextual elements that demonstrated how local and larger discourses were taken up/resisted in what I was observing and hearing; and (5) being attuned to moments or epiphanies that participants experienced (McCormack, 2000). A multiple lens approach reveals how meaning is negotiated as we continually adopt, resist or contradict our complex positions (McCormack, 2000).

The initial codes used to mark data were inserted onto the transcribed text by hand, and were drawn from my review of the literature, my research questions, my theoretical influences, and my previous experience as a GTA. For example, I began coding phrases that spoke to the performative aspects of the exam, e.g. staging, use of ‘props’, as well as utilizing the codes: “assumptions”, “motivations”, “suggestions for improvement”, “women in the community”, “discourse” and “gender norms”. I also coded how the ‘objects’ within the teaching space were being used, for instance, how the mirror used during the pelvic examination was discussed. As common themes were identified across transcripts through an iterative process of reading and coding, I revised the initial coding system to accommodate emerging themes and sub-themes. Further, I created conceptual ‘maps’ of emerging themes as I worked through the connections between codes/events (see Appendix K). I also paid attention to moments where something unexpected occurred, and coded this as “resistance”. I also utilized the code “my subject positions”

which attempted to demarcate various performances I enacted during my research, for instance: mother, doula, researcher and/ or performer.

Throughout the interpretive process, I kept field notes describing my interpretations, to help clarify an idea, or to give direction for future participant observation, interviews and interpretation. This iterative process of interpretation is a cornerstone of qualitative research (Srivastava & Hopwood, 2009). Immediately after each interview and observation session, all interview and field note data were externally transcribed, and then reviewed. During the coding process I simultaneously listened to the digital recording and read the transcription of each interview. I then reviewed the respective field note (see Appendix L). Interpretations focused on key phrases and themes that I identified in conjunction with my research questions and theoretical lenses, as well as my experiences as a GTA – noting points of resonance, departure and resistance. As I approached the texts from a (post)critical feminist perspective, I was particularly interested in looking at how participants, including myself, “[made] sense of their [my] personal experience in relation to culturally and historically specific discourses, and how they/[we] [drew] on, resist and/or transform those discourses as they narrate their selves, experiences, and realities” (Chase, 2005, p. 659). I endeavored to remain open to instances that did not clearly align with my research questions or theoretical lenses, jotting down such occurrences for careful consideration at a later time.

Within the focus group data I paid particular attention to how the participants’ experiences converged or diverged within the group, watching and listening to how power moved within the space (e.g. who dominated the ‘floor’), shaping the stories they shared, and how they were shared. The various methods I utilized garnished unique

understandings, ways of knowing and multiple perspectives that at times complemented one another, other times contradicted one another. I believe these (in)congruencies enriched my research findings.

Reflexivity. Much has been written about the notion of reflection and reflexivity as it relates to qualitative research practice. While reflection and reflexivity are often seen as analogous, it is more apt to view these concepts along a continuum (Finlay, 2002). Practices of reflection often hone in on an individual's internal thought processes: a "thinking about" endeavor wherein the individual looks back on an event or situation and explores their responsibility for their actions within it (Finlay, 2002; Kinsella, 2006). With the focus of reflection being on the individual's contemplative practices, such as what the individual did, thought, and felt at the time of the incident, there is little recognition of the contextual influences, or power dynamics involved; consequently there is no challenge made to the dominant ideologies that researchers bring along with them into the research process.

Consequently, a social constructivist might advocate for the recognition that taking an inward approach is insufficient, noting that such an approach fails to consider the ways in which our understandings about ourselves and our participants are co-constituted activities (Finlay, 2002). Such an approach requires the researcher to situate her/himself, to attend to issues of power, and to carefully consider the ways in which their own subjectivity within and across contexts is performed relationally.

However, even this approach to reflexivity, relying on methods of reflection that presuppose a person has the capacity to reflect on one's own constitution, seems inadequate. While I believe this is possible, I believe it is only possible to an extent. So,

extending this continuum even further are practices of reflexivity that problematize the very assumption that we are capable of accessing and understanding our own subjectivity with certainty (Gannon, 2006). To this extent, reflexivity is understood as only one means, fraught with ambiguity and uncertainty, that can be used to deconstruct the "the richness, contradictions, and complexities of intersubjective dynamics. [But it] is not the only way, and the process of bringing the self to the fore remains problematic" (Finlay, 2002, p. 542). To this extent then, even in extending our reflexive practices from solitary efforts to communal ones, we can only discover partial, situated, tentative accounts of who we are and our motivations for acting and thinking the way that we do. Embracing this understanding of reflexivity, a more post-critical perspective is about the ethics of research practice. I am capable of exercising a(n) (unknown) capacity to reflect on my actions, my intentions and the impacts of my actions; however, an account of myself is inherently limited by an understanding of how impossible it would be to trace with absolute certainty, the actions of the 'I' that my reflexive process attempts to locate.

Despite the limits of reflexivity, I attempted to trace my movements throughout the research process, and any shifting in my thinking by asking myself: what do I want to know? Are the questions that I am (not) asking participants 'effective' at helping me to construct newer meanings of the culture of pelvic teaching? And what *could* I know based on how the data was collected? Such questions encouraged me to work explicitly with my theoretical lenses, subjective, and 'field' understandings in accordance with the intentions of my research, my research questions and methodology (Srivastava & Hopwood, 2009).

Theoretical and methodological specific criteria for evaluating trustworthiness

Until we recognize these differences [of what constitutes 'rigor'] as a reflection of incommensurable ways of seeing, we cannot begin to engage in meaningful conversation with each other (Bochner, 2000, p. 266).

The work of autoethnography is about threatening privilege: challenging the privilege that has been, and continues to be, pervasive in analytic social science (Bochner, 2000). Questions regarding the appropriate criteria for evaluating such work illuminate the political dimension of research, the social construction of criteria and the associated language of rigor, validity and reliability (Bochner, 2000; Ellis, 2004). The accusation that personal narratives are more likely to be distorted (re)presentations is impossibly knotted to the notion that *undistorted* accounts are possible, or even desirable (Bochner, 2000; Lather, 2007). Within autoethnographic work, "There is a rigor of staging and watching oneself subvert and revalue the naked truth in order to learn to live without absolute knowledge, within indeterminacy ... [S]uch a project is situated in the loss of innocence of qualitative research" (Lather, 2007, p. 17).

Specific to the methodology of autoethnography, and when rooted in the "rich ferment" (Lather, 1986, p. 63) of feminist, critical, postmodern, and poststructuralist thought(s), readers are asked to consider the extent to which the researcher/writer foregrounded a "fragmented and tenuous self" and text (Gannon, 2004). Bochner (2000) would further ask: (1) is the work replete with abundant, concrete detail, including the emotions of coping; not just facts, but feelings?; (2) is the work structurally complex, presenting narratives that are non-linear?; (3) is the work emotionally credible, vulnerable and honest? (4); does the author show evidence of the hermeneutical uncovering of life's

limitations?; (5) does the work demonstrate cultural scripts that resist transformation, contradictory feelings, ambivalence, layers of subjectivity?; and (6) is the work ethically self-consciousness, demonstrating sensitivity with respect to how others are portrayed, with concern for moral commitments and convictions?

Laurel Richardson (1994) evokes yet another way for thinking about validity within the work of autoethnography. She invokes the metaphor of a crystal:

Crystals are the prisms that reflect externalities and refract within themselves, creating different colors, patterns, arrays, casting off in different directions. What we see depends upon our angle of repose. Not triangulation, crystallization. In postmodern mixed-genre texts, we have moved from plane geometry to light theory, where light can be both waves and particles. Crystallization, without losing structure, deconstructs traditional ideas of “validity” (we feel how there is no single truth, we see how texts validate themselves) and crystallization provides us with a deepened, complex, thoroughly partial understanding of the topic. Paradoxically, we know more and doubt what we know (p. 522).

In order to address issues of trustworthiness within my research interpretations, I have endeavored to remain authentic to an assemblage of criteria developed specifically for autoethnography, such as the aforementioned metaphor of crystallization, Bochner’s criteria, and according to feminist ethics of conducting research and representational practices (Lather, 2007; Lather & Smithies, 1997). As such, I have included a combination of data sources which gives rise to complexity within the unfolding narrative. The work of representation attends to ethical considerations, which demonstrates sensitivity with respect to how others are portrayed. I have staged the research to create moments of connection and departure, seeking both resonances with readers and moments of discomfort. I put forth efforts to problematize my own assertions by including contradictory data and discontentment with the perceived impacts of my presence within the research space. In the writing of my thesis, I present an assemblage

of ideas, data, reflections, quotes, and theory in order to provide a rich, multi-perspectival account of pelvic teaching using GTAs within a particular moment in time, in a particular location, and indeed to present pelvic teaching as a practice place where multiplicity is at play in the performance(s); however (un)intentional that might be.

Chapter Three continues to discuss issues related to representation. In particular I describe how I negotiated (re)entering the space of pelvic teaching, the tensions that arose as a consequence of conducting research within such an intimate space, with so few participants, and how to subsequently represent research participants.

Chapter Three

Methods in motion: Nomadic identities, hybrid spaces & (re)writing the stories of intimate others

Hello Jan,

Long time - no contact (-: I just wanted to connect with you (i am hopeful that you remember me). I was involved with the [pelvic teaching] program some years ago, as a midwifery student, and I'm now in my third year of doctoral studies. My research is on understanding the experiences of participants within pelvic teaching and the discourse(s) that inform teaching and instruction in the area of women's sexuality and health. There is simply little to no research in the area. The focus is primarily on comparing and contrasting the effectiveness against other methods from an administrator or student perspective.

So, I am touching base to see if we might have an opportunity to talk, so that I may share more, and perhaps you can offer me some feedback as well. It would be really important for me to know when the pelvic modules operate, as I can't quite remember, the year students enter and how many move through the program.

Please let me know your thoughts, and whether or not you would be able to meet sometime in the near future.

Thanks again and I look forward to hearing from you,

Cheers,

Jodi (email correspondence to Standardized Patient Program Coordinator
November 19, 2009)

This chapter will discuss issues related to representation within my research, particularly as it relates to my previous experiences as a GTA, and the relatively small numbers of GTAs and program administrators involved in my research. I will also discuss my own position(ality) as it undoubtedly relates to how the merits of my interpretations will be judged. In the section *Composite characters*, I will introduce the GTA and program coordinator participants as a 'cast of characters' developed using data from interview excerpts, focus groups and participant observation. I will also discuss why I chose to (re)present my participants in such a manner.

(Re)entering the space

The preceding email was the *beginning* of a dialogue, and my initial explanation to the program administrator(s) of what I was interested in understanding while conducting research on/within the pelvic teaching module. I met with the acting program coordinator, who was covering a maternity leave for the full-time coordinator, one week after this email was sent. I shared an overview of my research with her, including the background, rationale, theoretical perspectives, and the methods of data collection. During this meeting, she shared with me the difficulties she perceived I would encounter with the GTAs in eliciting anything “negative” about the program. Given the liminality of the program, an upsurge of interest in computer simulation in medical education and online teaching methods, budgetary constraints, and stigma, the GTAs were protective of the work that took place within the module. I explained that I would be using a personal narrative of my own varied thoughts and feelings on a teaching scenario as a move toward creating a safe space to articulate some of the silences within the program. As a former GTA within this specific program, I was familiar with the day-to-day activities of the program, expectations of the various participants, and some of the current GTAs were women with whom I had worked with during my time as a GTA.

Additionally, the program administrator shared that the GTAs had an interest in participating in research as a means of disseminating information about the benefits of the program. It would be this last point that would prove difficult for me to reconcile as I was welcomed so generously into the GTAs’ space while collecting data. That is, the very ease within which I gained access to the “data” was contingent on the relationships of trust I garnered because of my prior employment as a GTA, a fact I foregrounded during my early days in the ‘field’. Ironically, it would also be this familiarity and care

with/for the program and the participants, that would induce paralyzing angst around issues related to representation and interpretation as data collection unfolded. Given that this tension presented itself almost immediately after this initial meeting with the program coordinator, I attempted to make mindful choices regarding how much of my prior experiences as a GTA I shared with the participants, when and how to share my experiences (given the tight timeline of data collection), and I began to think deeply about the ethics of representation. In a subsequent section in this chapter, entitled *Composite characters*, I discuss the decisions I made regarding representation.

Research Participants

In total, 12 out of the 15 GTAs participated in individual interviews, and one out of two focus groups that were conducted within the second week of the pelvic teaching program. Participants were able to choose which focus group they attended based on their availability. In each focus group there was a mixture of new and more experienced GTAs. The three remaining GTAs that did not participate in a focus group signed consents to participate in an interview, but due to scheduling conflicts only observational data was collected for these three participants. Observational data was collected for all 15 GTAs, and demographic information was collected via a questionnaire provided at the start of my first day of data collection in the field. One GTA provided me with a written reflection of her experiences as a GTA, which I treated as data and interpreted accordingly. GTAs ages ranged from 29-70 years, and all self-identified as Caucasian. The professions of the women included: amateur and aspiring professional actors, teachers, alternative health care practitioners and medical receptionists.

Additionally, all four program administrators completed in-depth interviews

(three females, one male). Ages ranged from 31-40, all self-identified as Caucasian, and all had post-secondary education.

Medical students were invited to participate in semi-structured interviews prior to their teaching session with the GTAs, they were observed during the teaching session, and finally, were briefly interviewed again at the end of the session. In total, 29 medical students participated directly in the research (11 females, 18 males). They ranged in age from 23-33 years, and the majority self-identified as Caucasian. Students were selected to participate based on maximizing gender variation within the sample as I had wondered if different gendered pairings of students might perform differently. Students were directed by program administrators to pair with a student of the opposite gender, whenever possible.

All interview data was digitally recorded and transcribed verbatim.

Approximately 60 hours of total observational data was collected before, during and after the pelvic teaching sessions during the four-week module, and recorded in field notes for analysis.

The following table documents what type of data was collected, from whom, each week of the module. "PO" refers to participant observation *in* a teaching session. For instance, the week of January 31-February 6, 2010 a total of six GTAs were observed during a pelvic teaching session, with a total of six medical students. All six students completed brief interviews before and after they were observed during teaching sessions. One program coordinator participated in an individual interview.

Table 2: Timeline of data collected according to participant

Date 2010	Gynecological Teaching Associates (focus group, interviews, PO)	Medical Student Pairings (pre/post, PO)	Program Coordinator (interviews)
Jan 31 – Feb. 6	2 GTAs 2 GTAs 2 GTAs	2 Female students 1 Male/1 Female 2 Male Students	✓
Feb. 7 – Feb. 13	2 GTAs 2 GTAs 2 GTAs 2 GTAs Focus Group x 2	2 Male Students 2 Female Students 2 Male Students 1 Male/1 Female	✓
Feb. 14 – Feb. 20	3 GTAs 2 GTAs 2 GTAs	1 female/2 Male 1 Male/1 Female 1 Male/1 Female	✓
Feb. 21 – Feb. 27	2 GTAs 3 GTAs (one was a new coach observing) 3 GTAs (a repeat with a new coach instructing with an experienced GTA observing) 2 GTAs Individual interview x2	2 Male Students 2 Male Students 1 Male/1 Female 1 Male/1 Female	✓
Feb. 28 – March 6	Individual Interview x4		
March 7 – March 13	Individual Interview x4		



Figure 3: Subjectivities

A subject position incorporates both a conceptual repertoire and a location for persons within the structure of rights for those that use that repertoire. Once having taken up a particular position as one's own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines and concepts which are made relevant within the particular discursive practice in which they are positioned. At least a possibility of notional choice is inevitably involved because there are many and contradictory discursive practices that each person could engage in (Davies & Harré, 1990, p. 46).

Positioning Participants

I have included these photos as representations of my varied subject positions. These headshots were captured over a four-year time period, from September 2007 – June 2011, many taken during times of great transition, depicting wide-ranging moments of: accomplishment (the finishing of a half-marathon); contentment (settling into a new home); reflection (dining in South Africa); and loss (early days of my divorce). These photos were taken during my graduate studies as a deliberate attempt to capture who 'I'

was in addition to the subject position *graduate student*. Within each captured moment, ‘I’ am (tentatively) positioned-positioning-foregrounding a multiple ‘me’: mother, daughter, sister, lover, partner, athlete, dancer, novice scholar, woman abuse counselor, survivor, and friend. I use the term subject position(ing), as opposed to ‘role’, as it is a theoretical approach to identity that challenges traditional sociological role-theory that implies a transcendentalist concept of how one develops a social psychology of selfhood (Davies & Harré, 1990). As Davies and Harré explain:

In role-theory the person is always separable from the various roles that they take up; any particular conversation is understood in terms of someone taking on a certain role. The words that are spoken are to some extent dictated by the role and are to be interpreted in these terms. With positioning, the focus is on the way in which the discursive practices constitute the speakers and hearers in certain ways and yet at the same time is a resource through which speakers and hearers can negotiate new positions. A subject position is a possibility in known forms of talk; position is what is created in and through talk as the speakers and hearers take themselves up as persons. This way of thinking explains discontinuities in the production of self with reference to the fact of multiple and contradictory discursive practices and the interpretations of those practices that can be brought into being by speakers and hearers as they engage in conversations (1990, p. 63).

Positionality is an important concept utilized in the process of making sense of the various participants’ performances within the pelvic teaching module, including my own. Theoretically, positionality as a theory helped me think about what aspects of people’s lives were being (re)performed, and the multivocality within which participants spoke of their experiences within and outside of the program according to available discourses. As positionality focuses on the discursive practices which constitute the various participants, positionality implies room for resistance through the enactment of counter-narratives and counter-performances that resist normative understandings of our various subject positions. Recognizing my own (re)positioning, and recognizing that I might not always recognize my own positioning, was important for me in attending to issues of

representation, reflexivity and rigor. Qualitative researchers are often mentored to ‘spill the beans’ on their location, their positionality – *from where are you speaking? Where are you located?* Answers to such questions are the enactment of what DeLuca (2000) termed “vigilant subjectivity”, or what Harding (2004) called strong(er) objectivity, claiming, “It is a delusion – and a historically identifiable one – to think that human thought could completely erase the fingerprints that reveal its production process” (Harding, 2004, p. 128). I realize that I must provide some place within which the merits of my interpretations may be judged; however, I do so with the following sentiment in mind:

We cannot conclude that the "I" is simply the effect or the instrument of some prior ethos or some field of conflicting or discontinuous norms. When the "I" seeks to give an account of itself, it can start with itself, but will find that this self is already implicated in a social temporality that exceeds its own narration; indeed when the "I" seeks to give an account of itself, an account that must include the conditions of its own emergence, it must, as a matter of necessity, become a social theorist" (Butler, 2005, p.7-8).

In addition to the varied subject positions I have listed above, there are other elements of my story that are relevant to the unfolding narrative. In 1997 I graduated with a Combined Honours Degree in Women's Studies and Sociology from The University of Western Ontario. During my undergraduate studies I was introduced to a wide range of topics related to the politics of representation, voice, power and oppression, and cultural production. As a young (18 year-old) white woman coming from a working-class family from Northern Ontario, in relatively good physical and mental ‘health’ I found resonance in the writings of Socialist and Marxist feminist(s): I spoke the language of emancipation through consciousness raising efforts with/in marginalized and oppressed communities (Tong, 1989). My earlier scholarship was heavily influenced by the writings of Sandra

Harding (1991, 2004), Patricia Hill Collins (1990), Marilyn Frye (1983), Sandra Lee Bartky (1988, 1990, 1996), bell hooks (1981, 2000), and Susan Bordo (1993), whose influences still linger, informing in my present day theorizing.

Upon graduation, and wanting to apply ‘theory to practice’, I commuted weekly to Toronto, Ontario to attend midwifery school from 2000-2002 at Ryerson Polytechnique. During the course of my midwifery studies it became apparent to me that providing direct client care to women during the birthing process was not compatible with my own mothering choice, for instance, being on call 24 hours a day, and leaving my home for indeterminate lengths of time to attend births. I withdrew from midwifery studies and turned my attention toward mothering my two small children, and to figuring out how to combine my passion for working in the area of women’s health with issues related to social justice. After midwifery school, I was employed for several years as a woman abuse counselor, both in residential and clinical settings. I supplemented my income by working privately as a doula and childbirth educator. After a few years had passed, I became increasingly aware of the intersections between violence against women and the impacts on women’s transition to mothering. I developed a training program for health and social service workers devoted to supporting women survivors of abuse through the childbearing years. This work has allowed me the opportunity to travel all over the world, facilitating workshops with participants from a wide range of health disciplines and social service workers. While developing this training, I was dismayed by the lack of research literature dedicated to understanding the impacts of abuse on women’s experiences of pregnancy, labour and birth and the postpartum period. It was this discovery that compelled me to enter graduate school. Once I was accepted into my

graduate program, I was hired as the research coordinator for a Canadian Institute of Health Research study entitled, “Embodied Trauma: The influence of past trauma on women during the transition to motherhood” (Principle Investigators Dr. Helene Berman & Dr. Robin Mason). Initially, my doctoral research would focus on the experiences of transitioning to motherhood for women survivors of childhood sexual abuse; however, as I mentioned in my preface, during a graduate course on epistemologies of practice I had a ‘struck’ moment. This moment directed my attention away from studying the impact of abuse on the transition to motherhood, toward the culture of pelvic teaching. However, I do not see this move as a radical break or departure, rather a concern for women located at a different position(ality) along the same continuum.

Further considering ‘positionality’, I am also a survivor of childhood sexual abuse, which I feel inevitably informed my research process – I grapple(d) with issues of how power circulated within research relationships, the elusive boundaries between researcher/participant/therapist/activist/friend, and the process of ‘claiming’ knowledge. To attend to these tensions during the research process, I asked myself not just who ‘I’ was in/outside the research space, but *how* ‘I’ was, *when* ‘I’ was, and *where* ‘I’ was in relation to participants (Trinh, 1992). While recognizing the limits of self-reflection, I endeavored to trace my movements within (the) space and time, what my participation looked like, how I shifted from active participation to observation, and back again, and why. How was I positioned, and how did I position myself, and in order to open the space for our stories to be (re)told?

Before I continue with my interpretations, I will describe how I went about ‘opening the space’ for the research participants and myself to share our stories of

participating as GTAs to allow the reader to consider what this ‘sharing’ process meant for/to the research. An integral part of preparing to formally ‘be in the “field”’, was considering when and how to share the purpose of my research, and the types of issues/concerns I was interested in exploring. For me, these decisions were about being ‘transparent’ with my participants, a move toward a more relational-ethical informed consent process. I wanted my participants to ‘know’ that I was looking at the program, and our experiences from a feminist critical perspective, and what this meant to me. As previously stated, the acting program coordinator informed me that the GTAs were protective of the program; therefore, they may not want to share information that could potentially position the program negatively.

I had to acknowledge to myself that by virtue of my past experiences as a GTA, I would be familiar with the format of the training session, the general script of the teaching sessions, and have first-hand experience performing as both model and facilitator. As a result of this shared knowledge, I would likely then be granted ‘insider’ status by the GTAs. I had to carefully balance my desire as a researcher, allowing the silences to speak but needed to create space for participants not only to speak, but to *not* speak, with appreciating the impetus for participants to protect the program. With all of this in the forefront of my mind, to elicit stories of ‘a different kind’ than were represented in the current research literature, I ended the introduction to each of the focus groups with the following elaboration upon the intention of my research:

So really the purpose of the focus group is to bring us together to do just what you’ve been doing [with me] – which is to share some of those collective experiences that you’ve had as standardized patients in the program. One of the things I’m interested in, or the type of research that I do, would look at an environment such as the standardized patient teaching program ... and look at some of what remains hidden, and might not be obvious to you because you do it every day, and that’s the ‘taken-

for-granted' things about the way that you do your work, or the things that you say, or about the students behaviours. So because of how I look at this work, I like to ask and think about some of the things that are maybe less obvious, or feel like they're less able to be talked about because they might feel like they're 'risky' [to talk about]. So what I'll do is - I'm going to lead us through a series of questions and wherever those conversations take us, that's where they take us, and then I'm going to finish off today's focus group with reading a scenario that is a storied experience - which I'll explain to you what that means in a minute - but of an experience I had while being a standardized patient. It was my first year as a GTA, and it was a reflection I wrote a few years later, thinking about what my experience had been like as a standardized patient given - where I was at that time in my life, and the very complex issues I was negotiating [while I was performing] as a standardized patient [GTA].

... So I'm going to 'show' that experience and the reason I will do that is because I think it invites other types of things to be said about the program, other than the things we really love about it – that it's empowering and it's so important ... it might help us figure out how to do this work that's for me most importantly really respectful of the women that engage in this work and believe in this work – and also to think in a more extended way about how the field of medicine does this work in a way that really honors what it is that you do. So whether that means thinking about how they prepare their students better so that the best learning experience possible either before or after, but let's think about that. Because presently, the research doesn't invite yourselves to really have a voice, that's a big problem for me when you think about program evaluation and recruitment, and trying to make decisions between cadavers uses versus standardized patients, and we don't even really know anything about what the experiences are from their perspectives. ... So I hope that makes sense and I'm open to any questions before we get started.

Jodi – representation of the focus group introduction with GTAs

Partial Perspectives



Figure 4: *Partial Perspectives*

The photo *Partial Perspective* represents the struggles I experienced representing my participants. By placing myself in the frame as the photographer, I implicate myself as a (co)producer of meanings. Ultimately I made the choice(s) as to what data to include, and therefore what data was excluded – positioned outside of the ‘frame’ (intentionally or otherwise). I included this photo as a representation of my position as the crafter of this particular piece of work. I am aware that what I intended to represent (the participants, the setting, the culture) neither seamlessly nor unproblematically translate(s) into the meanings that others will make of what I have written – as such, all meanings made of my work are not, nor desired to be, solely under my “authorial” control. After all, this work is about exploration, (re)imagining the possibilities, opening up spaces for

(re)envisioning the space of pelvic teaching, sitting within seemingly irreconcilable tensions, and the reader is invited to participate in such an endeavor.

Composite characters

To placate the tensions I experienced grappling with issues of representation, and in conjunction with my research methodology, I drew on a tradition within autoethnographic writing which creates fictional characters from ‘non-fictional data’ provided by research participants (Ellis, 2004) . The decision to create characters out of participant data was as much a methodological decision, as an ethical one, as an enduring quagmire in autoethnographic research is grappling with the question of our responsibilities “... to intimate others who are characters in the stories we tell about our lives” (Ellis, 2007, p. 4), which includes how we story and represent our participants. I crafted the characters with the goal of making the participants “come alive for the reader” (Hollway & Jefferson, 2000, p. 70), without identifying any one GTA in particular. Given the small number of GTAs enrolled in the training program, I had concerns about protecting their anonymity, amongst themselves, but also from program coordinators who were responsible for their supervision and employment. I also considered the position of program coordinators who answered to the clinical instructors and Dean.

With these considerations in mind, and based on my interpretation of participant data, seven fictional characters were created from the data of the 12 GTAs who participated in all aspects of data collection (interviews, participant observation, and focus groups), and data from the two GTAs who participated exclusively in participant observation, and data from the one GTA who only participated in a focus group and participant observation. One character was created from the data of the four program

administrators. To develop the characters, GTAs and program administrators were originally grouped in a chart according to who had the following elements in common: (1) identities they ascribed to themselves, for example: teacher, mother, performer; (2) their motivations for participating in the program; (3) skills participants' perceived they contributed to the program; and (4) their length of employment in the pelvic teaching program. Additionally, I considered participants' answers to various interview questions, such as: how did you become involved with the pelvic teaching program?; Can you share with me what your experiences have been like as a GTA?; In your opinion, what are the benefits of the program?; and can you tell me what your own experiences have been like receiving gynecological care? As interpretation of data unfolded, and the writing of this thesis ensued, adjustments were sometimes made to the original groupings to enhance authenticity and/or narrative flow. Given the relatively larger numbers of medical students that participated, composites characters were not created; however, pseudonyms were used in place of their real names.

I would like to note that I found resonance with each sentiment that the GTAs shared with me – their words were not “other” to me, even if they ‘rubbed up’ against other aspects of my present situated being. Instead, their comments and reflections shared so generously with me rang familiar, and reminded me of GTA experiences long forgotten. Bringing these various characters together in conversation, sometimes directly with me, at other times with other characters, helped me to extend and deepen my thinking beyond my own pre-assumptions during data collection and interpretation of research findings. The characters and the stories they tell, manifested as part of a creative and ethical process involving the blending of their words, folded in with my own

meaning making process (Deleuze & Guattari, 1987) At this point, I would like to introduce you to the six GTA and one program administrator characters that are involved hereon in with the sharing of my research interpretations.

Amanda⁴

The initial contact I had with the program was an email that was sent by the program coordinator to a women's list, which is a group sort of forwarding email connection that has a lot of women on it and anything that's women-oriented that may be of interest to women. This is going back about 12 years or so. The program coordinator sent out a call for – wasn't for standardized patients particularly at the time, it was just for people who might be interested in working for the pelvic team specifically. So that was my first connection with clinical skills at all at that time. After I started working for that, then I heard about other, you know, kinds of work you could do for medical exams and that kind of thing. I thought it would be interesting to learn, and more about my own anatomy because it didn't feel like I knew much really. And also, interesting to meet all of these students and – you know, it is just a very unique experience, and not one that you can come across.

At the time I knew that it was looking for willing participants who were interested in both, who were ok with coaching or being on the table as a model and coaching from the table to basically learn how to teach, how to do a pelvic exam properly to second year medical students. I've definitely learned that the aims are to teach the second year med students proper protocol and physical, a pelvic exam I should say, so that there's a, a huge emphasis on making the patient as comfortable as possible so that they will more likely come back for further pelvic exams and covering every aspect of that including their physical comfort, their ability to communicate, feel an openness of communication with their doctor and ability to realize that their comfort is important, that they should feel free to express anything otherwise. You know, I just thought it was an interesting opportunity to learn and to be in and unique experience I guess. As it went actually that is when I realize more the importance of it -- you know like I didn't really know that - before this program maybe certain students would graduate without having done this exam or -- you know I just -- as it went I was like 'wow, this is actually pretty key to their education.'

Definitely there was some minor anxiety at the outset because it was new and that it was so, it was a step further into what I already had been doing on a physical level in terms of work so it didn't feel like a huge leap for me at the time because I'm familiar with working with people on a massage table as a Trager practitioner and with various levels of, and during the training clothes off and on during the original trainings that I took because we would practice on each other during classes and the clients coming to me who either removed some clothing or don't depending on the comfort level of the client.

⁴ All character names are fictitious and, as previously stated, characters are composites of data from grouping of GTAs and program administrators

Luckily the massage work that I do doesn't demand that they have to have their clothes off because there's no oil or lotions used, that kind of thing. But a lot of familiarity and comfort with the human body over the years from those various sources made it fairly easy to take that step. There was, the main anxiety for me at the beginning was my, that jump from being someone on the table to being a coach. It took a while for me to be comfortable with that as I think it does for a lot of people.

Caroline

I'm Caroline, and I'm in my second year of this program. I started with standardized practice because an elementary school teacher of mine has been a huge part of this program, and has been for years. We still meet with him once a year, and he said to all of us, "you guys, we're all teachers or retired teachers", he said "you guys would like this – why don't you try", he said "Caroline, you'd particularly like it because of all of your medical issues". Okay, he told me about all of the kinds of things that he did and he was right, I really do like it and I have had a lot medical issues. I've known hundreds of doctors over a few decades and I agree there have been some who have treated me in ways I didn't like and many in ways I liked very much and I think it's really important that young medical students learn as much the emotional part, the personal part of examining a patient, especially this personal exam, than it is the medical part, they know the medical part, they know the physiology or they will, they need to know more about how to treat a patient. And I'm certainly seeing that these young doctors, who all look twelve by the way, have already considerably more emotional ability and personal skills than the generation of doctors that I first got involved with forty years ago. I'm an older woman - medically it's good for students to be able to see every variation of the body and I don't mind undressing in front of people which seems to happen when you've had so many doctors examine you for so long and been in so many hospitals that you don't have any embarrassment anymore. Some people say, well as soon as you had a baby you don't have any embarrassment but it's true I don't embarrass easily. I think the common thread is that we are all very altruistic. I know one of the reasons that I wanted to join the program is that I was having a lot of difficulty finding ways to change the world and this seemed to be a way to start, and I since found out that it's not likely, I'm not likely going to be able to change the entire world but I do feel like changing a little corner of it.

Rosemary

I've been a GTA since 1997, so whatever the math is there ... many years, and started off as a standardized patient as well. Came here from an ad in the newsletter - that they were looking for actors. The ad arrived at a class I attended once a month where you could go in and you could do improv, you could learn techniques, you could, anyway it was an acting class basically. But she always, always came back to you have to find the love in every situation. She said it may not seem like there is love in some dialogue but there is love. Anyway she got explaining this so much and one night she came in with these acts and said does anybody want to take their acting career in a different direction because if

you do there is this program called the Standardized Patient Program at the university and I have applications for it. If you're interested I'll leave them here you can just take one. So I talked to her for a bit afterwards and I said I'm not quite sure what it is that they do. I mean isn't that everybody's line, well what is it you do. So she explained that there were all kind of different programs; just interviews, there was the invasive exams, there was, she said any way you want to go but put your name in and talk the woman in charge. So I just said, "well I'll take an application and think about it and the next week". I thought about it and I gave her the application and she took it in and I was just interested at that point I think more in going in a different direction with acting because I was interested in being on stage. And the invasive exam I backed off for the first year and the second year I thought, how many times have I had a really bad pelvic exam?! And that's when I just called and I said look, now if I need to fill in another form I will but I'm interested in being involved in the pelvic examination thing and that's really where I started from.

I've always, always felt that if I can teach a young doctor, one young medical student going out into the world, that every woman comes bearing a different load of grief regardless of age and that they can be caring or empathetic about this without being personally tied in and that they can do this in such a manner that the woman leaves and says to herself, "well I don't really like the exam but that wasn't bad". Then I've done what I really started out to do when I joined, which was to make sure that nobody else had a speculum rammed into them that practically shoved them off the end of the examining table. And that has happened to me. It's horrible, I mean you don't need to be that brutal so my teaching has always been geared to that end that I hope I have imparted something that tells you that you have a human being on the table and you should treat them as a human being. And, how many of these young people have seen an old body? Literally, how many of them have seen an old body? Not very many I'm guessing. That alone, this is what time does folks, time and, babies and surgeries and you know not everyone has a young gorgeous body. That alone I think is really important.

We've moved a lot and I've had probably 10 different doctors in my married life. And some of them are fabulous and some of them, probably without realizing it, just give you horrible, painful exams. Not just uncomfortable, painful. So I've driven more in the direction of, when I do this for the students, I drive more in the direction of I want you always to be aware of this person is a person, not a slab lying on a butcher's table and that it's not a gentle exam in any way. But if you can do it with some empathy for the fact that your patient is lying there naked for most of the time, then I've succeeded in giving to you the thought that this is a person and that you need to take care in doing this exam and you need to give back to the patient a feeling of their in control and they have a comfort zone. And I think that has always been my main driving force and the reason I've stayed with it is because you can't just look at a young body. There are people my age that are going to need pelvic exams and you need to be aware of the fact that the tissue is more fragile, its dryer, you need to know where you're going with it and you need to talk to your patient. So that's basically why I've hung in there. And I think my greatest asset, is my sense of humor! Cuts through the awkwardness, and helps the students just relax a little.

Drew

I am single-mindedly driving down the road towards to being a professional actor. So this for me is a good place to be, plus the fact that it pays me, and I am definitely in need of cash. I have no hang-ups about my body, at all. It's just; it's here. I'm young, and I have lots to learn.

For this module, I am learning to make the switch over from the theatrical actor side of things, like doing the standardized patient generally and not the pelvics, this year then they got me into the interviewing side, and I actually think I brought it up to them first to get involved with the pelvic teaching because they had mentioned it to me when I was first hired on that if I ever did have any interest, there's no pressure, but this is an option so let them know if I want more information and then I can still decide at that point, I don't have to commit to anything. So they were very open, and then I just decided after coming here this year and getting some time off and really getting to know the students and the very professional academic environment that everything they had us do, thinking that I would likely continue on and helping in every facet with their education.

Gloria

Well, I work in the health care industry. There's a lot assumptions that, you know, women know a lot about this exam and I've found out over the years that they really know nothing about what to expect and how to be treated and so I think over the years just from working in this environment and working at my other place of employment there's really a lot that we assume and take for granted that women should know or really don't know about getting a pelvic exam.

At first it was curiosity that brought to do pelvic teaching. I didn't start the first year the program coordinator asked me – I just wasn't interested at all, didn't think it would be something I would be interested in. And then the second year when I was still working with her she said you don't have to do the pelvic there is a lot of other things to do, just come and talk to Judy and maybe you can work something out or see if there's something else that you'd be interested in doing. And of course when I started I started right into the pelvics. *[laughing]*

At first I did do a little bit of SP work, more for the OSCE (Objective Structured Clinical Examinations) and things like that. Inside the rooms and then just a couple times I was asked to do standardized patient things and then I ended up just being site staff. Site staff is more for the OSCE's and the MCCs (Medical Council of Canada), it's like the actual running of the exam, like making sure the students are where they're supposed to be, the standardized patients are in the room, there's a physician and the standardized patient in the room. Just work on the bell system, make sure everything is running smoothly.

Just from the get go we watch the film and were asked to perform a pelvic exam. From the onset it was more that this is an important block for the medical students to learn how to do a pelvic exam properly as opposed to, you know just the ethics of the exam. Ethics meaning how to, how to communicate to your patient when you're performing a sensitive exam, like what to say and what not to say and how to appear confident and just portraying your confidence and experiences going to make it easier, you know, for the patient to deal with.

I think, I think from the beginning when I first started doing this it was just a block of teaching that was available to the medical students. Now I think it has become a prerequisite in their learning experience in the medical school. So from going to kind of like an option or you know they didn't really, some of them felt that they really didn't need to learn this from the beginning, they may never use it. But now I think this has become part of their learning experience, now they have to do this more or less.

Well I remember when I was about 18 and I went to have a pelvic exam at a clinic that I had a bunch of these young interns and I think they over did it just because was so young and I can remember to this day just saying you know you guys need to calm down here, I don't need to be over examined. You know I'm just here for a pelvic exam. But I had to go to a clinic and than that's when I realized you know what I need to have a family doctor, I need to really, just for woman's health and just not a bunch of strangers looking at my body. I think I need a family doctor. So it was at that time that I realized so I went and got a family doctor. But I'm not saying that's always the best way too, I hear some people have breast exams with family doctors with their bra on so the doctor doesn't know how to do it or can't be bothered or in a hurry. But you know and I have a daughter too and you know you listen to the experiences that you just feel embarrassed because it's a sensitive exam and the person's not making them feel any other way but embarrassed you know because maybe they're embarrassed too and they're not confident in doing. But my experiences have been pretty normal. They're not a pleasant exam. I've never woke up in the morning saying yippee I'm having a pelvic exam today, it's just like agh.

Suzanne

Like, part of being SP was just for fun but then you'll see and hear why I think it's important, it's more than just enjoying what I'm doing, I have reasons for it too ... but for the pelvic exam, it had to do with that person on the bus. She, ah, her daughter had a friend who had never gone for a pelvic exam and wouldn't go to the doctor, like it just really scared her, and ah, another friend who died of breast cancer a couple years ago, she, they found it at the fourth stage, she hadn't been to a doctor in 12 years and she didn't go until it was severe, so there are just too many people that are uncomfortable with their doctors. So, anything we can do to help them, especially with these very personal or invasive exams to make it more comfortable for the patient, make it more comfortable for the doctor and it will encourage people to go more, get the help they need.

My assumptions coming in where - that it was about the examination, and that they were to perform in our human being. And learning how to actually do it. I thought this was the first time that they had ever done a pelvic examination.

I have heard rumours since then that it is not - I don't know. I thought that the feelings of how the patient felt ... like the wording, was the important part of it. So that if I were a rape victim, or somebody who had been abused, that I would have a feeling of more empowerment, okay? But I didn't realize that that was the main objective, right? Coming out of it though, I now know that is the opposite of what I thought. And that finding the cervix isn't a big deal. And that is more making me feel comfortable in such a vulnerable position. But I think as we get older, we almost lose that - I want to say that sensitivity. When you have had kids, you have been exposed, you have been poked, you have been prodded. Sadly, everybody has seen everything at that point you don't care anymore. You lose that little bit of yourself. And I think it would be great if I hadn't lost that little bit of myself, because I probably would have entered this with a different opinion. Does that make sense? But because I had been poked and prodded with my first, everybody had seen everything. With my second, it was the same thing. I had breast-feeding problems, so everybody had seen that. I had breast reduction, so everybody had seen that, right? It was basically 'oh, is just another person poking and prodding again', right? But if I had realized at the beginning that it was more about 'okay, it is not about the poking and prodding, is about how I feel and making me feel comfortable with the whole situation'. And if I hadn't had all of that, I would have had a different expectation, right? So day one - like let's say I had done the training, and the day one that I was on the table I probably would have said 'you know, no -I am going to teach the internal', or 'I want you to show them what you're going to do to me first' - I would have asserted myself more. But I didn't have that knowledge on day one to do that, or day two or whatever.

Anna

I'm new to the role of a program coordinator, and I will be back as a GTA next time it comes around. I became involved in the program because I'm very interested in women's health. I came from a background where it wasn't really talked about. Nobody in my family really addressed anything; it wasn't out in the open. We weren't educated about it and I also, growing up as a teenager, had horrific pelvic exams, horrific pelvics and PAPs. My doctor was a woman; I'm not sure why they were so painful and awful but as I hit my early 20s and moved onto a different doctor than I sort of understood that they didn't have to be that awful. So it, I see the value in the teaching, essentially is what it comes down to.

I started right off in the pelvic teaching program, a few years ago. There is only a certain type, I don't want to say type because we're not a type - but there are only certain women are willing to volunteer, or believe in that, or put the value of that teaching above their own reservations. There doesn't tend to be a waiting list, so if you're willing to go there and join that group then you're in.

The goals I believe of this program, or this specific teaching block, give them in as gentle a way as possible an overview of the female anatomy, give them something practical, I suppose. You can look at all these things in a textbook right and the fact, they can read and it's about practice, it's about practice. It's a valuable exam I think, they've got to know how to do it, and they've got to know how to speak to a patient. They've got to know how to build trust. So I think planting the seed in their mind that the patient is a human being and what are the possible things that could be running through this person's mind while this exam is going on, what kind of background they are coming from. This exam is going to take a whole different tone if they come from a background of abuse. So I think it's about perspective and practice. Mechanically, how do you perform this and what headspace you are in to make this as easy as possible on the patient?

Cultural Artifacts: Pelvic teaching module 'prop' participants

External objects, implements, and instruments with which the subject continually interacts become, while they are being used, intimate vital, even libidinally cathected parts of the body image. ... Part of the difficulty of learning how to use these implements and instruments is not simply the technical problem of how they are used but also the libidinal problem of how they become psychically invested (Grosz, 1994, p. 80)

Before I describe a 'typical' day in the pelvic teaching program, and proceed with 'interrupting the flow' of the pelvic teaching module, I would like to introduce the objects, the non-human actors, that participated in the (re)construction of the culture of the pelvic teaching program (Latour, 2005). While this section has contended mainly with data collection methods and issues of representation, because these objects may go otherwise un-noticed in the unfolding narratives in subsequent chapters, and given the significant role in what they played in constructing possibilities for the teaching/conduct of the exam (including a role in the (re)presentation of women), I will introduce them here now. These 'objects' played a fundamental role in (re)creating data as various participants, including myself, interacted in space with them; therefore, the enactment of these objects was neither neutral nor insignificant. With the assistance of all of the various participants in the teaching space, these objects became animated and infused

with socio-cultural meaning that helping the work of pelvic teaching ‘get done’. The pelvic teaching module objects are represented ‘in action’ by utilizing excerpts from the data:

Examination table

Student: Yeah. So in the video the head of the table was inclined a little bit.

Facilitator: Yes it was.

Student: I’m not sure if that’s always the way?

Model: Ah, preference.

Facilitator: Some women really like that, some women absolutely hate it.

Student: So is it good to ask what they prefer?

Facilitator: Only women know, yes.

Student: So which would you prefer, incline the head of the table.

Model: Lying down is fine for me.

Student: Lying down, ok.

Model: And in a lot of cases you’ll be doing this in conjunction with the breast exam so there is a good chance that they’ll be lying down already.

Drape

Facilitator: Even then, and this I’ve never had done on me, the using the drape and pulling the drape down so that there is a v-shape and so that where the doctor is sitting the doctor can make instant eye contact all the time with the patient, that’s very important. I mean that’s not usually done and that’s very important and you do have the opportunity to see the brow furrow, see the face turn white.

Gloves

Facilitator: *[talking to students]* Theoretically, you shouldn’t even really need to wash [your hands] first but physiologically it’s just a darn good idea.

Model: yeah. Even though gloves are going on I think most patients would just be more comfortable.

Facilitator: I had a physician do the exam without gloves once and that was just creepy. Physiologically gloves are a barrier.

Metal stirrups

Student: Ok could you please put your heels in the stirrups.

Facilitator: Yup, and sometimes they need help in which case, if it looks like they're flailing at all just gently guide them by the ankle and set them in sort of...

Model: A lot of people can't see [the stirrups]

Light

Student 1: I've not found [the cervix] ...Can you move the light student 2?

Lubricant

Facilitator: Don't dry it [the speculum] ... it's going to be inserted.

Student 2: Do I put the lubricant on even though I put it under water?

[model nods her head 'no']

Facilitator: You don't think you need lube?

Model: No, you can if you want – but it doesn't matter.

Student: Ok. *[Proceeds to lubricate the speculum]*

Mirror

Student: I see they suggest offering a hand mirror

Facilitator: I have never wanted to watch. I can't believe I would have ever wanted to watch that. I really can't.

Speculum

Facilitator: So this one is small one, it's called the Peterson, this is the medium, well for this purpose, medium, this is the Graves, basically, just different sizes. The role of the speculums is to move tissue out of the way so you always want to default to the Peterson unless you know that somebody needs the Graves. If you've had children, if you, if you have a patient that's sometimes very obese or what not, if there is just more tissue for some reason the Peterson might not be

doing the trick so you might need to move up to the Graves. So I'll let you guys play with those. We're not using those ones on the model so you don't have to worry.

Training Video – the DVD produced in a different standardized teaching program in the province that does pelvic teaching with GTAs.

GTA: [To prepare to model] I would definitely wash, clean. I contemplated at first waxing, just because of the video. And I thought 'you know what, no. [That] is not real. This is real life.'

Jodi: So what is in the video?

GTA: They show a completely bare – no hair down below. And I found that that wasn't very realistic of women today. Not everybody walks around shaving or waxing down there completely bare.

Door

Facilitator to medical student: ... at the end of this exam you don't have to tell any woman that this is what you need to do, but you point out the Kleenex and some doctors have pads and say "you know because we've done cytology there be a little spotting, it's just, and there is Kleenex here and there's pads here and please help yourself. I'm just going to go outside, and when you're ready would you just crack the door for me".

Windows/Blinds & Ear Phones

GTA: But the thing is I'm not sure how often we're monitored. I...to be honest with you because we close the blinds on the room, I'm not sure if there's somebody out there actually plugged in with the ear phones listening to this. I've never had anybody come back and say anything to me one way or another. So I'm not sure if I'm being monitored.

Other objects that were present in the room were the biohazard containers used for the disposal of used latex gloves and speculums, and plastic pelvises that were referred to occasionally to demonstrate the angle of the inserted speculum. The plastic pelvises in the room were utilized to demonstrate the internal anatomy of the female body that was not visible. While these objects remained on the periphery of the actual teaching, they nonetheless assisted with (re)dressing the teaching space in particular normative ways. Now

that I have introduced the cast of actors that assist me in the telling of my/our story, the following chapter will represent a 'typical' day in the pelvic teaching module.

Chapter Four

A 'typical' day

Before I represent a ‘typical’ day in the pelvic teaching module, I would like to discuss issues related to timing and data collection. In my research, the timing of data collection was an important consideration during the research process in at least two significant ways: (1) the pace within which data needed to be collected, given the four-week duration of the pelvic teaching module; and (2) a newspaper article in the Globe and Mail which appeared January 28, 2010 entitled, “Time to end pelvic exams done without consent”. The first consideration relates to my role as a researcher as well as the benefits and challenges of collecting data in such a relatively short period of time. When I was involved with the program as a GTA, the pelvic teaching module took place over a few months, with two sessions or so per week. When I was designing my research proposal, I was under the assumption that the program was still operating in this fashion. It wasn’t until I met with the acting program coordinator in November to discuss my planned research that I became aware that the once-a-year module was now condensed into 4 weeks, operating almost daily. Additionally, the module was moved from September (as it had been in the past), to the start of the winter term. This gave me roughly 3 months to complete my proposal, and clear the proposal through the ethics review board, rather than 10 months as I had anticipated. Needless to say, proposal development moved quickly.

Additionally, given the short duration of time available to be “in the field”, multiple methods of data collection were necessary to optimize the likelihood of eliciting multiple perspectives from the varied research participants, which would complicate a single linear telling of the activities within the culture of pelvic teaching. However, the

time-limited nature of the module also left me little time between sessions to process my observations, or the data collected during interviews. Field notes were digitally recorded immediately after each session as a means of collecting emerging insights to be analyzed after all field data had been collected; however, a deeper reflecting and explication of my interpretations would take several months to unfold after data collection in the field had ceased. This acceleration of proposal development, and the collapse of the program from months to weeks increased the intensity I felt during data collection ‘in the field’, which ended up being an interesting parallel between myself, and the quickened pace of program delivery GTAs discussed in Chapter Five, *Training Day*.



Figure 5: Time to end pelvic exams done without consent

Frequently, experience conducting pelvic examinations is gained by practicing on anaesthetized patients who are undergoing gynecological surgery (Goedken, 2005). The above image was taken from an article entitled “Time to end pelvic exams done without consent”, published in the Globe and Mail January 28, 2010 – one week prior to the

commencement of the pelvic teaching module. The opening lines of this article were as follows:

Imagine that you are undergoing a fairly routine surgery – say, removal of uterine fibroids or hysterectomy. During or right after the procedure, while you are still under anesthesia, a group of medical students parades into the operating room and they perform gynecological exams (unrelated to the surgery) without your knowledge (Picard, A. para 1).

The article went on to report findings of research conducted by Wainberg, Wrigley, Fair, and Ross (2010) who distributed questionnaires to pre-operative gynecology patients at a Canadian pelvic disorders clinic. Participants were asked questions about who they believed would be present in the operating room, their understanding regarding what procedures students might undertake, and whether patients would give consent for students doing pelvic exams during surgery. Based on their findings, the authors suggested that the majority of patients were willing to assist medical students to learn how to conduct pelvic examination, but they expected explicit, instead of implicit, consent to be obtained if medical students were to perform pelvic examinations on anaesthetized patients; that is consent *specifically* for the pelvic examination procedure (Wainberg et al., 2010).

Despite the development of a joint policy statement crafted by the Society of Obstetricians and Gynaecologists of Canada (SOGC), and the Association of Professors of Obstetrics and Gynaecology of Canada (APOG), ethical issues arising from the performance of pelvic examinations on non-consenting anesthetized patients is not a new issue – indeed, the practice is “age-old and universally performed” (Goedken, 2005, p. 232). The use of anesthetized women for student learning still remains common practice for medical students to conduct pelvic examinations women without their explicit written

consent in Great Britain, the United States and Canada (Wainberg et al., 2010; Wilson, 2005). Coldicott et al. (2003) found that 53% of students at one medical school in the United States performed intimate examinations on anesthetized patients. Collectively they performed roughly 700 exams without obtaining any written or oral consent in 24% of the exams. This practice persists particularly for teaching ‘abnormal’ anatomy (Wilson, 2005). This practice is underpinned by a belief that such practices offer, “a unique opportunity for students to practice this highly personal exam without inflicting pain or negotiating the embarrassment often experienced by both patient and student” (Wolfberg, 2007, p.889). This article was specifically referenced by various participants throughout the duration of the pelvic teaching program as justification for the existence of pelvic teaching programs employing GTAs.

While these are two specific examples of how ‘time participated’ in the generation of data, notions of *time* and *timing* are reoccurring themes I interpreted in the data, which will be revisited in subsequent chapters. For the remainder of this chapter, I draw on observational data, field notes of teaching sessions, and interviews with various participants to depict how a ‘typical’ session in the pelvic teaching module was performed while I was there collecting data. Excerpts of notations in my field book taken during teaching sessions appear in [*brackets italicized*].

I begin ‘a typical day’ by enticing the reader to ‘enter the field’ with me. My accounts depicted hereon in are not attempts to represent what “really” happened before, during, or after teaching sessions –my accounts are not to be privileged over others’ accounts. However, writing ‘this’ out *was* an authentic attempt to “convey an acceptable-to-me-for-the-moment portrayal of self [in relation to others]” (Ronai, 1995, p. 399),

and others in their relationships to/with me. I utilize methods of representation that feel ethical to me, and responsible to my participants.

Interlude: It was funnier from behind

To an extent, the pelvic teaching module reminded me of a play I had seen years ago, entitled *Noises off*, "It was funnier from behind [the scenes] than in front and I thought that one day I must write a farce from behind." This quote was said to be uttered by play writer Michael Frayn while standing in the wings watching a performance of *Chinamen*, a farce that he had written. The outcome of this observation was the stage production *Noises Off* (1982), written by Frayn as a play within a play. My interpretations involve swinging the stage light around to critically engage with the performances that went on "behind the scenes" in the pelvic teaching module – those aspects of staging the pelvic teaching program that remain absent in the current research literature, and as I found out, remained unspoken even amongst the various participants themselves.

A 'typical' day



Figure 6: Views

A tiny wave of nausea and tension again washes over me as I approach the newly constructed building that exclusively houses the standardized patient program. It's a combination of feelings that I've grown accustomed to throughout data collection brought about by the growing familiarity with the women (fostering my increasing concerns with representation), mixed in with uncertainty (e.g.: will I get "good" data today?, will the students let me observe?), that comes with data collection in the "field". I pull the door open that will bring me into the front reception area, taking a quick glimpse to my right to see if any of the GTAs are waiting in the lounge area. If the 'clinic' area hasn't been unlocked, this is where the early arrivers can be found flipping through pages of outdated magazines or the campus newspaper, until the program coordinator arrives and unlocks the hall door. This morning the lounge is empty. I stamp the snow off my boots and clap my mitts together before I proceed down the hall toward the simulated clinic space.

I enter the space where the standardized patients gather in the morning. It looks like a small classroom, with a table in the middle that would seat 12 comfortably, illuminated by fluorescent lighting. There are windows that line one wall allowing a view to the outside street that runs parallel to the building. As I wrap my ski jacket around the back of my chair, I look out to see if anyone from the program is walking toward the building, and notice snow still lightly falling – hope that doesn't cause trouble for any out-of-towners driving in today. I am most often the first person to arrive, and this particular morning is no exception. I use this morning time to settle into the space, read over my field notes from the day(s) before, check my recorder, and jot down any thoughts I would like to follow up with throughout the day's session. There is a coffee

maker in the corner of a double size closet, which I only ever see utilized by the Obstetricians who rotate through here daily. They're responsible for supervising the history-taking portion of this module with a group of separate second-year medical students. There is a rather large white board on one of the walls populated occasionally by notes, or reminders to the standardized patients.

As the women start filing in, we fall easily into conversation with each other: "How was your night?"; "Is your daughter feeling better?"; "I hear we're short-staffed today." One GTA I've worked with before in the program asks me questions about how to become a doula. Her sister is interested in training programs, and could I recommend a good instructor? There are a handful of other women who are not participating as a GTA who are also present around the table. They're women who role-play patients in one of four possible scenarios related to gynaecological issues as part of the history-taking portion of this module. The Ob/Gyn on duty for the day will lead medical students through the process of taking a history after he/she says a few quick words to the students doing the pelvic exam. A sidebar conversation between the program coordinator and a few GTAs catches my attention. "So ladies, there's a change in lube practices because of money. We won't be supplying individual packages. Instead, you'll find bottles of lube in the rooms. Remember, you squeeze the lube onto the paper towel – not your finger or else you'll potentially contaminate the lube". She demonstrates the new procedure on the table in front of us.

There are several references to the "pelvic squad" – a term being tossed around to refer to the women who work as GTAs. As I see it being used, "pelvic squad" is a term of endearment, a title worn proudly by the women 'able and willing' to perform as GTAs.

During previous morning gatherings, the women who participate exclusively in the history taking portion of the gynecological module express a kind of reverence for the GTAs, making comments such as “oh I hope one day I’ll feel comfortable enough with my body to do *that!*” Within this learning space, there is a specialness about the GTAs that is expressed by both the women who are GTAs, and the women role-playing histories. A vet of the program leans into the table, which instantly quiets the other women, “I call myself a *labia warrior!*” Her proclamation garners enthusiastic applause and belly laughter, nods of approval and looks of sheer admiration from the new ‘pelvic squad’ members. I join in the laughter and applause – it’s infectious. “Jodi, it’s time”, is how the program coordinator informs me that the medical students have arrived, and are assembled in an adjacent teaching room. This is my queue to gather up my student information letters and consent forms. I quickly review to myself the brief spiel meant to enlist the students’ consent to participate in my research. I note the washrooms to my right, and slip quickly inside to take one last glance at my appearance. Not one to dress in ‘business casual’, I note the performative aspect of my grooming and clothing choices. My hair is pulled back into a tidy ballerina’s bun, cheeks still flushed from the harsh winter’s wind that greeted me that morning. I’m rather warm in my black wool sweater, but it matches my dress pants and by the time I got my three kids out the door, I didn’t have time to dig around for anything else. “Okay, good enough - gotta go” I say aloud to myself. A few more steps and I’m outside the door to the room where the students are settling. *Deep breath* - I knock lightly before proceeding inside. The room vibrates with the buzz of their chatter, and as I enter the room I take inventory of who’s present. Today there are nine students – five women and four men. This will mean that students will be

separated into three groups of two, and one group of three. They'll be encouraged by the program coordinator to pair with someone of the opposite sex. I note their attire, and like the previous students I've met, they are all dressed in business casual, the men are wearing ties, and all the women except one, are wearing knee-length skirts and blouses. Nametags adorn the lapels of sports jackets and blazers. They've just found out that they will be conducting a pelvic exam today, and not a history. This particular group of students had the benefit though of hearing the "rumors" that they will have a 50/50 chance of doing the pelvic exam this morning, and not the history. During the first week of the module medical students reported to me that, only during my introduction to my research did they learn they would be conducting a pelvic exam. I stand somewhat awkwardly leaning on the large screen television stand next to me. I feel like an outsider to this space, but here I go:

Hello my name is Jodi and I am a PhD candidate in Health and Rehabilitation Sciences, in the field of Health Professional Education. I have been conducting research since the beginning of the pelvic teaching module this term. My research questions center around trying to understand how the various participants, GTAs, students, program administrators, conceptualize the program, how participants interact throughout the training sessions, and how pelvic teaching is experienced from the student perspective. As you might be aware, there is little in the research literature that evaluates the experience from the student's perspective – and I am interested in your experiences. So, I am inviting you to participate in a brief interview before the teaching session, observing you while you go through the teaching module, and then interviewing you briefly after the session has ended.

Even though I will approach and follow only one student pairing, I hand a copy of the letter of information and consent form to each student as all students will be observed as they move throughout the space – my rationale behind pursuing consent from all the medical students.

As requested by the program administrator, I switch on the pelvic teaching DVD for the students to preview as part of their ‘preparation’ prior to the session with the GTA after the letter of information is reviewed and consent forms signed. I rejoin the GTAs in their gathering room just in time for them to start pairing up for the teaching session. There needs to be one model and one facilitator per each student pairing. The model will be expected to have two pelvic exams performed on her, unless they have an extra student and if willing, a third exam will be performed to accommodate the extra student. The model remains virtually silent unless spoken to directly, or she needs to stop the exam. During the bi-manual portion of the exam, the model generally assumes a more active role as the facilitator is unable to give direction on whether or not the student is actually locating the ovaries – only the model can ‘know’ this. The model will also take part in the de-briefing portion of the teaching session with the medical students after the formal teaching session ends. Otherwise, the facilitator is charged with the formal teaching aspects of the stages of the pelvic exam.

In their pairs (usually one veteran paired with a ‘newbie’, sometimes an additional newbie who would also be observing), the GTAs shuffle off to the rooms where they will work together to ensure all the proper equipment is in place and in working order. I drift in and out of the four clinic rooms used for this module, observing who is paired with whom, and to check with each pairing that they still consent to having me present during the day’s teaching session. This was done each day to ensure participants were always given the opportunity to decline my presence, and as a subtle reminder to them that I was conducting research and not merely observing. I carry my field logbook with me, which as time goes on, becomes a participant itself, eliciting comments from GTAs that range

from reminding me to get my book, to questions about what I write down. I never attempt to keep my notes private, and when I notice curious looks from a GTA, I offer to share what I have written.

When the task of stocking the rooms is completed, we sit waiting in the hall that divides the rooms into sets of twos (see photo entitled “views”). The lighting is quite dim compared to the brightness of the clinic rooms. On the outside wall of each individual clinic room, are headsets that allow an individual outside to listen to the teaching scenario inside, and if the blinds were not drawn, the observer could view the session inside. The GTAs who will play the role of the “model” use this waiting time to undress and go to the washroom one final time. Coming from one of the rooms, I hear a question from a new model. It’s Drew and she asks her GTA partner, "Is it time to strip?"

Some of us are sitting on desk chairs; others pace or wait in their rooms. I note one GTA wearing a pair of knitted slippers. Models’ tops remain on while the “drape” wraps around their waists held closed by one hand that rests casually on their hips. The program administrator, with her infectious enthusiasm, loudly calls to us from down the hall, disrupting the flow of casual conversations, "The students are coming!" It’s time for everyone to get into position. Keenly, I watch as the students come out of the room where they’ve finished watching the video, looking a little disoriented. They walk hesitantly toward the clinic area where we are waiting. I beckon them forward. They appear unsure of where to stand, what’s expected of them now, and are clustered together moving like a single organism. I approach the pack, informing them that in their pairs they’re to wait outside one of the room doors until the facilitator comes to greet them. I approach a dyad that consists of one male, and one female student. I ask them if they would be interested

in participating in the research, and in unison they say “sure”, handing me their signed consent forms. Before we begin the pre-interview, Rosemary opens the clinic room door with a wide smile, extends her arm outward and with a welcoming gesture invites us into the clinic room. The session is about to begin:

Well hello, my name is Rosemary, and you're Julia, and you're Corey? How are you? Drew is going to be our model for today; she's just making a little visit to the bathroom, so she'll be back in a mere moment. And basically what happens today is that you have seen the video, but what we're going to do is walk you through the three parts of the pelvic exam, which is the examination of the external genitalia, the speculum exam and the bimanual exam. I really am Rosemary, that really will be Drew and we don't have any hidden agenda's here at all, unlike your first year introduction to interviewing. So this is not a test or an exam or anything so by all means at any point during this if you just have a deer caught in the head- lights feeling, stop everything. So this is your clinical experience day. We know that you've had an opportunity to do the prostate exam so in the past its been that this would have been your first experience with a invasive exam like that you already have that under your belt so I think there is a little ah, little less anxiety in this one I hope. Anyway that's about all I would have said before the beginning. We'll wait for Drew to come back in and then ...

Jodi: We'll come back then.

I usher them back down the hall into the room where they just finished watching the training video, place the recorder in the middle of the table, turn it on, and begin:

So my name is Jodi, and like I said, what I'm really interested in is just trying to capture the student experience of coming in and learning to go through a pelvic examination using the standardized patients [GTA]. So I just have a couple questions. I guess the first one I'd be interested in is, just to know how you're feeling right at this moment.

Corey: Let's see, umm, I don't think either of us, myself personally, are very nervous about it. It was nice that we got to cover more or less of this material in class over the last few weeks, we've written an exam on it recently. So we feel like we know a little bit more of the medical side; which I think, makes the exam a little bit less awkward.

But I don't know – I think I was more nervous for the male genital exam and the digital rectal than this one, for sure. I can't speak for Julia but I've, I've done a

couple rotations, with obstetricians here ... And so I've seen live births and, so after seeing that kind of, less nerve wracking, certainly. But there are apprehensions to it as well. Umm ...

Julia: Yeah, I've done the speculum exam before, during rural week.

Jodi: Other than those experiences, what was your preparation for today, how were you trained or what was the educational process to prepare you for today?

Corey: There wasn't really any warning – we weren't sure if we were interviewing, or if we were doing pelvic exams today, we didn't know until we got here.

Jodi: You didn't know until you got here that you would be doing pelvic, like this morning?

Corey: Until like you put the video on and told us we were doing pelvic exams, like when you came in that is when we found out then that we were doing pelvic exams.

Jodi: So what is the conversation amongst the students at that point? That explains to me a little bit about the affect on your classmates faces.

Corey: I think it was just like; "oh, ok so are we all doing it today", like there was a lot of confusion about what exactly was going on, and if half of us were interviewing and if half of us were doing the exam, or what.

Jodi: Ok. And you had the training module in oby/gyn up to this point, is this where this module is taking place?

Julia: Yeah, we've had four weeks of our obstetrics block, and we've got two more weeks to go.

Jodi: Ok, any feelings of nervousness or concerns?

Corey: I guess that – nervous that I can injure the patient in any way or make it uncomfortable for them. I mean obviously we don't look forward to it. But I guess my biggest concern at this point is just the use of language.

Julia: Yeah, I'm not like, I don't feel very nervous but I don't feel like completely at ease or anything. Particularly, I thought with the video, the one part that made me a little bit more uneasy is the finger insertion.

Jodi: Can you tell me what about the finger insertion makes you feel a bit anxious?

Julia: Umm, just 'cause I, I don't know what I'm feeling in there first of all. Unless there's like a big lump, umm, you're not supposed to feel anything at all. But uhh, I don't know if I'm going to be 'putsing' around in there or...

Corey: It's going to be awkward and, I don't know. So that's ... I'm not like, I don't feel very nervous but I don't feel like completely at ease or anything. With standardized patients, they usually do a pretty good job at walking through people's exams. I was more nervous about the rectal exam.

Jodi: Can you tell me what you were more anxious about the prostate exam? Can you identify what made that feel more nerve wracking?

Corey: Umm, I don't know, I guess just something I've never done before, I've never done a pelvic either but I don't know, just gut feeling I was more nervous about that then this. Yeah well there are a lot of societal perceptions about touching another man's penis – sticking your finger in an anus.

Jodi: Yeah.

Corey: I mean, and it comes with the work and I obviously have to do it, you've got to get over the initial anxiety... doing it. I think it is, well, something that we have to do and something that we have to learn and do well. So, I think I am happy to learn it but it is not something I'm just like 'oh yes, let's do it'.

Jodi: And I'd like to just follow that up a bit because one of the things that I, I'm interested in, which I don't think there's a lot of opportunity to really talk about is, that movement across cultural and/or social boundaries. You know, "I'm a professional – a medical doctor", and so somehow I need to move beyond these, or I'm supposed to, or I'm not supposed to have these kind of thoughts. You're trying to negotiate a lot of things in your head as well, when you're learning just to get the techniques down, and so, I'm wondering Corey, if maybe part of what's more comfortable today is that at least you're not having to cross a cultural boundary in terms of the same gender? But there also may be newer or different concerns because you're also working with the opposite gender.

Corey: Umm... I think there are maybe different aspects that would make someone anxious about this exam, as oppose to the male one. With the female genital exam I think, a personal worry would be more that she would feel uncomfortable. I think that's made better by having another female chaperone there, whereas in a digital rectal exam, you don't have that. It's just done. Whereas, with the female pelvic exam I'm pretty sure we will always have the female chaperone present. As a male practitioner you will always have a female chaperone, right? And it might be the same for a female practitioner as doing the male exam. Maybe they want her husband or his wife rather... someone to watch. You know, um, but yeah in terms of crossing umm, you know, cultural boundaries umm, I myself I'm kind of liberal, so it wasn't, that old mind set

where like, what who's body is her business and it should only be touched by, you know, her husband and this and that so, I didn't grow up on that, so I understand that professionalism, you know, need to, need to be able to be versatile, right? So you, if you, there should be male obstetricians, there should be female neurologists. Umm, yeah that being said I mean, because you come in, 'cause those kind of cultural anxieties exist, and even though I try to ignore them, you know, there's a bit of anxiety that surrounds doing an exam like this.

Jodi: What do you think the role is of the GTA is?

Julia: In teaching. I think really the main role, because this exam is rather kind of benign, it's not a particularly technical exam? I think the role is to for us is to reduce their anxiety in doing future exams.

Corey: I think they get across more the patient perspective and cultural ahh, things that surround the exam. When we have like a physician coming in, you know, its very, it's very medical knowledge based, where with the standardized patients they do more of the you know, make sure you don't say these words, make sure you drape properly – things that would concern the patient more.

Julia: That's what I think. Normal experience for us, so that when we do it in the real world we don't make the patient uncomfortable and we're also not uncomfortable ourselves.

Jodi: What do you think is the goal of this teaching session?

Corey: This session? I guess the goal would be to perform a pelvic exam, and be comfortable with performing it, knowing what I'm doing and why I'm doing it. At the end of the day, I mean, I'm not going to be perfect at the end of this, and I know that. I don't have the expectation of that. But at the same time, at least I'll have, I'll at least have that one experience, right? So, something to draw when I'm in the real world and I have to do a real pelvic exam on a real patient, you know, may or may not have pathology. Having this normalized experience just gives you something to draw on, right?

Julia: The more practice, you know, some obstetricians have been at this for 20 years, just gets in there and does it.

Corey: Agreed. I think starting on a real model, like you said that moving towards any sort of mechanical model, I would disagree with moving towards ... anything mechanical, I think a real person, like there's no other learning experience that can simulate that.

Julia: And even with, cadavers, they were alive but umm, they're not nearly, you know, their skin is plastic; it's not a real experience. Everything is desiccated.

Corey: Nor are you dealing with like the same sort of scenario if the person, if the person is awake – you're talking with them. You know, that, you know that makes it much more real-life.

Julia: Yeah.

Jodi: Thank you for sharing. It's time – let's go

I gather my recorder and field book and follow the students back to the clinic room door, which rests slightly ajar. Corey knocks, and Rosemary once again gestures us to move inside, only now she's grasping a metal speculum in one hand. She closes the door behind us and proceeds seamlessly into her introduction to the teaching scenario:

Rosemary: What we are going to be doing is starting right from scratch. Now, we don't do it exactly the same way as the video shows. And that video is extremely detailed. It's a new one to us too. We are going to be teaching you the same method that we have used - or that I've used - for the last nine years I have been doing this. It doesn't diverge from what you have been taught - it just teaches it somewhat differently. So if you have got questions or you saw something in the video that you don't feel that I am covering, certainly stop me and ask me okay? First - have either one of you, by the way, ever performed this exam at all or assisted at one?

[I am sitting on a stool off to the side of a small table that's positioned between myself and the 2 students standing with Rosemary. Her back is to Drew as she faces the students – they form a tight circle. Julia has her hands tucked into her skirt pockets – Corey's arms are crossed over his torso.]

Julia: I did a speculum exam in rural week last year, but it was my first time. We hadn't learnt the anatomy yet *[laughs]* so it was a bit like ... blind I guess.

Rosemary: You sort of didn't know what you're looking for?

Julia: Yes, physician was there and they were telling me exactly what to do, but it is more meaningful after you have taken the course and you know.

Rosemary: Yes, understood. So the first things that we are going to look at, actually, are the speculums. And I want you to observe that these are two different widths. *[Rosemary hands a disposable plastic speculum to each student]* We use these plastic ones because we don't have an autoclave. And for obvious reasons, we suggest that you either put your thumb in there *[a spot under the lever that will block the bills from moving]* for the insertion, or your finger in there so that

when you are inserting it, the bills are not suddenly - you know - flapping open. And if you Julia have experienced a speculum exam ... you understand that if the bills open wide it is an extremely disconcerting experience. We try not to cause any more discomfort than necessary. This one, in the plastic anyway, this one is small and this one is large. If in fact you are using the metal ones, this is called a Graves and it equates to the large, and this is called a Peterson. Okay? Just play with it for a minute *[students fumbling around with the speculum.]*

When we insert the speculum, we push it firmly up against the body generally with a little bit of pressure there. And once it is up against the body being held in there, we just open it gently, keeping it firmly against the body. And the reason I say keeping it firmly against the body is that is a fairly powerful muscle we have down there. And one of our gals was on the table when she and I were doing a teaching session and the young man doing the insertion didn't hold it firmly and it popped right out and shot across his lap *[Rosemary laughs]* Which was a little disconcerting for him *[the students' laugh]*.

Julia: You just hold it down? Because it doesn't lock down?

Rosemary: Right. You just hold it in position.

Julia: Open?

Rosemary: Yes. Just hold it open. And that will enable you to see ... We try to just keep it down and just push the handle down so the bills open. And the one other thing, which we do suggest you do before an insertion, is to check the edges of the speculum. There can be rough edges on these things. And better to discover it and discard before you try inserting it into somebody's vagina. *[Rosemary demonstrates how to check the edges of the speculum by running her index finger down one side of the bills, then the other side of the bills. The students follow her movements]*. This is the second part of the exam that you will be performing on Drew today, and I will walk you through it. It's not life - threatening or scary or, you know, heart attack inducing. The trickiest part of this exam is getting the hair and labia outta the way.

Here, give me your hand Drew, and make a loose fist. *[Drew stretches her arm out for Rosemary and makes a fist]*. This is the angle within which you insert the speculum. *[Rosemary demonstrates the angle of the speculum insertion, about 75 degrees, using Drew's fist as the vagina]*. It is surprisingly steep – you'll aim for the table.

[As of yet, Drew hasn't uttered a word. She wears a smile, but says nothing, nods occasionally in agreement]

Now you will notice one of the things they emphasized in the video was the use of language. This is a drape, not a sheet. This is an examining table, not a bed. And

we try to exclude the use of the word feel in terms of ourselves. I am not going to *feel* Drew - I am going to assess her, check her, envision, palpate, examine. Just because feel is one of those words that can be deemed rather sexual in [this kind of] context. We also use what we term the non-business side of the hand [*tops of the hands*] as opposed to the palms [*laughter from students*].

Now I do notice in the video that doctor was using their palms. The other thing I did notice in the video was her request for the patient to - “just put your legs apart until they touch my hands” - was very wide. If you were that wide apart you would be killing yourself. We also use stirrups. There are several positions that can be used. We can elevate the back of the table, we can just leave it flat, and we can do the feet together - like this [*Drew models the positions*], which some doctors prefer to use. In a reclining position the cervix tends to, the uterus tends to come down the canal a little bit towards us, which sometimes makes it easier to envision. However, we are now going to start. And before we do anything else because this is not a sterile environment that you are going to be examining in, so we do everything we need to do physically before we wash and glove, okay?

Okay, so here we go. Follow-me. [*Rosemary now turns toward Drew and the scene shifts from offering direct instruction to the medical students, to a parroting back, ‘follow-the-leader’ method of instruction*]

So Drew, “My name is Rosemary and I would like to perform - if you are agreeable - I would like to perform a pelvic examination on you today - three steps.”

[*Rosemary’s comedic/casual stance and big gestures that were used initially to alleviate anxiety with the students are quieted as she takes on a more stoic ‘professional’ posture*]

Drew: Sure.

Rosemary: Ok. In that case I would like to ask you to move your feet around here so they just come up onto the end of the table here. And if you'd like to recline - lay back there ... in my doctor's office, these [*motioning toward the drape*] tend to be about the size of a washcloth. But anyway. Now Drew has been very helpful. She has placed her feet extremely quickly in the stirrups. A lot of your patients cannot see that far. So, you would just grasp her foot behind the back of the heel here, and on top and say “Drew, I am just going to assist you to put your feet in the stirrups, if that is okay with you?”

Corey: Did you want one of us to go through the whole exam, and then the other person goes through the whole exam?

Rosemary: That's right. And the one who is not doing the exam first gets to observe and assist in terms of lights. And you can use either one of these lights whichever one sort of turns your crank.

[Rosemary motions to the swivel lights that are attached to the wall – it's interesting to me how many 'objects' are part of the performance. We've got the table, drape, gloves, lube, speculum, and mirror. All of these objects make the performance possible, but also restricts or facilitates the exam in particular ways]

Corey: Ok. Sounds good.

Rosemary: The other thing we need to do to make sure that Drew is in position so that you can start the exam – we have to lower this end of the table. And because these things are very noisy *[the foot of the table]*, please tell your patient otherwise she might think that you are trying to murder her or something *[everyone laughs – I think that's a strange choice of words]* Anyway Drew, I am going to lower this table and it is quite rucky so don't be alarmed. So all you do to lower this one is just lift up a little bit and push down on the lever. Now at this point, you would sit down here and go 'yeah, I can't even see you' *[drape blocks eye contact between physician and patient]* if I could just get you to put your legs against the back of my hands, and I am just going to lower the drape a little bit. We will keep you nice and honestly covered here. I am just going to lower it...

Drew: Fold it over like three times ...

Rosemary: We are just going to do the karate chop, okay? *[Class laughs]* No, we will do it this way *[Rosemary gathers up drape at Drew's knees and uses the slack to create a "v" between Drew's knees]*. And I need Drew at this point also to move herself down until she is... and feel the back of my hand here if you wouldn't mind please on her thigh. There we go. She is now in a perfect position to start the first exam, which is the external genitalia. So while I am explaining that, I think we will just get you Drew back into a more comfortable position, okay?

Corey: You can sit down if you want. *[He says to Rosemary]*

Rosemary: No it's okay. That is very bad practice *[laughter]*. The first thing you are going to do, will be to sit down – I will stand up. The first thing you're going to do is wash your hands and glove. And we have three sizes of gloves there I believe. And you're going to perform the examination of the external genitalia using the two fingers on each hand. And you start at the mons pubis, and you work your way down to the labia. In a circular motion - and don't lift your fingers, try to keep overlapping circles going all the way - when you have reached the bottom to the perineum, you separate the labia majora so that you can see the labia minora, and you examine it just for lesions, discoloration - anything that might just look a little out of context, or out of whack. At this point, you would

also examine the glands, which are at five and seven o'clock. And you would insert your finger -your index finger - up to the first joint only and the motion you would use is grasping it firmly is just a firm pinch.

[Rosemary pushed on one of the student's shoulders to demonstrate the amount of pressure they will need to apply when they are examining the glands – it's interesting how the model's body operates as apparatus, as well as flesh and bones]

Drew: But don't say pinch *[laughter]*

Rosemary: Pressure! *[more laughter]*. And keeping your finger inserted you - this is one part of the exam where it is really quite easy. You go to five - pinch, pinch, pinch, move over to seven, pinch, pinch, pinch, up to eleven. Lift with a little more pressure back to the center and lift your finger under that urethra. All we want to do there is see if there is a discharge. There may in fact be some discharge - there generally is in a young healthy woman. Not necessarily in post menopausal. But if there is a discoloured discharge or a bloody discharge, you wouldn't say to your patient something like "ooh, I don't know what that is. God, that looks bad". *[students laugh]*. We would say "oh, we have a bit of discharge here. We will check up on that a little further." And just leave it at that. Never tell a patient who is lying there in that kind of condition that there is something seriously wrong. That is not what she wants to hear at that point. So again, it is a language issue. Keep your face - in just a small smile.

And always keep your eye back and forth on your patient's face because if in fact there is something there that is bothering her or it is hurting or is really uncomfortable, her face is going to show it at some point. Some of your patients will scream loudly. Some of them will just not...

And, while I am on the subject of doing this exam, you can have somebody in the room with you if you feel that this is something you would like to do, or if your patient would like to have somebody. You would say at the time of setting the appointment "would you like to bring somebody with you? Your friend, your mother, your aunt, your cousin – somebody?" If she says "no", that is fine. "Do you want somebody in the room?" "No, I don't care." But if you have an office nurse, you can ask your nurse step in. That is just a comfort zone for everybody.

[I find this interesting because, on the one hand, a woman might feel more comfortable with a friend, or relative with them, or even the office nurse (although I guess this means the office nurse is always a woman?) ... but this isn't suggested for the male exam, and when I speak with the students, the idea of a chaperone is usually about protecting themselves legally]

Julia: I see they suggest offering a hand mirror

Rosemary: I have never wanted to watch.

Corey: Would it be like a moving mirror. We'll tie one up in a corner for your convenience?

Rosemary: I can't believe I would ever want to watch that. I really can't.

[Rosemary is providing personal (political-social) commentary about what she would/wouldn't want while the students appear more interested in the pragmatics]

Julia: Is the labia minora exam - is that just a visual inspection?

Rosemary: It is just a visual inspection, yes. And that covers the external genitalia.

Julia: I am sorry I just had another question. When you are doing the urethral sweep, that's in the vestibule that you're, yeah ...

Rosemary: Well some people tend to pull their finger out and then put it back in and pull their finger out and put it back in, which is really, you know, its just one of those things that's, its making it more complicated than necessary. Just as a thought, if in fact the glands are engorged or infected in any way your patient will be on the ceiling the moment you touch them. They're very sensitive. So the next portion is the, yes it is, is the speculum exam and I'm going to explain to you the method that we have used as long as I've been doing this program. And it's not quite the same as what you saw in the video. There is no right or wrong other than don't just push it in straight all the way because it won't work and it will cause pain. That's another word we try not to use, but in that case if you do that, it will cause pain.

So I've got this lined up and I use, if I can use your hand if you just do this for me. *[Drew is providing her hand in the loose fist position again]* This is her vagina, we use the 2 finger platform method generally and what you do is separate the hair and the labia with one hand, or use both hands, the small fingers and then insert 2 fingers and pull down, this is a very strong muscle at the back. Pull down, keeping your fingers there as you insert the speculum you remove your fingers, you've got it up against her body and you open gently. Now we use, thank you, we use lube here.

And the bimanual is when you have your patient lying down flat and again with her feet in the stirrups obviously, and you explain to her what you're going to be doing, just placing one hand on her abdomen and the second hand two fingers will be inserted into her vagina and what you are doing, attempting to do, I'm not always successful at this either, is to sweep down the uterus quite deeply and with this hand insert your fingers here, turn them as you have inserted and between the

upper hand and the inner hand you're trying to sandwich the uterus so that can, you can palpate it to see if its enlarged, if its maybe a little out of position, if it's doing odd things. I'm assuming yours is dead center.

[Why would she assume it's "dead center"?)

Drew: Generally, I have had it tilt before though, so...

Rosemary: So that's something to be aware of. Mine tends to be over to the left and down further than you think. We generally say at a 75-degree angle. I generally say if you insert it almost straight and then tilt down towards the table you're bound to meet the uterus and cervix, generally speaking. So which one of you lovelies want to go first?

Julia: I'd love to go first.

Rosemary: If you'd just like to wash.

Julia: Then I put on gloves.

Rosemary: Those are medium right there. Yes, excuse me I'm just going to get this out. We have a biohazard container.

Julia: I'm Julia, I'm going to be performing your pelvic exam today. Do you have any questions? *[Drew nods 'no']* So I guess we start with the positioning.

[Julia looks to Rosemary for what appears like affirmation]

Rosemary: You do start with the positioning and Drew has already, really kindly laid herself down for you so...

Julia: Ok if you can place your feet in the stirrups.

Rosemary: Generally speaking your patient won't be able to see those things so you would take her...

Julia: I'm just going to hold your foot and put it in the stirrups.

Rosemary: And we're already draped in since, oh the other thing I didn't mention, go ahead and because you're not going to glove until after this was done, I'm sorry. That's my fault.

Drew: Because you touched things along the way so...

Rosemary: So we'll turf those. That was my fault I should have checked. You need to...

Julia: I need to be putting the end of the table down so you might hear a loud noise. *[A loud clanging sound]*

Rosemary: And the other thing just for your information of course is if at any time you're feeling uncomfortable or for any reason you want to stop this exam just please drop the drape - because she will be holding the drape. This is what we do we tuck it up like this *[lifting the drape up from both of Drew's knees in order to create a "V" between her legs]* and then, give it to her and say "would you mind holding this?"

Rosemary: We're going to ask her to just...

Julia: So can you please open your...

Rosemary: Could you just move your legs to...

Julia: Can you move your legs until they touch the back of my hand?

Rosemary: And she needs to move down here. *[indicating the edge of the table]*

Julia: And can you move down...?

Rosemary: I think you're as far down Drew as you need to be. I don't want you falling off. You do tell your patient at all times, you can stand over Corey *[pointing to the corner]* you do tell your patient at all times what portion of the exam you're going to be doing. "I'm going to hand you the drape, if you wouldn't mind holding it while I exam, do an external examination."

Julia: Ok. So I'm going to hand you the drape and the first part will be the external examination. So if you feel uncomfortable at any point just drop the drape or let me know.

Rosemary: Yeah, that's great. So then we start our touch in the inner thigh just so that we're not sort of diving in so every time you're going to do something physical you just say "I'm going to just touch you on your thigh and then I'm going to be starting the external exam."

Julia: Ok, I'm just going to touch your *[laughing]* inner thigh and then I'll be starting your external exam.

Rosemary: And with this you can put both outer parts of your hands on her inner lower thigh, and you just roll in and your two fingers of each hand onto her mons pubis, right. Start palpating.

Drew: Probably a little harder.

Rosemary: The one thing you have to realize is that it's a boney structure and you need to be able to assess what's under the skin and if there were in fact anything but the boney structure you would be able to feel it through your fingertips which are very sensitive. And you separate the labia...

Julia: With these two fingers? *[Indicating index and middle fingers]*

Rosemary: Yeah, absolutely. And you're going to have to separate a little more than that so you can, there you go and you're just doing an external here and everything appears fine.

Julia: So now I do the glands?

Rosemary: I'm going to insert one finger up to the first knuckle so I can check your glands.

Julia: I'm going to insert 1 finger so I can examine the glands.

Rosemary: Ok and it's between the thumb and the forefinger at "five".

Julia: So the thumbs outside.

Rosemary: Pinch, rolling pinch. Firm enough?

Drew: Yup.

Rosemary: Switch it to "seven" keeping your finger inserted bring this finger up, lift, no you don't pinch there just lift and over to 1:00 and lift and up under the urethra and up and out. And that completes the external exam.

Julia: We're done part one.

Rosemary: Ok, the next thing that we're going to do is, and you should check this to make sure that everything is organized and working and is...

Corey: Not sharp.

Julia: Doesn't feel sharp. Done the sharp test. Should I warm it?

Rosemary: You're just going to smoogy it, do you want to...

Drew: I'm fine.

Julia: Do you need to warm the plastic ones.

Rosemary: I would run it under the warm water, Drew says she's fine but it's going to hurt. Don't dry it its going to be inserted.

Julia: Do I put the lubricant on even though I put it under water.

Rosemary: You don't think you need lube?

Drew: No, you can if you want but it doesn't matter.

Julia: Ok.

Rosemary: Water in itself is a lubricant as well. But I'll give you a little bit of lube. That's fine, and you can explain to Drew what you're going to be doing.

Julia: Ok, so we're going to do part two of the exam which is the speculum exam. We won't be doing cytology today but I'll just be inserting the speculum and if you're at all uncomfortable let me know.

Rosemary: And again, I'm going to give you the drape.

Julia: I'll pass you the drape to hold.

Rosemary: Again you're going to need to part the labia, you can use your two pinkies or you can use your left hand and separate.

Julia: I think I can do it with the hand. Two hands and then switch to the left.

Rosemary: Ok, that's fine and again you need to touch.

Julia: Oh yes, sorry. I'm going to touch the inside of your thighs and...

Rosemary: And then you're going to separate the labia.

Drew: Yeah, it's awkward. I'm sure you eventually get a technique down.

Julia: So you'll feel me insert two fingers.

Rosemary: And pull down on the back muscle. Feel how strong that muscle is, is that ok.

Julia: Ok.

Rosemary: No, you're there. Insert your fingers more than that.

Julia: Both of them?

Rosemary: There is that better?

Drew: Yup...

Julia: Pull down towards the table?

Rosemary: Pull your fingers down towards the table and insert along the line of your fingers, removing your fingers as you're inserting the speculum and keep it going, right up against your body. Right up against her body, firmly and remove your thumb. No keep pressure on the top there. No remove your thumb from there and open gently but firmly. Now don't tilt it. Have we found it?

Julia: I've not found...Can you move the light Corey?

Corey: Yeah. This one is a little awkward.

Rosemary: No, this is fine, move this way for you.

Julia: We're just adjusting the light. Yup that's good. Ok I don't not see the os.

Rosemary: If you can move your hand just a bit so that I can, I think we're just above it. Is that what it feels like to you? If you can just move the handles slightly.

Julia: Can we get the light back? Sorry. Is that uncomfortable for you?

Drew: No, it's fine. Rosemary has been doing this for years so she knows where hers is. I haven't, I have no idea.

Rosemary: Don't move it too much because small movement on the outside is huge movement on the inside. Ok, I don't think we're down far enough.

Julia: Ok, should I close it?

Rosemary: No, withdraw a little bit and then take your thumb off here, it will collapse itself and ...

Julia: I feel like it's pinching the skin.

Rosemary: What you need to do is tilt it a little bit more and push in again...are you ok Drew?

Drew: Yup.

Rosemary: Ok, now open the bills, keeping your finger firmly there, no don't tilt it back towards you. Just open the bills.

Julia: Can you move the light to the right?

Drew: That's a warm light.

Rosemary: Yeah it is because it's getting close to your body too.
[Laughter]

Rosemary: Can I see?

Drew: Sorry, best to keep the pressure there or I'm going to shoot it out when I laugh.

Rosemary: I think you're tilted under today.

Drew: Yeah, ok.

Rosemary: Because that's what we're seeing is the backside.

Julia: How do you know it's the back?

Rosemary: Because if it was the top of it, it would be up and there is a little round donut there which is called the os, but it's under because...

Julia: So do I close?

Rosemary: Just pull it out a little bit and let it collapse and we're withdrawing the speculum. You had it down deep enough that it looked to me like it was just tucked under and I don't want to go guttling around in there, just on the off chance that we might be able to...

And I would suggest at this point you change your gloves because you're now going to do the bimanual.

Drew: Sorry I have no control over what it decides to do, what it wants.

Julia: Not a problem.

Corey: So what happened to the position of the...

Rosemary: Well Drew has told us that her uterus, generally your uterus sort of goes like this, if I can just see if maybe that thing is in here.

Julia: Did that feel uncomfortable or normal?

Drew: It was good until when you first started to take the speculum out there was a little pinch.

Julia: That's what it looked like it was pinching, like when you...

Rosemary: We'll just go a little deeper when Corey does his just to see if we can get it. There are two ways to do the bimanual. You can do it from sitting from here, which is what you saw in the video this morning. You are tall enough that you should be able to do it from the side and I think its maybe easier for you to do it this because the thing is you can tuck her knee back there while you're doing this and it gives you better vision or you can do it from the end, it's up to you.

Julia: I'll try your side approach.

Rosemary: Well the thing about that is that you still tuck her leg behind you and you lean in so yes you could do it but I am not recommending either, I'm just suggesting to you that those are the two ways to do the bimanual. The thing about this is your first contact will be on her abdomen, so you tell Drew "I'm going to just lower the drape and ask you to pull your shirt up", if it's down there a little bit and you just lower the drape to just below the bellybutton, and you place your hand here. *[Placing hand on belly]*

Julia: I'm just going to be doing the third part of the exam now, so I'm just going to lower the drape and I'm going to place my hand on your abdomen.

Rosemary: "I'm going to give you the drape to hold on to and I'm going to be inserting two fingers into your vagina so that I can check your uterus between my, other hand..."

Julia: So this is the last part of the exam, I'm going to be inserting two fingers into your vagina and I'm just going to be checking your uterus size...

Rosemary: And ovaries.

Julia: And ovaries.

Rosemary: Ovaries, if they're lovely and healthy, you shouldn't feel a thing. You shouldn't find a thing.

Julia: You shouldn't find anything. Ok.

Rosemary: So again, now do you want some lube for this on your fingers, it might be a little easier for you.

Drew: There's not much visual really on this end, I find it comfortable enough on the side.

Rosemary: And when you insert your fingers do in the gun position but turn them.

Julia: This might be awkward. Is it alright if I reach over?

Drew: There you go. Keep going and its deeper than you think.

Rosemary: How're we doing Drew?

Julia: Like in the video. Ok what am I supposed to...?

Rosemary: With the other hand you are sweeping down, very deeply and pressure. You tell her if the pressures...

Julia: You're going to feel some pressure.

Drew: This is a great time to remind before all this goes on to let the patient go to the washroom ... It's ok I'll live.

Julia: Sorry about that.

Drew: No big deal.

Rosemary: Can you assess the outline of it a little?

Julia: I think so, yeah.

Rosemary: Did she find it? Swing it to the other side and let me show you that this is extremely awkward.

Julia: I can't feel anything here really.

Rosemary: You can't find anything there?

Julia: Sorry I can't find...

Rosemary: This is the commonest error and we all make it, believe me.

Julia: I can't find the ovary.

Rosemary: And as you come out, as you withdraw the fingers you check the walls.

Julia: Do we feel the ligament?

Drew: Oh, they have that bit in the video they said don't worry about that.

Rosemary: No, please don't worry about it because we haven't a clue.

Julia: Ok, so you can drop the drape, thank you very much.

Rosemary: The important thing to do is not to leave your patient in this position. We'll also go to the washroom. And you would move her feet back onto the table. At this point, you know, I mean Drew is fairly limber and she's probably not going to have any problem getting her feet over but for somebody like me who has a hip issue.

Drew: Sitting in that position for a while is probably...

Rosemary: It really locks you up, now the other thing to do and this is for your benefit as well because as a physician you're going to be on your feet one heck of a lot and your back is one of the most important parts of you anatomy. When you see your patient this way, as I said Drew is limber she could probably sit up all by herself but you're going to have people like me who are older, little crankier, little stiffer and you say can I give you a hand up, ok.

Julia: Yeah.

Rosemary: So just be aware of that and at the end of this exam you sort of don't have to tell any woman that this is what you need to do, but you point out the Kleenex and some doctors have pads and say "you know because we've done cytology there may be a little spotting, it's just and there is Kleenex here and there's pads here and please help yourself. *[Turning to Drew]* I'm just going to go outside and when you're ready would you just crack the door for me."

The exam takes maybe 5 min from start to finish. So now do you have queries before we let Drew go use the facilities?

[The entire three-part exam will now repeat with Corey acting as the physician and Julia observing]

After the teaching is complete with both Corey and Julia, a feedback session is conducted. Rosemary opens the floor for any questions or feedback:

Julia: So just as a couple points; let's say you can't view the cervix but she's in for a Pap smear.

Rosemary: I would venture a bet that when you've done half a dozen of these you'll be able to find the uterus. This is a first time deal and because Drew's uterus is tipped, I'm really sorry we couldn't find you the os *[cervix]* today but because her

uterus is tipped this morning and it really is I could see it was just back farther, just being shy. I'm sorry we couldn't find it for you but I would suggest also ask your instructor again when the uterus has turned itself backwards like that, even though we went down steeper and we still couldn't sort of tilt it back up, ask him what he would do, what he would suggest in that instance. Because I mean if you have somebody who's come in for cytology, you can't really say; well I guess I can't do this because I can't find it.

Drew: Actually that's pretty much what my doctor did the one time. The first time that it happened she said that she'd have me back in a couple weeks to see if it moved back normally.

Rosemary: So it does happen and I know we've got one of our standardized patients who has a retroverted uterus and it's just impossible. I can never find hers. It's there, I know it's there, I mean she's got all the equipment I just can't find it.

Drew: Its really strange mine just flips, strange, it's like it's this free floating entity in there somewhere, just whatever it feels like.

Rosemary: Any other thoughts?

Corey: I just had a question about the uterus size and how to do that?

Rosemary: Again, that's a question for your instructors – it's not for us.

Drew: As for the physicality – I know you guys will figure out how to do the internal. But just watch the external exam. Make sure you keep them out of the way.

Julia: The....

Rosemary: Fingers. When you've got two fingers inserted, and I know....

Drew: The ones that are on the outside make sure you keep them away, like out towards the other end of the body.

Rosemary: And I realized that on the video they showed with her fingers stretched and her thumb up. I find that very awkward. Again, it's a matter of what works for you. And in your case because you said that you're fingers are shorter, if you have it like this its easier for you to drop the heel of your hand.

Drew: And of course when you're inclined to put your hands like that so....it's an awkward thing to try and train yourself to get your fingers out of the way.

Rosemary: And chopping off two fingers doesn't work. It's not a good thought. Anyway, any other thoughts, any questions. I think you both did a good job.

Drew: I think so too.

Rosemary: Your language was good. Do you know something? We all make the mistake of feel, "I'm going to feel for...", we all do it.

Drew: And most people are probably going to be fine with that anyways, it's just how your general demeanor needs to be with something that's going to have the most affect. Jodi would like to have the floor now.

The students shake the hands of Rosemary and Drew, thanking them both for the(ir) experience. Rosemary opens the door for us, and we proceed back to the group room space we left just over an hour ago. We pull out our chairs, and settle back in. I place the recorder back in the middle of the table, and we begin the post-exam interview:

Jodi: So I got a little bit of your reaction, obviously, just from being in the feedback session but I'm just wondering if you could check in with me, let me know how you're feeling right now, what are you thinking?

Corey: I feel good, I feel like it went well. Especially going second it's a lot easier. Like I just saw Julia do it and saw the mistakes that she made so then I know to fix them and it was comfortable.

Julia: Yeah, I feel that same way. I feel as if I did it again it would be a lot quicker. So I feel comfortable, confident with it.

Jodi: It felt, from where I was sitting, when I watched your reaction to the amount of feedback you were getting at the beginning of the exam, it seemed like you got overwhelmed.

Corey: Yeah.

Jodi: That was the only time I felt that you were almost emotional. Like it was, and that's normal, that's, I've seen that with lots of students and I've been a standardized patient myself, so I've seen lot of students respond in lots of different ways. So I'm just wondering what you were feeling in that moment because I'm making assumptions about how you were feeling.

Corey: Um, yeah, I guess it makes me look like a bad person. I feel as if she wasn't a standardized patient, if she was a real patient I would have just continued myself, but I just wanted to let her [Rosemary] know what I was expecting out of

this, that this is my first time and I do want to learn the skills, and *sorry* if I called it a sheet instead of a drape.

Jodi: When you said it makes you feel like a bad person, what do you mean by that?

Corey: Um, a bad person ... that maybe I wasn't giving as much respect to a standardized patient as I would to a real patient if I was doing it on a real patient for the first time.

Julia: I don't feel like the standardized patient, like a normal patient too would question, or would be like do this, do this and like kind of repetitive keep doing that too.

Corey: Just the little things like what kind of exam, well a pelvic exam.

Jodi: So your experience in that was that, that you weren't being as respectful with her as you would have been a regular patient?

Corey: I feel as if it was a regular patient and she was egging me on like that I would have just been completely composed and contained but because it's a standardized patient I'm not as, I'm not as just sort of, I guess calm. I'd rather let her know what I'm thinking as well because it's a learning process.

Jodi: And you did that and I think that's what you needed to do, for sure there's no judgment and it was interesting for me to watch because it is, I was trying to understand what, if it was me and there is obviously lots of anxieties and you're already nervous as it is and if I was getting that much feedback or that much I might have had the same reaction. Julia, what you were feeling for your classmate at that point?

Julia: [*Turning to Corey*] I noticed you were a little frustrated just when you were like; "work with me."

Jodi: Anything else, anything about the experience that either of you were thinking or feeling that was surprising or different than you had anticipated.

Julia: I think for both the breast and this exam they should make their own videos. Because I find that like both times when we're in with the standardized patient they were like; well you saw the video do the karate chop, we're not going to do that or you saw the video do this and we're not going to do that. So why not just teach us from the beginning, if they just made their own video I'm sure it would be a lot easier.

Corey: Yeah, I agree.

Jodi: Instead of having to unlearn something.

Julia: We were just like focusing so hard, ok and then we get in there; they're like oh no we're not going to do that. So both videos actually did that for the prostate and the one and we changed a bunch of things. So that could help.

Jodi: Do you feel that the goals that you might have had for this learning session were met for yourself?

Julia: I think so, I actually didn't even know if I would feel the cervix or anything. So feeling it I feel like I exceeded any expectations that I had.

Corey: Yeah, I think the goals were met. The only thing is that you learn it, you learn the skills, the first time and you almost need to practice it one more time before you're actually confident to do it in a clinic on a real patient. Where I feel now is that my first real patient is still going to be that second time putting it all together.

Jodi: I agree, there is the, like the comment that you had made that there is a difference. It's like I can do it and then I have to say something but learning to do it simultaneously to talk and do it at the same time is totally different experience.

Corey: Yeah, I kind of... like, I'm just a different learner. I kind of like to get the physical skills and then look confident and spiel the report and everything the second time kind of thing.

Jodi: [Laugh] Yeah, it's true. Anything that would have made today a better learning experience for you, either preparation that you could have done ahead of time or something that you could do now from here?

Julia: I feel like they have assigned readings and stuff online, I can't say why I didn't do them but I'm sure if we read we might feel a little more comfortable. I still felt comfortable though, so.

Corey: I guess the only thing is if you know you go back to the 60's, like you there on say like cadavers up in the lab just doing that initial; ok there's the, just kind of get that feel before you try it on a real patient might be beneficial.

Jodi: So instead of sort of replacing one method to another but look at ways of combining the various methods to build on one another, complement one another?

Julia: Maybe, I was just thinking, like I know we like it...that there is standardized patients and we're seeing it from the patients view but I don't know how I'd feel if like a doctor was there and giving us their kind of perspective of things too because we don't really get the doctor's perspective of it.

Corey: The problem when the doctor's come though is that every single doctor is going to show us their way and then there is no standard, where I feel like they've all gone through the exact same training and teach us the exact same way.

Jodi: Anything that you feel could have emotionally prepared you better for today?

Julia: I don't think so.

Corey: As I said the whole doing the standardized patient for the prostate was preparation enough and if they were the other way around it would be the same deal.

Jodi: Right. So it's important to have the breast exam be the first, it seems like the least non-invasive or the least invasive of all of it and build on.

Julia: I think that's the best one.

Jodi: As the only man in the room was there anything that you can reflect on, did that feel any different?

Corey: Um, I guess everything is just brand new to me even you know holding the speculum [*laugh*] sort of thing. Overall I feel it's the same experience whether I'm a man or a woman going in. I feel they're professional enough that it's not really awkward for a male over a female. At least I didn't really feel.

Julia: I think it depends who you go in with too because like Corey and I are pretty good friends so I feel like we felt comfortable but maybe if it was someone, like that I'm not close with, I might have felt a little like embarrassed if I messed up or something like that but I don't get embarrassed with you so....

Corey: Yeah, that's true.

Jodi: I think that trust is important in all of, between the standardized patients, there needs to be trust and I think that it can be a better learning experience if there is trust between the two students coming in. Anything you would like to share before we end?

Corey: No, I think that's it.

Julia: No, I'm good.

RECORDING STOPPED

We push ourselves back from the table, and make small talk about the weather as we pack up our belongings. I thank the students for their time and wish them luck for the remainder of their studies. I leave them and return back to the standardized patient group room. I am once again alone in the space. With a sigh, I sit back down for a few minutes to jot down a few last observations. I'm relieved that another day of data collection has come to a close – it's exhausting and I'm starting to get a headache from the fluorescent lighting. I clap my notebook closed, and exit out the same doors I entered earlier that morning, saying a quick good-bye to the receptionist that has now arrived and is plucking away on her computer keyboard. On my way to my car, I turn my recorder on one last time for the day – time to record my field note: “Ok, so this is my field note for ...”

Now that a teaching session has been represented in detail, subsequent chapters will serve to “interrupt the flow” of these sessions by using an assemblage of accounts of my storied reflections of being a GTA with representations of participants' data, relevant research literature, and various theories. The following chapter entitled, *Training Day* returns us to an earlier point in time than ‘a typical day’ depicting the process of training to become a GTA. It is here I begin to interrupt the pelvic teaching performance, to demonstrate how normalized discourses of being a ‘woman’ are (re)enacted in the production of pelvic teaching, specifically by focusing on what is involved in ‘training’ to become a GTA. In subsequent chapters, I will extend my argument by focusing on (per)forming the practice(d) body, and listening for/to the silence(s) within pelvic teaching.

Chapter Five

Training day

It's 'training day', and we're assembled excitedly (and some of us nervously) around a rectangular conference table in the learning resources room at a large teaching hospital. Posters with the latest immunization recommendations line the walls, while pamphlets detailing good hand-washing practice, prenatal screening options, and dietary guidelines for the 'early years' are haphazardly stacked on cluttered bookshelves that at one time appears to have housed a resource lending library. We introduce ourselves, popcorn style to one another, the program coordinator and the male gynecologist who will lead us through our initial training exercise. The introductions sound something like this. "My name is so and so, and I have been involved with this fabulous teaching program for such as such length of time. I'm so pleased to be back here again this year and want to assure all the 'newbies' that you are going to just love it too!" As I glance around the room and listen to the introductions, the age range of women is impressive – looks like early 20's to 70's, but as far as I can tell, we're all white. Some of the women speak to being mothers who are picking up this job to supplement their income, some are students needing the extra cash for books and food. The remaining women are actresses, schoolteachers, and women's health activists whose collective reasons for participating hover around improving pelvic examination experiences for women at large. Now it's my turn, "My name is Jodi and I am a midwifery student. I'm looking forward to learning a lot about how to actually conduct this exam and helping medical students learn more about doing a good pelvic exam". This was a learning opportunity for us too, and we would commit to such work for the greater good of all women.

Next they hand us each a training

booklet which consists of: 1) a checklist of items to review with medical students during the teaching scenario; 2) a photocopied chapter from a biology and physiology text of female genitalia; and 3) a booklet specific to the pelvic teaching program. With so much emphasis on language, draping techniques, control, and proper use of instruments, I feel safe and at ease. My shoulders relax, the knot in my stomach eases, and I feel myself settling in for the training video. The video walks us step by step through how to conduct a pelvic exam. The narrator stresses the importance of good eye contact and keeping a pleasant, but professional facial posture. We are shown how a pelvic exam can be done in a sitting position – wow haven't seen that before! The video reviews types of speculums, draping and sterile collection techniques. "When the exam is complete," the video instructs, "please remember to assist your patient up, offer a tissue and leave the patient to dress before you discuss your observations."

It's break time and the "old-timers" proudly share their best and worst experiences in the program, like veterans swapping war stories. I am not sure if this is meant to be soothing or terrifying, but I find it all exhilarating. My stomach is doing handsprings and my cheeks flush with anticipation – I can hardly wait to get on that table. Was I really going to do this?

As a GTA, being a good 'partner' with one another is hugely important. We are the gatekeepers, assurances of our partner's safe journey through the pelvic exam. We move on to learning how to do the exam by getting into groups of three, one experienced GTA with two trainees. I quickly volunteer to go first on the table in our group, too nervous yet to try out the exam on another woman. I can hear them talking outside the door as I

disrobe. "Do I leave my socks on? Shit I didn't shave my legs". Such thoughts are now racing through my mind. My heart is pounding, my hands are sweating – can't we dim the lights a little?

The (in)formal training process(es) in becoming a Gynecological Teaching Associate

The above reflection represents the initial training session from my perspective as a new GTA. The research literature on medical education and standardized patients is replete with examples of how training with standardized patients is said to improve the educational process for burgeoning practitioners (Hendrickx et al., 2006; Kleinman et al., 1996); however, very little research documents how standardized patients, specifically GTAs, are trained to provide such instruction. Of the articles that touched upon the training of GTAs, most described training sessions that ranged from a half day to more comprehensive, ‘graduated’ training process involving a series of steps that started with observing teaching sessions, and ended with the potential GTA performing a pelvic examination on another GTA (Robertson et al., 2003; Siwe et al., 2007; Underman, 2011).

Carr, Tregonning, and Carmody (2001), reported findings from their research wherein GTAs were asked to complete an 11-item, five-point Likert scale questionnaire to record their perception of the training they had received prior to the program, and the effectiveness of the program in preparing medical students. Eight of the 12 GTAs returned completed questionnaires. Only one question asked about the adequacy of the preparation for performing as a GTA with the remaining questions were directed at evaluating student performance and the perceived usefulness of the program. While those who completed the questionnaire reported feeling adequately prepared to participate, authors did not provide any information as to what was actually involved in the preparation/training program for the GTAs,

making it difficult to contrast the preparation these GTAs received with other GTA programs. The reader then is left questioning how possible similarities and differences in training length, duration and content may have contributed to their responses. Similar to other research conducted on pelvic teaching programs utilizing GTAs, the program coordinators were also involved in data collection; therefore, fear of reprisal due to a lack of anonymity may have been a contributing factor in the positive evaluations of the program. With the exception of this article, no other publication was located that evaluated the training program from the GTAs' perspective.

Given the absence of GTAs' qualitative experiences of their 'training to become', this emerged as a critical area for further consideration in conceptualizing how GTAs positioned and performed themselves within the teaching context. To address this absence, during the focus group discussions and interviews with GTAs, I invited participants to share their own varied accounts of their initial training session. It was my intention to understand the nuances of the training process from the perspectives of other GTAs. I wondered how assumptions about the purposes of the pelvic teaching program were, or were not, reflected within the training session(s) and training materials provided to the GTAs, and considered how and why this mattered. My assumption was that the process of training to become a GTA was not something confined to one specific time and location. Rather, becoming a GTA would be a cumulative process, and iterative processes of gathering and discarding strategies, both tangible and intangible, personal, and relational, to learn how to adequately (re)perform the expected role(s) of a GTA. Based on my own

prior experiences, I also assumed that the training process would have elements that troubled new GTAs, as they confronted, perhaps for the first time, their own deeply embedded notions of normative gender ‘identity’ performance. Insights into the process of training to become a GTA add to the discussion of how the culture of pelvic teaching was possibly being (re)constituted through the enactment of normative discourses of gender performance.

“You understand more what the students are going through”

Amanda, a long-time GTA, offered her recollection of the process of training to become a GTA:

We, I’m sure we watched the video, which is different than the video that they have now, and then like they talked to us. I think sort of like the ladies that have been doing it for a while were sort of talking about, you know, the things, sort of like what had gone on in years prior and like the stuff in the video that was right, the stuff that was wrong and like they’re sort of pet peeves with the video and all this. And then we split into groups and then anybody who hadn’t, well like all, well the new people and then like anybody who hadn’t done a pelvic exam, that they got us to perform them if we were comfortable and if we hadn’t done them so I did one because I figured it was no different than what I did on the flip side of things. So I think it was a good thing to have done but you sure, you can’t force people to do it at all but I think it’s an important thing because then you understand more what the students are going through.

Amanda’s comments resonated with my own experiences of training to become a GTA. During the training session, GTAs were encouraged to empathize with the feelings of women undergoing the exam, and with the medical student conducting their first pelvic examination. To create the conditions that would facilitate this identification, GTAs were encouraged to practice the examination on one another. However, her comments draw attention toward a notable tension in the training process, that is – while performing a pelvic examination on another GTA was not an

activity that a GTA should be coerced into performing, doing so was understood to offer the most salient way of engendering empathy for the medical students.

“I have to *look* at her?”

...normative sexuality fortifies normative gender. ...One is a woman so long as one functions as a woman within the dominant heterosexual frame and to call the frame into question is perhaps to lose something of one's sense of place in gender (Butler, 1999, p.xi).

In regards to Amanda's first point, while performing a pelvic examination on another GTA was not an activity that a GTA would ever be explicitly coerced into performing, performing this exam on another GTA has been a cornerstone of training to become a GTA in this program. This 'rite of passage' of confronting gender norms to 'get over' them is a central aspect of the training, signifying one's commitment to the program, and one's capacity to transcend socio-cultural taboos. During a focus group, Rosemary reflected on her initial feelings of looking at another woman's genitals:

I think when I first did the, signed up to do the pelvic exam and because you have to do it yourself to learn it, Carol, who is no longer with the program, was the model and you [*nodding toward another experienced GTA*] were my coach and I remember thinking, I don't think I can go there. I was really, I had no qualms about taking my clothes off and letting somebody else look at me, but boy I wasn't going to look at another woman and it took me a long time to get past that initial; I have to look at her. By the end of the first year I was getting comfortable enough with it that I no longer just felt that I had to force myself to walk into the room.

Additionally, as Amanda's comments also addressed, more experienced GTAs were the gatekeepers of knowledge. They were seen as the experts, able to discern between what was "right" and "wrong" with teaching materials. They had a powerful presence in the training of new GTAs, as they role-modeled for new GTAs the(ir) performance

expectations. *Not* conducting an examination on a fellow GTA, or not allowing a fellow GTA to perform an examination on you, without a ‘legitimate’ reason (e.g., menstruating) would raise suspicion as to one’s suitability for the program. However, the work of transcending the socio-cultural taboo of looking at, and touching another woman’s vagina was not addressed within the research literature related to the experiences of becoming/being a GTA.

It is interesting to note that, men who participated in the digital rectal exam were not asked, nor expected, to complete a rectal exam on another standardized patient or have an exam performed on them prior to being accepted into the program, or as part of their training. I asked GTAs why they thought this might be so:

Gloria: They’re probably not pushing it so much because they don’t really seem to have a problem filling this program. Like we get enough women but the male they’re always advertising, they can’t get enough. So they don’t want to do it they’re probably just trying to push it. But yeah, it doesn’t seem right either. Like I like having done it because it helps me understand what the student is doing and what it should feel like for them to do it, like I think it was good to do it. But...

Rosemary: I think my issue is that we’ve desexualized it and that’s part of the point and they obviously haven’t made that much of a desexualization if they’re still going to have issues with one another’s bodies.

Rosemary’s comments reflect another central element of learning to become a GTA – learning to ‘desexualize’ their bodies. Not only were GTAs charged with the task of desexualizing their own bodies, but through practicing with one another, they could learn to desexualize the bodies of their fellow GTAs. Chapter Six deals more thoroughly with how GTAs learned how to (not) talk the/their bodies in order to (re)script the teaching space as nonsexual.

“I didn’t know what the training was”

Suzanne foregrounded a different aspect of performing the pelvic examination during the training sessions. She focused on the expectation of having an examination performed on her:

When I came into that training day, I didn’t know that we were actually gonna do a physical session. I guess I should know because we did it with the breast exams but you, a lot of the time, the first time you come in, you just watch and somebody is like coaching somebody as a model and you watch them do it, you don’t necessarily end up being a model. When we came in for that [breast screening module], I didn’t, I thought maybe we were gonna do something like that, maybe but I didn’t know what the training was, and then she wanted me to be on the table, the first day in training, and I had no idea. Like you’d want to know that, maybe you know, you’d even wanna, maybe trim or whatever, right but there was no heads up about that. There was only one other new person and she didn’t go on the table either. I couldn’t that day, but even if I could’ve I wouldn’t have been comfortable with that – it was just like all of a sudden you’re gonna be doing that... if I’m going to the doctor I know I’m going to do it but coming here I didn’t expect that.

The above excerpt from Suzanne demonstrates how knowing one is going to have an examination performed on them during the training session changed how one performed, and presented the body: “Like you’d want to know that, maybe you know, you’d even wanna, maybe trim or whatever, right but there was no heads up about that...”. The lack of a ‘heads up’ would not have allowed Suzanne to (ad)dress her body according to sanctioned social-cultural norms, unlike an appointment with her physician, occurring during a predetermined time. Therefore, the acceptable woman’s body was performative, even within a space where normative discourses were said to be challenged.

From the excerpts above, you can see a myriad of different responses to the initial training session – everything from trepidation of crossing normative gender boundaries, to the sense of being caught off guard with training expectations, precluding a GTA from

appropriately preparing her body to perform. For some participants, these initial training sessions adequately prepared them to participate as a GTA; however, newer GTAs who did not feel adequately prepared were concerned not only with what *they* could expect for themselves during the teaching sessions with students, but as Suzanne's comment reflect, they were also concerned that their lack of preparation could unknowingly cause harm to a fellow GTA:

Like, I don't like the thing where all things will just happen, and you learn as we go. Well, you're on the table, you're just always – well what's gonna happen? What's gonna be next? Like, how comfortable is that? I like to be part of it, and I want to be able to keep my models safe. If I'm coaching, how could I feel good about coaching if I don't know what's gonna happen? Like, you know, somebody's cervix getting snapped, there are ways to prevent that.

Suzanne learned that a model's cervix could be “snapped” after hearing my personal narrative of such an experience. The fact that she learned this by happenstance – through the randomness of my presence, was deeply concerning to Suzanne who felt like such information should have been shared during the initial training session.

“But I don't feel ready to teach it yet, not at all”

...through a variety of means, the most significant of which is modeling, new members of cultures begin to deliberately adopt mannerisms and attitudes, speech and behaviour that they perceive to be characteristic of established members of the culture (Donnelly & Young, 1988, p. 224)

Danger lies in transitional states, simply because transition is neither one state nor the next, it is undefinable. The person who must pass from one to another is himself in danger and emanates danger to others (Douglas, 1966, p.119)

The notion of *time* returned when considering the process(es) that new GTAs went through while acquiring the confidence needed to perform in their roles as model and/or facilitator. As a GTA, and during my subsequent time with research participants, the topic of training to become a GTA was a lingering, often

contentious issue. The concerns GTAs' identified with the training process varied among the participants, from feeling surprised by what was expected of them during the initial training session, to the briefness of the training and residual feelings of unpreparedness to begin working with actual medical students.

Generally speaking, newer GTAs had different impressions about the adequacy of the training program than the 'vets'. This could have been a reflection of how the program was delivered in the past, wherein newer GTAs had the opportunity to integrate their learning over a longer period of time – months rather than weeks. As a consequence of the longer duration of the pelvic teaching module in the past, the training program needed to provide less direct instruction to new GTAs. Learning would be consolidated during subsequent teaching sessions over time. However, given the revamped structure of the overall clinical method rounds, newer GTAs had much less time to integrate the teaching material and to refine their performances accordingly. GTAs reflected on how this change impacted on learning, and the integration of training materials:

Perhaps so, that's another issue. This organization is way beyond what any of us have control over. It's the whole access to facilities and scheduling and they do it in blocks now and I don't even know ... I don't care because I don't have control over it anyway. But I think from that perspective there was a long learning curve and you had a whole week to think about what had happened instead of a mere 24 hours before going in again. So some of that learning could have taken place over a longer period of time because of the gap. Now there's no gap at all (Caroline).

... also what you're saying about the over and over, [repeated examinations with students] like here we're allowed to be the model as long as we want to learn the pattern which is really good but that's the other thing is I don't just want to be the model, I like being the teacher a lot and I don't want to just be the piece of meat on the table. But I don't feel ready to teach it yet, not at all. So it is, like I have to be the model for a while (Suzanne).

I don't have a day to day full time job now so I'm already feeling like I'm probably going to have to take, once this is all done, a little time to reflect over it. But things are coming at me pretty quickly and I'm getting the information and am able to work through it. I don't know where I'd be if I did have a full time job that I have to keep shoving everything to the side on (Drew).

[We use to meet] over there and but really it was probably like one Wednesday morning a week for like 3 or 4 months, they went on forever. Whereas this is a really tight little package of 4 days a week for 4 weeks and boom it's over (Rosemary).

Furthermore, while there were anxieties in assuming both the role of facilitator and model, there were varied reasons as to why this was so. New GTAs most often found themselves repeatedly in the position of model, initially hesitant to take on the seemingly more difficult task of facilitating the teaching session. The facilitator role was viewed as the 'higher ranking' position of the two, indicative of competence. During my individual interview with Amanda, she shared the following:

The main anxiety for me at the beginning was that jump from being someone on the table to being a coach. It took a while for me to be comfortable with that as I think it does for a lot of people.

The following comment from a program administrator reified the notion that being 'the body' was the easier of the two roles, so needing more time to become comfortable in the role of facilitator was understandable, but to become the model it was expected that less time was needed:

So some GTAs, ones who we tend not to use, or we encourage them to think about maybe not continuing are the ones who think they need more training for modeling. More training before coaching, obviously that makes more sense. Some people aren't comfortable talking in front of a group or playing the instructor role and sometimes it's just a case of miscommunication about what the role of the coach is.

I asked Amanda to share further why it took more time to become comfortable with the role of facilitator:

Probably just performance anxiety about hoping that all of the information will get covered properly, that I would be able to convey it clearly to them and come off as professional even though I was not a medical professional in any way, shape or form So that was probably the main anxiety was hoping that I'd come across professionally and also be able to do it properly, cover all the information and make sure that also that the person on the table was being treated properly as well because I think we tend to feel some responsibility for each other when we're the coach and you've got someone else on the table. ...But for me being the model is so comfortable because it is my body - I am not responsible for somebody else's body.

In addition to feeling responsible for “someone else’s body”, Amanda’s goal was to appear ‘professional’ despite her lack of a formal medical background. As was the case with other GTAs, this was accomplished through the adoption of biomedical discourse, used interchangeably with ‘lay’ person language, regarding female anatomy and the medical instruments used during the examination. Learning the ‘right’ terminology to pull off the performance of a professional was often difficult for newer GTAs given the noted time constraints. To manage their ill-prepared feelings, as a strategy some GTAs relegated themselves strictly to the role of model for the better part of, if not the entire, four-week training module. This was Suzanne’s strategy:

So one training session can leave people with our personalities, type “A”, probably feeling a little like they’re at a loss, and that you are just kind of going in there to be a body. That’s why I decided myself these first two weeks to just be the model and to get a better handle on how everybody’s approach is, going into something that is this intimate in the first place one of my chief concerns was obviously same as the students, don’t be overly sexual and don’t crack too many jokes that are going to be perceived in an inappropriate manner, that sort of thing.

If a new GTA was not prepared to facilitate the session after the initial training, as was often the case, they would stay in the role of model until they felt they had acquired the needed knowledge, and could impart it confidently to the medical students. However, this

strategy was not optimal for every GTA. As the following quote exemplifies, this left some GTAs feeling as though they were merely “meat on the table”:

We had one training session like a few weeks ago but nothing before that, and then at the training session we watch the video that the students are going to see, and discussed it a little bit and then we break into groups. So, experienced people with non-experienced people and each playing the different roles, like you each do one of the roles and I couldn't be on the table at the time so I was a student. So somebody taught me and I ran through how the student would have to run through it. I found that a little difficult because at least the students when they come into it they've already had anatomy training and they know all that, whereas I had no preparation and I like to come in prepared and know my stuff. So I found that difficult and I had asked for it [training materials] before [the training] and couldn't get it. And then at the end of that day, like we had gotten a cheat sheet and there's, like when we do the breast exam, there's a cheat sheet. There's also, like the section of the book that the students learn from and we didn't get anything like that this year so asking for it and another one of the other GTAs had to give to and we got it copied ... So actually I found that a little frustrating, being a new person I didn't feel prepared and didn't feel like I was being given the tools to be prepared and like I'm more being a piece of meat on the table instead of being part of the teaching experience (Suzanne).

“It's easier to just lie down”

There was more understanding shown toward the GTA who was uncomfortable in the role of facilitator than the GTA who was uncomfortable in the role of model. The GTA who wanted to stay as a facilitator for the duration of the program could do so only if there was something “legitimately” wrong i.e., missing from her body, or had ‘served enough time’ over the years as the model. Being merely uncomfortable with being the body for the exam was not a legitimate reason to not perform the model role. Women, who did not perform the model role eventually, risked being asked to leave. However, if a woman would like to stay in the role of the model, and never assume the role of facilitator, this was not problematized nearly as much. Amanda shared some interesting thoughts that demonstrate how the ‘model’ body was being constructed – this notion that

to be the body was the easier of the two roles is reflected in Amanda's comment:

I had no problem ever going on the table in fact I used to prefer being on the table as I know some people do because it's a bit easier in terms of what your mind has to do because there's so much talking involved in coaching and if you're the least bit tired it's easier to just lie down and have a pelvic exam and give feedback.

However, 'just' being the body was not what was expected of the model, they also had to 'know' their own bodies, as this was often seen as an integral characteristic of the models' skill set (Underman, 2011) – a critical component of her currency that set her apart from 'other' women in the community: "Yeah, the fact that she could basically mark herself made that part of the exam really easy" (male medical student). However, learning to read one's own body to/with a level of literacy required for teaching a medical student to locate one's cervix and ovaries with such exacting proficiency, to acquire that level of familiarity with one's internal anatomy, was a process. As Drew explained:

... being a first timer it took a good solid week before I even had that in me to know, yeah ok you need to go at this angle [with the speculum], yeah I feel that you're going for the right spot now. So it's kind of kinesthetic for ourselves in the first place for the training. You can't really figure it out until you start.

So new GTAs were caught in a 'double bind' – they either stayed in the role of the model, or they performed the role of the facilitator regardless of how ill-prepared they felt. This sentiment of being "meat on the table" was exacerbated further when the facilitator assumed the primary role in the direct teaching of the medical students. While program administrators stated during training that only the facilitator was to directly instruct the medical students, so that students would not become overwhelmed by too many people giving instructions, some GTAs felt this approach silenced the model, relegating them into a passive role. Consider the following comment made by Caroline speaking in the 'voice' of a facilitator who assumed the dominant role during the teaching

session:

I'm teaching, and to the students, you are learning and you're showing [the model] rather than this is a shared experience in which information will be imparted. But, everybody is free to add something, "oh you forgot the ... and don't you mean? Just helpful asides sometimes.

These thoughts provide a transition into the following section where I discuss GTA roles further, specifically looking at the concept of role allegiance. I represent a teaching incident where the 'failure' to enact the 'standardized approach' produced a fracturing in the teaching relationship between the facilitator and the model.

Allegiance to y/our role

"The term "performance" highlights the idea that gynecological practice is constructed and open to multiple readings and interpretations. Far from static or given, gynecology is continuously negotiated by performers who are simultaneously agents actively making choices and subjects directed by institutional forces. Performance is neither "not real" nor implicitly staged" (Kapsalis, 1997, p.5).

Just as integral to the initial formal training session as conducting and having the examination conducted on oneself, was the importance of adopting the proper GTA 'script'. Each participant in the training session with students was to be clear about the role she was expected to play, how to play it, and the boundaries and expectations of those roles. As I described in the 'typical day', the two formal roles available to the GTAs in this program, were that of either the model or facilitator. Occasionally, a newer GTA might be in the role of an observer. These roles (re)positioned the GTAs in particular ways, with stringent guidelines of how they would perform their specific part according to the script. Ironically, each woman was also expected to infuse into the script her own personal 'touch', according to her own personal experiences with seeking gynecological care. The capacity of the GTA to perform as both a woman from 'the

community' *and* pseudo gynecologist, was fundamental to the believability of her 'knowledge'/performance.

However, as I rotated from room to room, there were considerable variations to the script. How these variations at times unfolded, and the residual impacts, is represented in the following interlude entitled "An (un)standardized approach". The material used to depict an (un)standardized approach was drawn from individual interview data, and then re-arranged so that each participant is commenting on the same teaching scenario from her respective position. I believe this staging allows the audience to feel the difficult emotions that each participant experienced during the examination, and in the telling of her story. The scene demonstrates the confusion that occurred as a consequence of deviations from a 'standardized' approach when an unprepared and new GTA (Suzanne) was paired with an experienced GTA (Amanda).

Interlude: An (un)standardized approach

Suzanne

So I've had two coaches who have taught everything, every session, and then all of a sudden I have another coach and I am halfway through, and they are saying *I* am going to teach the bimanual. And I was like 'well okay'. And that caught me off guard as well. But I found that actually suddenly empowering, because now I was in control. And I hadn't felt that control up to that point. I felt like the coach was in control and they were telling them - unless something hurt, and at that point I'm like 'Stop!', or 'watch the hair' or which ever. But I hadn't really felt like I was in control, until the part, which she said 'ok, you're going to teach'. And I was like 'hey, I have a say now', right?

So, I have seen differences between coaching styles where one wouldn't even explain the procedure at the beginning, and then the next two would before they even started things. So variations in how the exam is done is how I actually compiled what I was going to do when I eventually got in the role of facilitator. The final day of the module was my first day of coaching, okay. I came in with *no idea* what the day was going to hold for me, and was asked if I want to coach. And I was like 'I suppose', and off I went. I had no time to review notes, to go through anything, and I went with what I have learned over the last month. And my approach was the wrong approach.

Amanda

I had a big issue the last time I had a new coach on the last day of the module, with nobody else in the room and I jumped in all the time because she was missing big, big chunks, and actually when I jumped in she said 'I am going to do that later' and afterwards I said 'you know I really want that done before they start touching me'. And so, we have had some pretty big conflicts. And you know, she went to talk to Maria about it for a long time and Maria e-mailed me to make sure that I was okay. And basically, I am not. I am pretty easy-going, but I really felt at the beginning before the students came in she had said to me, 'you know you can stop me if I miss anything,' and I said 'oh, don't worry about that'. And then when I did stop her she sort of 'shed' me, and I felt like oh my God. Basically what happened was she didn't do any explanation of the external genitalia; she waited until their fingers were inserted to say what they were looking for. So, it just felt uncomfortable to have that happening. They didn't even know – she says just insert their finger and they are just 'and do what?' And I know they've seen a video, but I don't trust the video. I know that is good but I don't know how much they are paying attention, I don't know if they get stuck on a certain thing and then miss the next chunk. So I like explanation prior to – I mean Rosemary does a lot of explanation, and I have been with coaches that do very little and I am comfortable with both. But I need that, and it wasn't happening. I don't know, it was a very – the students were great, thank God. But, there was a very weird dynamic – I have never been in that scenario where I wasn't really allowed to say my piece. And with a brand new coach that has only been in the program for a couple of weeks, I felt so strongly about it that I was really upfront with her afterwards and I was like 'that was not okay with me'.

Suzanne

I mean, I had a speculum exam, and I had somebody who just went and touched me and didn't ask. And I had another person who did ask and go and touch. And I thought 'well you know, that was pretty intrusive for her just to go and do that without my consent'. And the reason it came up was because when I was coaching, I said to the student a couple of times how to spread the labia , etc. and when she didn't, I had a glove on, and I said 'you're going to do it like this'. And she [the model] was like 'are you wearing gloves'? So I made my patient feel uncomfortable which just floored me because this was what was done to me, and then the more I thought about it the more upset I got about it.

Amanda

I felt angry to be honest, that I wasn't being listened to by the coach. Yes, I think what you said about boundaries is interesting because that is kind of how I felt. It's like, okay, yeah, I'm here doing this, but you need to look out for me because I cannot see what is going on. And at one point the man's glove ripped and I was the one who noticed it, you know? I mean, that is fine and that can happen to anybody, to not notice that. But, that just made me feel like, okay, you're not paying attention, you are not paying attention. And that is fine too in some ways because you are processing – you are trying to think 'what I am going to say next?' as the coach, maybe. But, you know – I don't know. That is just a symbol I

guess of the whole experience – this ripped glove that nobody noticed but me. I don't know, I just –I mean she did keep checking in with me, “are you okay, are you okay?” But at that point I was like in my head, "no, no I am not actually. I would like to start again", or you know.... But I don't know – it is not that she is a bad person or not caring or anything. I just felt very out of control in that situation...

Suzanne

I struggled with this for about a week, seriously. It really bothered me. And it wasn't just the fact that it was done to me; it was that I had done it to somebody else. And that really bothered me.

“It’s the pot of gold at the end of the rainbow”: Situated understanding of the purpose(s) of the pelvic teaching program

As participants in this program, you are making a difference in the quality of health-care that women will be receiving from their doctors in years to come. The Department of Ob/Gyn respects your commitment and willingness to be a part of this very worthwhile project (Patient-Centered Clinical Methods – Clinical Associates’ Handbook for Gynaecology, 2010 edition).

GTAs’ expectations of their initial training session were often reflective of their various beliefs about the broader purposes of the pelvic teaching program, and therefore, how they should be equipped to achieve program goals. Generally speaking, all GTAs understood the purposes of the teaching program to primarily be teaching medical students the proper approach to a pelvic examination through an emphasis on language, positioning of the ‘patient’, and draping. However, beliefs about *how* this should be accomplished and *who* was responsible for what within the teaching space varied greatly between GTAs, thus revealing paradoxical purposes of the program. For example, Rosemary explained to me the differences between what the espoused purposes of the program were, compared to students’ goals for the session:

Ok. For us I don’t think visualizing the cervix is any big deal. It’s, you know, it’s there. But for the students because they talk among themselves and they’ll talk to last year’s class and it’s almost like, “oh you just haven’t lived until you’ve seen [a cervix]”... So if they don’t see it, you can explain it until the cows come home,

I mean Drew has a uterus that just tends to want to go away. It's retroverted, not a lot but it is, it's tucked back. You really have to go down deeply and get under it so that you can visualize. I've had a hell of a time and I look at the students and you just see the disappointment all over their faces because to them this is the Holy Grail. The pot of gold at the end of the rainbow; "I looked at it, I found it!" And they just feel in their own minds and I think this is an expectation coming into the room that that's what's going to happen, "boy they're going to help me and I'm going to be able to see it."

My own observations and interviews with medical students mirror Rosemary's sentiments. While students, GTAs and program administrators all reported that the primary purpose of the program was teaching a proper approach, when a student was unable to locate and visualize the cervix, their responses ranged from visible frustration and disappointment, to what appeared to be an enacted posture of indifference. For example, the student might repeatedly say 'it's okay, no problem' to the model while their body language would reflect otherwise – flushed cheeks, crossed arms, shrugging their shoulders toward their fellow student.

Was it possible then, that there were competing interests within the program, and if so, did this matter, and to whom and why? Could it be that teaching healthy boundaries, the appropriate use of language, and draping techniques fluctuated in importance, with feelings of accomplishment and success for both the GTAs and students, contingent on visualizing the cervix? If the emphasis was on both – both on locating and visualizing the cervix, *and* the proper approach could this dual foci of the program have been in tension with one another? If so, I wondered what the possible implications might have been for the GTAs.

If they saw themselves as merely a body for students to learn and practice their technique(s) upon, what of their own comfort, and what might they forgo in the process

of trying to assist a student to “succeed” in locating and visualizing the cervix? If the *proper approach* was foregrounded, would the examination look different, and would the enactment of boundaries from the GTA be more forthcoming? Would different types of conversations between the participants be possible? I raised these questions with GTAs and program administrators.

During my individual interview with Suzanne she shared with me her confusion regarding the primary focus of the program, and how the confusion personally impacted her:

Suzanne: I guess my thought of, until the last day of the program, was that we were educating the students on how to do a ‘Pap’ as well as the patient's well-being...

Jodi: Okay.

Suzanne: ... and things that they should be more concerned of, whereas on the last day it was made clear to me that the ‘Pap’ was not the objective. The pelvic exam was not the objective. It was actually treating the patient.

Jodi: Okay. And how did that change over ... why was that a significant shift for you?

Suzanne: Because I thought the whole process is for them to see the cervix so they can have that ‘awe’ factor, and not just the mental well-being [of the patient]. Can we stop for a second? I don't really want to...

I turned off the digital recorder. I gave Suzanne the opportunity to withdraw her consent for the individual interview, and reminded her that she did not need to share anything she did not feel comfortable sharing. We were in the classroom space that was used for the morning “gatherings”, so it was possible that she was concerned not only about what she shared with me “on the record”, but who might have been listening outside the room.

After a few moments, Suzanne decided to carry on with the interview:

Suzanne: So the objective I thought was for them to see the cervix, not realizing that they could have potentially already seen it before through their own [studies].

Jodi: Ok. And who informed you of that, the co-facilitator or the student?

Suzanne: Somebody who works here.

Jodi: Ok.

Suzanne: So, being that it was the last day and that I had the belief throughout the whole month that the process was for the pelvic exam and the student to be able to experience it on somebody who could respond to them. And that whole motion changed to more the feelings and the emotions of the patient and not the actual exam. It made the process a little bit... I don't want to say upsetting - over the past month. Because then I realized that there was things that had been done to me that probably shouldn't have been.

My assumptions coming in here was that it was about the examination and that they were to perform it in on a human being, and learning how to actually do it. I thought this was the first time that they had ever done a pelvic examination. I have heard rumours since then that it is not - I don't know.

I thought that the feelings of how the patient felt... like the wording, was the important part of it. So that if I were a rape victim, or somebody you had been abused, that I would have a feeling of more empowerment, okay? But I didn't realize that that was the main objective, right? Coming out of it though, I now know that it is the opposite of what I thought. And that finding the cervix isn't a big deal. And that is more making me feel comfortable in such a vulnerable position.

Suzanne's comments raised several critical questions about the primary purpose(s) of the program, and the impact on her of the perceived lack of clarity around the teaching goals/program objectives. According to Suzanne, her lack of clarity underpinned how she decided to perform within the teaching space. Believing that the space was focused on providing students with the opportunity to visualize the cervix with feedback from the "patient" produced a performance focusing on being a body for medical education. Once she learned through "rumours" that the purpose was to assist students with understanding the emotions and feelings of the

patient, she felt differently about her experiences as the 'body', and problematized "things that had been done to me that probably shouldn't have been".

There was also a sense from Suzanne that her cervix being the *first* cervix that the students would have seen was significant, and played into her feelings regarding the (un)necessity of herself and/or the program. The fact that some students had already visualized the cervix prior to the teaching module concerned Suzanne; especially when she had held the belief during the course of her employment as a GTA that the primary purpose of the program was to assist students to visualize the cervix. Perhaps the fact that they had already seen the cervix robbed Suzanne of the feeling that she was offering something unique and special to the student in return for her allowing them to utilize her body as a learning site. This transactional/reciprocal aspect of the teaching space was compromised as a consequence of a 'prior cervical viewing'. This sentiment has some striking similarities with the 'romantic' fixation with being 'someone's first sexually, and that somehow subsequent experiences are 'less than'. This interpretation would lend insight into earlier findings by Siwe et al., (2006) who concluded that the positive feedback GTAs got from the students promoted feelings of being valuable and significant, increasing their pride in being a woman and affirmed their femininity. The authors noted that the women could never have imagined the positive outcome of their participation. What does this say about women's relationships with their bodies, particularly female (re)productive bodies, with its/their value bound up with 'being novel'?

Suzanne continued to reflect on how, with the experience of becoming a mother, she lost a piece of herself. This ‘piece’, she inferred, might not have allowed the performances on her body to have happened in the manner that they had:

But I think as we get older, we almost lose that - I want to say that sensitivity. When you have had kids, you have been exposed, you have been prodded. Sadly, everybody has seen everything at that point you don't care anymore. You lose that little bit of yourself. And I think it would be great if I hadn't lost that little bit of myself, because I probably would have entered this with a different opinion.

Does that make sense? But because I had been poked and prodded with my first [child], everybody had seen everything. With my second, it was the same thing. I had breast-feeding problems, so everybody had seen that ... It was basically ‘oh, is just another person poking and prodding again’, right? But if I had realized at the beginning that it was more about ‘okay, it is not about the poking and prodding, it’s about how I feel and making me feel comfortable with the whole situation’. And if I hadn't had all of that, I would have had a different expectation, right?

Her comments offer a poignant example of the fluidity between who a GTA was “outside” of her role within the teaching program, and other subject positions she occupied – in this case, the position of “mother”. Suzanne made the connection that had she not had the prior experience of transition to mothering in the way that she had (“Sadly, everybody has seen everything at that point you don't care anymore”), then she would have entered the program without the experience of being “prodded” and therefore would have been less immune to what in hindsight she regarded as unnecessary intrusions. I was remiss to have not followed up with Suzanne on what exactly would have been the difference.

“There are a lot of different balls to juggle”: Program administrators negotiate competing priorities

There are variations in the ways in which pelvic teaching programs utilizing GTAs are coordinated and managed (Underman, 2011). Some programs are delivered on university campuses within medical schools with specific time blocks dedicated to various clinical skills modules. Other programs contract pelvic teaching to independently owned-and-operated community-based businesses, such as Oakland California's *Project Prepare*. Generally, when pelvic teaching occurs with the use of GTAs, they are delivered through medical schools overseen by program administrators/coordinators that are primarily responsible for recruiting and interviewing potential GTAs, handling any difficulties that arise with and/or for GTAs, distributing training materials, conducting training, and serving as a liaison between the educators and GTAs. The final approval of training materials and program delivery generally rests in the hands of the medical schools themselves (Underman, 2011). While program administrators' perspectives regarding the perceived effectiveness of various types of teaching methods is the most prevalent perspective in the literature on women's involvement as GTAs, there has been little attention paid to the *experience* of coordinating these programs, and how their performances (re)shape the culture of pelvic teaching.

From the data collected over the course of my research, program administrators were expected to ensure that the performances of GTAs adequately met the learning goals of medical students, while balancing the needs and concerns of the GTAs. Program coordinators had to "juggle" competing priorities at any given time, including times when they acted as a GTA due to an insufficient number of GTAs available to perform on any given day. Common grievances program administrators managed included challenges with the schedule, dealing with 'flagged' medical students, and GTAs' occasional

requests to de-brief. This first quote by Anna demonstrates that her first priority was to the medical students:

I have a couple different responsibilities. In the immediate moment my first responsibility is to protect the [GTA], who has given themselves over to the program. But really, other than in the moment, my first responsibility is to the students and to providing the best student experience. So set aside the SPs [GTAs], a SP [GTA] who isn't 100% comfortable and who is doing something against their better judgment or maybe not, that's not a great teaching experience for the students. That's not ideal. If there is somebody else out there who can do the job better, if there is another SP [GTA] that can pick up another shift, that's a better option. So my responsibility to the students is to not use that SP [GTA] anymore.

Generally speaking, program administrators had different understandings than some GTAs about what was needed to adequately prepare GTAs for their roles, and how much time was acceptable for a GTA to become comfortable with her role:

It's not that, it's not that we're limited in how much money we can spend on training but we definitely could not afford to have every new GTA shadow for two weeks before beginning to model. So our current, the current training model is a three hour training session in which they watch the video, the same video that the students watch, we talk about the common things that come up, so they learn from the previously experienced GTAs and then they trio up or a group gets put into four and they take turns, well one SP plays the coach, one GTA plays the model and one or two GTAs play the students and they run through what the teaching looks like. After that training if a GTA is still, they're not sure how ready they are to do it, we often have people observe once or twice and then we encourage people to model the first couple of times. We have some GTAs who kind of bow out of coaching for the entire first year that they participate and when they do coach for the first time we encourage them to trio up. We almost always have spares and so we can send in a trio of GTAs so that there is a more experienced coach with them. If somebody says they're not sure that they're comfortable modeling after seeing the video and going through the training session that sets off a little bit of alarm for me. I'm not sure that seeing it done one, two, five, ten more times is going to change that comfort level. I never want to force anybody to model but that's when we start asking people are you sure you want to do this, it's not a big deal if you don't, there are plenty of SPs who've come and tried and it's not for them we still will happily use you for other things....

Yet, while the quality of the medical students' learning experience was *the* priority, program administrators also felt a level of responsibility for the GTAs' well-being, and toward giving them a fair 'shot' at becoming a GTA:

I also have a responsibility to these SPs [GTAs] who I, well I don't think I have a responsibility to them, I feel a responsibility. I may not have it, but I feel a responsibility to when we tell SPs [GTAs] about this program and they express interest to give them a shot, right. So, and then not necessarily to fire somebody right off the bat if it's not going well. Give them opportunities to better and improve themselves, train them within the limitations of protecting the students and because the students aren't perfect either, protecting the SPs [GTAs] at the same time. So there are a lot of different balls to juggle there.

So, amidst all the priorities, and as a consequence of their own status as employees within the medical school teaching institution, program coordinators stated that their primary allegiance was to the medical students. The learning experience of the students was of upmost importance.

There is also a responsibility to the program and the dean's office, which funds the program, to maintain a professionalism...I think that I have those 3 responsibilities. Protecting the program, you know there are some issues of liability and that sort of thing, protecting the students and protecting the SPs [GTAs]. At any one given time, whichever is most important to me might change. But really, overall because I'm an employee of the university, hired, my first responsibility has to be to the students, coming in a very close second is the SPs [GTAs].

The aforementioned quote highlights the institutional framework that was simultaneously trying to create medical students that were better able to provide more comfortable and less anxiety-inducing pelvic exams through the use of GTAs and the feedback they offered, yet it also necessitated a context in which their primary allegiance went to the students, the program, and the medical institution. Program administrators had to learn to work within a hybrid space, where their multiple subject positions were at times, in

tension.

At the outset of this chapter, I stated that it was my intention to understand the nuances of the training process from the perspectives of GTAs, that I had wondered how assumptions about the purposes of the pelvic teaching program were, or were not, reflected within the training session(s) and training materials provided to the GTAs. Indeed my assumption was that the process of training becoming a GTA was not a static process, but a process replete with performing acts that were not only (un)familiar, but loaded with socio-cultural implications for women who had no prior experiences touching or being touched by other women, or practiced on by medical students. As GTAs confronted, perhaps for the first time during the training session, practices that challenged their own deeply embedded notions of normative gender performance, temporary feelings of disorientation occurred for new GTAs. In the following section, I discuss how students conceptualized the(ir) experience of preparing to conduct their first pelvic examination.

**“But there is a wide range of comfort levels. And that wasn't addressed ever”:
Medical students and pelvic teaching**

Broadly speaking, there were three categories of how medical students performed when it came to conducting their first pelvic examination with a GTA: (1) the ‘Jacques Cousteau’s’, these were the students that jumped into the task with unbridled enthusiasm and ready to embrace the challenge of navigating their own uncharted waters; and 2) the little lambs, medical students who were so nervous that their fear was palpable. They were like deer in headlights: avoiding eye contact, and barely squeaking their words out – personally, I preferred these types of students. I speculated that they had never seen women’s genitalia so explicitly – so intimately (at least in a non-pornographic medium), much less have had a conversation with a woman while looking at it and touching it. And then there were the in-betweeners who vacillated between a façade of confidence, and deep, almost paralyzing, uncertainty (Jodi, personal reflection, 2009).

“... disgraceful, disrespectful & misogynist”: When a student speaks the silences

It is arguable whether or not third year medical student Brent Thoma had any idea of the controversy that would ensue after his reflections on learning to conduct pelvic examinations were published in a 2009 journal article he wrote entitled, “The other end of the speculum”, which appeared in the *Canadian Family Physician (CFP)*:

I know women hate Pap smears. I wouldn't enjoy a complete stranger shoving foreign objects into my body either. But here's a little known fact: men, especially young men, hate performing them. I know the first thing that pops into a woman's mind as she spreads her legs is not going to be “I wonder if he's uncomfortable,” but please hear out the guy on the other side of the speculum—I detest this procedure more than you....So, you enter the room and note the inevitable inaudible groan from the hapless female. There are a number of variations on this groan, depending on the patient's age: The young teenager: “Aghh!! A boy!?!?!” followed by immediately looking at the ground. In the meantime, you thank God that she doesn't need a Pap smear. The old teenager: “Omigod. I, like, totally can't believe that this, like, totally random dude is going to see my vajayjay! I've got to text [best friend]. Wait ... he's kind of cute.” The 20- to 30-year-old woman: “AWKWARD.” The 30- to 45-year-old woman: “Ugh, a student ... and a male student! Just my luck, he probably hasn't even found a vagina yet.” The > 45-year-old woman: “Hahaha, oh, a young buck!” (Thoma, 2009, p.1112).

There was swift backlash by the general public and members of the medical community to this medical student from the University of Saskatchewan. The reaction to this piece, published as a “Reflection”, was outrage and disgust by the vast majority of email responses to the editors and online forum. The following was written by the editors of that edition:

Brent Thoma's Reflections article in the November issue of Canadian Family Physician, “The other side of the speculum,” has generated more expressions of outrage and more Rapid Responses [email comments posted online] and letters than any article published in the journal within memory (Pimlott & Ladouceur, 2010).

Comments directly attacked Thomas's lack of professionalism, and criticized the journal for publishing the article in the first place. Readers suggested that his comments would best be made in the company of his friends, and “not in a national journal read by

patients and physicians alike” (Fairfield, email comment Rapid Response, March 15, 2010). The stated mission of the CFP is to provide practitioners, researchers, educators and policy makers with current information in “the discipline of family medicine; to serve family physicians in all types of practice in every part of Canada ... to advance the continuing development of family medicine as a discipline; and to contribute to the ongoing improvement of patient care” (http://www.cfp.ca/misc/cfp_about.dtl). The journal has stood firmly behind their decision to publish the reflection piece. As the Scientific Editors of the journal stated in the subsequent edition of the CFP:

While we at Canadian Family Physician regret that Mr Thoma has been exposed to criticism and embarrassment by the publication of his article, as well as the expressions of anger toward the journal the article has engendered, we are grateful that he allowed it to be published, for his further reflections on the matter, and for the open and frank discussion that has taken place in these pages. That is one of the purposes of a medical journal (Pimlott & Ladouceur, 2010).

The negative reaction by the majority of respondents was telling – it would be easy to demonize Mr. Thoma, claim that he was a student on the ‘margins’, and his reflections unrepresentative of the larger student population. To the contrary, based on my interviews with medical students, I contend that Mr. Thoma articulated what many medical students were thinking and feeling as they grappled with the expectations associated with transitioning from “novice” to “professional”, and that his statements should not have resulted in personal scrutiny, but large scale examination of the normative discourses (in)forming, and setting the boundaries within... medical students performing within medical education.

Fundamental to the discourse of biomedical education, is a strict understanding about what the professional identity of a medical student must be, or must become –

which includes above all else, the subordination of one's own needs (Swick, 2000). Articulating their 'true', ambivalent, or outright disconcerting feelings around pelvic examination was a potentially risky disclosure for medical students. As the responses to Thoma (2010) suggested, such 'disagreeable' thoughts/expressions opened students up to deep scrutiny regarding their appropriateness for the practice of medicine. It was no wonder that Thoma's (2010) comments were received with such disdain, there was little recent research published about the feelings of medical students undergoing training with GTAs, with the majority of the existing research focused on students' evaluations of the effectiveness of the learning, rather than on their experiences of the process itself (Kleinman et al., 1996; Siwe et al., 2007). While some more 'palatable' fears continue to be documented in the research literature (e.g. hurting the patient, fear of being judged as inept), in the twenty-some years subsequent to Buckwald's (1979) article being published, students' perspectives on other aspects of learning how to perform a pelvic examination have not been well documented in the research literature (Hendrickx et al., 2006). This absence is notable given the implementation of pelvic teaching utilizing GTAs in all most all medical school across North America (Underman, 2011).

Guided by my own experiences with medical students, and the early literature that documented the ambivalent or disconcerting feelings of medical students conducting intimate examinations with women, (Buckwald, 1979; Siwe, Wijma, Silen, & Berterö, 2007) during the brief pre-interviews with medical students, I sought give additional breadth and depth to my understanding of these feelings, and to consider how students' comments during pre-interviews related to their performance within the exam space. In order to do so, I asked them questions regarding the formal and informal preparation

medical students underwent in order to conduct their first pelvic examination, their thoughts and feelings prior to the examination, their expectations of the teaching session after the session completed, their understandings of the role of the GTA, and possible gender(ed) differences they perceived in performing the exam on the GTA versus the male SPs used for teaching the digital rectal exam. I begin by discussing how students linked their capacity to conduct the exam and become a professional, with the ability to ‘separate’ off aspects of themselves. I examine briefly medical students’ perceptions of their preparations prior to the teaching session with GTAs, followed by students’ perceptions of the role of the GTA. I conclude with a discussion of how normative discourses regarding gender were enacted within the teaching space.

“I have the upmost confidence in my abilities”

Throughout my time with medical students, a very narrow definition of what it meant to be a ‘professional’ circulated. This definition centered on the capacity to see the female/GTAs, and practitioners’ body(ies) as segmented and compartmentalized – the discourse of professionalism reaching so far down as to construct what thoughts medical ‘professionals’ ought to have/not have. During a pre-interview with a male medical student, he made the following comment, which exemplified this strict enactment of professional identity:

I feel that like, although slightly anxious, I feel that I have the upmost confidence in my abilities, to be professional and separate the two things just because I’ve worked really hard to get to this point, and I’ve been able to separate my personal life and my role as a future [physician] in the past with previous examinations such as the breast exam.

Note that his professional identity was cleaved off from his personal life. He noted that although he was anxious, he possessed the confidence needed to separate “the

two things” – not that he had the confidence in the exam itself, but in his abilities to operate as a divided self.

“I’ve had a bunch and then I have done one, and watched a couple”: Medical students’ preparation for conducting pelvic examinations

To me, the way(s) that medical students were prepared, the types of instructions they received, the kind of support or “words of wisdom” they were provided with prior to conducting the exam impacted on how they positioned themselves, how they would conceptualize the purpose of the program, and how they would interact with the GTAs in the teaching space. Based on the amount of ‘resources’ directed toward pelvic teaching utilizing GTAs, and the emphasis within the biomedical literature on addressing low rates of pelvic examination, I assumed that medical students would have had the opportunity to prepare for the pelvic examination through a variety of teaching methods underpinned by an awareness of the social-cultural implications of conducting the examination, for both the practitioner and the patient. Consequently, I was intrigued and surprised to learn that students felt they had not had any formal preparation specific to conducting the examination. The following dialogue unfolded between two female medical student in response to the question “what was your preparation for today?”:

Female 1: Well, actually the university didn’t really let us know this was happening. It is not really on the schedule anywhere. We found out by word-of-mouth..... I mean, I’ve had a bunch and then I have done one and watched a couple and so – yeah.

Female 2: I think for most people, I don’t think they prepared necessarily for this. But they have ranges of experiences. Like for me, I have only seen one - but I have never performed [one] before. Yes that is just me though. It’s like there is a big disconnect because in class like [it’s] very scientific, very medical things and then we come here and we are expected to do these procedures but like - there is no preparation for people that ...

Female 1: It is also supposed to be sort of like - such a bad way to put it – but I

want to say like touchy-feely. And I don't mean it in terms of the exam, I mean like feelings oriented. We are supposed to be caring people, we are supposed to be considerate about other people's feelings and maybe get in touch with our own. But there is none of that going on around us. And there are people here who are comfortable and can make jokes and – for some people [they] are making jokes because they are uncomfortable. But there is a wide range of comfort levels. And that wasn't addressed ever. And in fact, I think I would really criticize the program for not adequately warning us. We could've walked in last week and half of the group was doing physicals and half of it wasn't. And I personally had no idea that I might be up for a physical, you know?

Female 2: No, I know people in my class that - they didn't even know that we are supposed to do one today ... like a ... like a genital exam. And like, they were really uncomfortable with it just because they weren't prepared like mentally you are not prepared for it and if you don't have that, like – if you are just not comfortable with it and you don't have the preparation, it is not a good experience.

Female 1: For us, I guess, we had heard that there is going to be a ... like this kind of exams. So we were ready for it but definitely the people that had to do it last week...

Jodi: Yes, the first week...

Female 1: Yes, and I just can't understand why the university would ever do that, and not let the people know that they are doing this. I mean medicine is full of surprises but when you're doing something like this for the first time, I don't think it should be a surprise – there was no literature provided –nothing, in terms of preparation.

Female 2: Yes, for sure. No one – but no one says anything when we are like thrown into the cardio exam or like a respiratory exam. People are like whatever. But last semester when we had to do the male genital exam, there was like - I thought there was tension in the room just because people aren't comfortable with it. They are not -I guess it is just like societal culture and pressure. These aren't things that people openly talk about. And so - and they are sensitive topics, so I mean there is definitely a difference for sure.

The above dialogue highlights several areas of concerns raised by the students: (1) finding out about the examination through word-of-mouth, (2) a disconnect between the “very scientific” class, and the procedure, (3) the expectation that the students demonstrate caring, yet caring was not being demonstrated toward the students’ needs,

(4) because of a lack of comfort, students resorted to making jokes, (5) the lack of adequate warning and preparation could leave people unprepared mentally, and (6) while medicine might be filled with surprises, learning to conduct a pelvic examination should not be one of them.

“Make sure you don’t say these words”: Medical students’ perceptions of the role of the GTA

Generally speaking, medical students viewed the role of the GTA as one of a skilled ‘escort’, ushering students seamlessly through the landmines of possible socially awkward events that could arise if they were left to their own devices. The GTA was positioned by the teaching program and through the pelvic education process, including training materials’ (video, handbook) rhetoric, as primarily responsible for transmitting technical information in such a manner so as to reduce student anxiety. Embedded within the very definition of a GTA was the assumption that she was capable of not only traversing various discursive fields, but also coaching medical students through the process of accomplishing such a performance themselves. Here again is the definition of a GTA as provided by the Association of Standardized Patients [ASPE] broken down, italicized and bolded to account for the various discourses and respective subject positions weaving throughout the definition:

***Gynecological Teaching Associates** are **women** who are specifically **trained** to **teach, assess, and provide feedback** to **learners** about **accurate pelvic, rectal, and/or breast examination techniques**. They also address ‘**the**’ **communication skills** needed to **provide a comfortable exam** in a **standardized manner**, **while using their bodies** as **teaching tools** in a **supportive, non-threatening environment** (Terminology Standards, ASPE)*

The terms and phrases used in this definition are telling – *trained, teach, assess, accurate, the communication skills needed to provide a comfortable exam, standardized*

manner, their bodies as teaching tools, supportive, non-threatening manner combined into one definition of the role of a GTA, predetermined their performance. The concept of ‘discursive field’ as developed by Foucault, attempts to account for the relationship between language, social institutions, subjectivity and power. The law, family, education, and medicine acting as regulatory institutions all contain a number of competing and contradictory discourses wherein power circulates to give meaning to social institutions and processes. They also ‘offer’ multiple modes of subjectivity (Weedon, 1987, p. 35).

The following response from a male medical student exemplified how various discourses came together to (re)construct the role of the GTA:

I expect that they’re, when we’re performing the exam, they’re to take away the anxiety, socially awkward part of the examination so that we can actually learn the physical skills without being completely nervous.

In a separate pre-interview with medical students, another male student shared a similar (re)construction of the role of the GTA:

The anxiety part, you know that we’re going to hurt someone, that we’re not talking to them right to put them at ease and all that kind of *socially awkward* aspect of it. In teaching, I think really the main role, because this exam is rather kind of benign, it’s not a particularly technical exam? I think the role is to, for us, is to reduce their anxiety in doing future exams.

In addition to reducing their anxiety, and relieving the medical students of the awkwardness of the exam, the students also entrusted the GTA to convey *the* “patient” perspective:

I think they get across more the patient perspective and cultural ahh, things that surround the exam. Uhh, when we have like a physician coming in, you know, it’s very, it’s very medical knowledge based where with the standardized patients they do more of the you know, make sure you don’t say these words, make sure you drape properly.

Throughout the teaching session, the GTAs’ experiences came to represent the

experiences of women generally in the broader community. GTAs speak from their own encounters with health care providers, but they also come to speak for “women” as a homogenous group. The wants and needs of women during a pelvic examination were supposedly demystified during the teaching session. And, while the *bodies* of women were marginally understood to have physical variations, even though little variation was permitted within the teaching module, what they needed from their health care provider during the exam itself could only be encapsulated by the opinions of the two (or three) GTAs present in the room that day.

After interviewing students and GTAs, and observing them in interaction together, I noted a tension between positioning this exam as one that is so essential to women’s health and potentially laden with socio-cultural meanings so as to warrant the pelvic teaching module, while at the same time, hearing from their preceptors that it was just like any other exam – not “rocket science” because the exam was being conducted on ‘just another organ system’:

Jodi: I am wondering if there has been any talk from your clinical instructors about how to be emotionally, mentally, psychologically prepared for either this experience, or actually doing the work?

Student 1: Not really.

Student 2: No. I can’t say that...even the DRA [digital rectal exam] we have, we are told the details but the technique and their suggestions on the things to...how to prevent awkward situation [to be] emotionally or psychologically ready, I don’t think there is anything we have had. There were very kind of distant about it, you know, it’s another procedure, it’s another exam. One of the body parts, just another organ system that you need to be aware of.

Student 1: Right, even I think words, you know, when you and I speak, I can say words like feel and I can say things like that without such worry I think. But within a certain environment where we, as a professional, are given [a] firewall population or a situation that is...that can make somebody uncomfortable and I think we need to have a different, I guess, plateau or mindset to rely on. It is a

little bit more strict but I believe it is strict for a reason and we are learning through these experiences that what is proper here may not be proper or may be proper or vice versa.

In this way, the pelvic exam teaching space was simultaneously normalized and problematized, making it difficult to locate opportunities for students to process such feelings of ambivalence, fear, revulsion, and/or pleasure. This is particularly difficult if the absence, or at least the absence of expression, of such feelings is equated with achieving professionalism. So similar to the recent literature on student experiences of pelvic examination with GTAs, within the teaching of medical students – the “body” had gone missing. Whereas students in the past shared anxieties around the first pelvic examination representing an initiation rite within medical education, with clear sexual undercurrents, fear from both male and female students of becoming sexually aroused, and fears of finding aspects of female genitalia unpleasant are no longer spoken about – well at least in formal spaces and only along normative lines (Buckwald, 1979). Considering the responses to the article by Mr. Thoma, and the information medical students shared with me, if there were to be any discussion around the “disagreeable” emotions that medical students might experience, they were to be expressed out of the public view – they have no place within biomedical education discourse.

Chapter Six builds on how GTAs and medical students learn to (re)form the practice(d) (disem)body by examining how carrying out the purpose of the pelvic teaching module involved bodies to be thought of or not thought of, spoken about or not about, in particular normative ways.

Chapter Six

(Per)forming the practice(d) body

Getting ready for (body) work

There was one GTA whom I will never forget; she made me very uncomfortable. She always biked quite a ways to get to the sessions. She had a strong body odor, pungent, bitter, and I remember thinking. "Damn ... I feel sorry for the students working with her!" Inside I was furious. I was angry with her because she didn't seem to be trying as hard as me to present the vagina as a friendly, welcoming place to visit. Stinky, vulgar smelling, prohibiting vaginas were surely talked about by students – 'that' smell. Worse, if I was paired with her, I'd be working extra hard. I'd be ignoring my own olfactory responses and urges to stand-back. To recoil.

I on the other hand, went to great lengths to get my vagina dressed for work. The mornings of our sessions I scrubbed and shampooed my vagina to get it as clean as I could, taking extra care if I went to the washroom - re-wash, particularly my rectum. I'd position myself on my back, spread my legs wide open in front of my floor-to- ceiling closet mirror. Straining my neck, I'd try to get a glimpse of what they would see inside me. And if any pubic hair seemed "out of line" I would shave or trim it off, which sucked because I would get so itchy. When ovulating, I'd add baby power to my underwear to absorb the increase in discharge and hope it wouldn't get all clumped in there. I never had sex the night before my vagina was booked to work. I didn't want anything about my vagina to be memorable – the subject of student gossip after the session was complete.

The above reflection represents the work of preparing my body to model as a GTA, and the privileged position of the student in being able to get a/the 'view' that was not available to me. Carrying out the purpose of the pelvic teaching module involved bodies to be thought of, or not thought of, in particular normative ways. Part of the work of the body was the work *on* the body. Broadly speaking, this chapter will consider what it meant to be a practice(d) body in pelvic teaching by representing these preparations and alterations to and on the body in order to perform in the teaching space. The preparatory activities of GTAs relates to invisible aspects of the work of being/becoming a GTA, shaping, reducing and (re)inscribing possibilities for interactions among participants within the teaching space. This chapter will begin with a critical analysis of the 'preparations' undertaken to transform into the role of the GTA. I will then discuss how language is (not) used in (re)scripting the bodies within pelvic teaching. I conclude this chapter with a discussion of how GTAs navigate the possible stigma related to their work, demonstrating how complicated the whole endeavor of pelvic teaching becomes given that GTAs receive monetary compensation for their (em)bodied performances.

“They are owed a clean body”: GTAs and the work of becoming ‘the body’

There is no gender identity behind the expressions of gender; that identity is performatively constituted by the very “expressions” that said to be its result (Butler, 1990, p. 34).

Part of the work of the GTA body, was the work *on* their body – before, during and after the teaching session(s). These work of 'being/becoming' the/a body of a GTA model are invisible in the research literature, an oversight that makes liminal the elements of the GTAs' work that is undertaken in order to assist with accomplishing the performance of the(ir) role. The preparation process utilized prior to enacting the role of

model seeped into very intimate aspects of the GTAs' lives. Participants shared with me aspects of their preparatory work that assisted with the emotional and physical dimensions of the model role – from avoiding heterosexual intercourse without a condom, shaving and bathing, to managing possible negative judgments from significant others in their lives. Consider the comment made by Susanne to the question: “Were there any preparations you made to your body the morning you were scheduled to work as a model?”

I think you'd just be calmer mentally if you're expecting it [modeling] and you have physically prepared, and like, physically preparing for example, is just trimming the hair short. Um, some people probably shaved it [pubic hair] off or whatever, but like everybody had it short because when they're doing the exams, like the speculum exam, or putting the fingers in, having too much hair, it drags in the tissue too and can make it painful and maybe if you go to the doctor, [*slight pause*] well you'll wash up maybe a little bit more just before you go sort of thing but you might not trim, it only happens [the exam] to you once, but here it's over and over and over again, and you would need to do that [trim].

The repeated speculum and finger insertions that took place in the teaching space, as opposed to the clinic space, meant that models took measures said to minimize the potential for physical discomfort by shaving or trimming their pubic hair. The repeated representation of the vagina hair as shaved and trimmed (re)produces normative ideas about the aesthetics of the vagina that are ‘imported’ from elsewhere. The female body within pelvic teaching is analogous to public consumption in pornography, in a different way than porn is, but at the same time the sanitized version of the body/vagina is the same. In both spaces, a disservice is done to women in trying to (re)present bodies as ‘all the same’ bodies. Rather than educating medical students on how to manage pubic hair during insertions, GTAs, in order to manage their own varied forms of discomfort, prepare, or eliminate, the hair in advance of the training session.

In the quote above, Suzanne noted that being informed ahead of time that you would be expected to model would allow you to prepare mentally and physically. However, given the challenges with scheduling around menstrual cycles, it was not always possible for GTAs to know ahead of time which role they would be expected to play. For some GTAs, this lack of predictability was an issue; particularly for newer GTAs who found themselves caught in the position of not being able to work if they were menstruating, but not yet fully prepared to assume the position of facilitator. Additional comments made by GTAs further exposed how normative discourses about the female body were embedded into the preparation process. During my individual interview with Rosemary, an older adult in the program, she shared the following comments regarding her own preparation process:

I shower, and I don't shower all the time. That doesn't make me a dirty person - I just have very dry skin. So when I'm going to do the pelvic exam I shower in the morning simply because I feel that they're owed a clean body. Otherwise probably I'd shower twice a week, and the rest of the time I would either have a bath before bed or I would get up in the morning and do a head to toe wash. But basically my skin's too dry, it just flakes off, and I just feel they are owed a clean body.

Such physical preparations were seen as part of their obligations to the students – they were “owed a clean body”. The notion that the body ought to be ‘clean’ for medical practice(s) and examination was thematic, “[I] make sure I've had a shower *[laughing]*, make sure I'm clean, make sure I shaved my legs, make sure I've got nice socks because I always wear socks” (Caroline).

As the preceding quotes illustrate, rituals are undertaken to prepare one physically, in order to be prepared emotionally, for participating as a GTA. These techniques involved transforming into an idealized image of femininity that includes being clean and shaven, healthy, and chaste, all of which are achieved through various grooming behaviors. Such disciplinary practices reflect the embodiment of ideas about the ideal body and the sanctioned processes of *becoming* that/the ideal female body (Heyes, 2006). Norms about what constituted a clean body are rooted within deeply entrenched racial and classist discourse, wherein the notion of ‘clean’ is positioned as the binary of ‘dirty, light to dark, black to white. This particular image of femininity was consistent across the pelvic teaching space. Trimmed (or shaved) female genitalia were the images portrayed in the teaching video that students and GTAs were shown as part of their orientation to the exam. In the textbook chapter provided to GTAs and medical students, the women’s external genitalia were also hairless or trimmed. Pubic hair was positioned as an obstacle to the exam; therefore it was either eliminated via shaving, waxing or trimming, or something to be ‘managed’ throughout the teaching scenario.

The common practice of showering or bathing, and shaving the legs and pubic hair was indicative of how larger discourses related to the female body were enacted within the program. Despite disrupting normative notions of ‘proper’ femininity on one hand, by participating as a GTA, GTAs also actively engaged in re-constructing ideas of how the female body should be displayed –a hairless ideal. Body hair in Western culture signifies sexual maturity in both men and women, the removal of which is not universal (Tiggermann & Lewis, 2004). However, women who refuted this cultural norm often face intense negative social reactions and judgments that men, within Western culture, do not

generally experience. Body hair on women has come to represent poor hygiene, and a sexual orientation toward lesbianism (Basow, 1991). While much has been written about female body modification to conform to aspects of the idealized female body propagated through Western culture (Bordo, 1993; Wolf, 1991), little empirical work has been conducted to explore the meaning of hair removal for women themselves and other women (Tiggermann & Lewis, 2004).

While I did not intend to elicit data related to attitudes regarding hair removal, that this norm was repeatedly cited as part of the preparation process for being a GTA model was intriguing to me for at least two reasons: (1) Because the women in the program present themselves as ‘women in the know’, confident with their bodies and committed to educating medical students about the variety of female bodies, yet conform to normative femininity in the production of the model role; and (2) By conforming to the hairless (or hair reduction) ideal, GTAs are (un)intentionally scripting the exam in such a way as to preclude students from the opportunity to practice on genitalia that have not been shaved, trimmed, or waxed bare. For some participants, preparations they made to model were also representative of preparations they made for ‘real’ pelvic examinations:

They’re not a pleasant exam. I’ve never woke up in the morning saying yippee I’m having a pelvic exam today, it’s just like agh. You know you have to have a bath and make sure you’re cleaned out properly and shave your legs and just get all the preparation and you know (Gloria).

Only one GTA problematized the shaving of the vagina, and this was in relation to the training video that actually utilized a model that had no visible pubic hair. Suzanne had the following to say in regards to preparing to model:

Suzanne: I would definitely wash, clean. I contemplated at first waxing, just because of the video. And I thought ‘you know what, no. This is not real. This is real life.’

Jodi: So what is in the video?

Suzanne: They show a completely bare – no hair down below. And I found that that wasn't very realistic of women today. Not everybody walks around shaving or waxing down there completely bare. So I found that very - kinda of silly. But I did, you know I clean myself up. I made sure that I wasn't in the middle of the period or something like that. So I did bathe, the day of.

No other GTAs troubled such preparations, not surprisingly, as the prescription of/for hair removal is “so socially normative in Western culture as to go unremarked” (Tiggemann & Lewis, 2004, p. 381). In my own narrative account of preparing for performing as the model, I can feel my angst and insecurity that the appearance of my vagina must be ‘unremarkable’ – that is, there would be nothing memorable, or discussion worthy. I attempted to accomplish such un-noteworthy attention by conforming to the hairless ideal. As maddening as it was for me to engage in the act of surveying my vagina, as I ‘knew’ from completing a degree in women’s studies that I was engaging in grooming rituals that reproduced particular notions of femininity, I did it anyway. The urge to conform and not be the subject of scrutiny was far more powerful than my willingness to uphold such noncompliance with the ideal. But I felt like a hypocrite.

In addition to (per)forming the hairless ideal, Gloria’s comments below demonstrated how the performance of normative femininity informed, and is informed by, the performance of ‘health’:

Probably not have sex the night before. Definitely shave my legs and you know ... *just try to look as healthy* [as possible], and mentally it’s definitely a heavy thing trying to not be - look nervous, or you know try to be calm and confident as much as you can, but some days are better than others ... as far as preparing yourself

just more the you know cosmetic stuff, you know, as far as the mental stuff the first, in preparation of the first person [medical student] doing it was probably the hardest, second [medical student] is the easiest you know because you're already ... you know you have a feel for it – your students at that point after the first one.

As Gloria's comments reflect, the gendered performance enacted by the GTAs extended to performing 'health' in particular ways, e.g. shaved legs. In addition to the performative aspect of health, the above quotes also depict how power was embedded in the mundane, ordinary, repeated actions of the daily practices of GTAs. Power existed through the disciplinary practices enacted to (pre)form the idealized GTA, (re)producing particular individuals, institutions and cultural arrangements. However, disciplining the body wasn't just about disciplinary practices on the material body, e.g., grooming behaviours, but also involved emotional discipline achieved through an active re-framing and repetition of their prescribed role. I find it interesting that Gloria also mentions that "...getting a feel for it – your students at that point ..." helps to make the second exam easier. This comment suggests an intersubjective relationship that forms between the medical students and the GTAs, something *unstandard* that could not be scripted nor rehearsed. It was a feeling in and of the body; embodied knowledge in the fullest sense.

While grooming practices alone could not guarantee a successful performance, they contributed to the overall possibilities of a positive experience for all participants. When I asked Caroline if she had any suggestions for a new GTA that had not been shared with her, she responded with the following:

Well the first time you do it [model] it's strange. As I'm sure everybody's first pelvic exam is strange. But it's embarrassing, it's strange, you're naked, you're legs are open, you don't know this person and this person is twelve [*laughs*]. It makes you nervous, it can physically hurt by, maybe they have had it [the exam] hurt, and that's why they're doing it. So if they're worried that they're going to get hurt that might be a whole other issue, depends how much pain but, excuse me

I've had a lot worse pain than that. No it's emotional, be calm, relaxed, for me it's humour. Just because the more tense you are the worse everything is going to be. The more likely it's going to hurt and the more nervous you will make the doctor and possibly even the coach and again as a teacher you learn that even if you are nervous you need to appear not nervous and as an actor you got to go out on stage no matter how you feel. One of my colleagues threw up before every single performance of his entire career. You need to be able to do it anyway that's probably something I would say is that you need to do it anyway.

Caroline's comments drew attention to the vulnerability of the exam. She noted that "it's embarrassing, you're naked, you're legs are open, you don't know this person and this person is twelve [laughs]..." yet in spite of these exam elements, your obligation as a GTA ultimately was to perform – to not appear nervous, and to get on "stage no matter how you feel".

The scripted nature of the teaching space, particularly how to (not) talk the body", assisted the GTAs in accomplishing this performance. As Suzanne's earlier comments reflected, other aspects of her 'self' assisted in preparing for her role as a GTA; specifically in the role of the model. Her position as a(n) (overexposed) mother assisted her in acclimatizing to the experience of being naked in the presence of strangers. In fact, a core ability of GTAs was to draw on these 'outside' resources, experiences, and 'selves' to enact aspects of their performance. GTAs capitalized on these other subject positions as resources in the (re)production of pelvic teaching, demonstrating the blurry and elusive boundary between the 'outside' and the 'inside' pelvic teaching culture. When asked to further explain an observation that Caroline herself had made, namely that many of the GTAs had previously been employed as school teachers and/or professional actors, this was our conversation:

Caroline: It attracts teachers because it's teaching and teachers like to teach ... Actors like to perform roles, like to show off, like to pretend to be someone else and teachers also like those things. If you go to any community theatre and you

happen to know who's backstage, who's on the crew and definitely who's on the stage I can tell you high school teacher, drama teacher, elementary school teacher, retired teacher, it's just a personality that likes, I don't want to say show off that's a bit not the right word, but a personality not afraid to express in front of others.

Jodi: That was going to be my next question, tagging off of what you just said is, can teachers be considered a type of performer?

Caroline: Of course. You spend every day in front of people who are an audience and you're on all the time and it's one of stresses of the job is that you have to be on all the time it doesn't matter if you've got a headache or your mother died a week ago, you've got to be on and you have to perform. So there has to be a little bit of a disconnect between your personal life and the performance. But there also has to be information from your personal life that informs your performance and kids know, even kindergarten kids know if you're not being real.

The above quote demonstrates, literally, how performing as a GTA was an act that utilized both the discourses of biomedicine to gain legitimacy while at the same time using 'personally' grounded epistemology to give legitimacy for the place from 'where they speak/spoke'. The GTAs, as 'non-experts', utilized these discourses in such a way as to legitimate their teaching position(s), which in turn (re)legitimated these very discourses. This 'professional speak' was intertwined with 'lay language' to such an extent that the experienced GTAs were able to seamlessly deliver their performances. For example, they would use medical terminology for female anatomy (labia rather than 'lay' language, lips) and then in the next utterance used a term like 'smoogy'.

“Okay, so just repeat after me”: How to (not) talk the body

We do not just use language; language uses us ... As a result, what we speak always means more than we mean to say: language that we use carries with it implications, connotations, and consequences that we can only partially intend (Burbules, 2000, p. 262).

I confess, however, that I am not a very good materialist. Every time I try to write about the body, the writing ends up being about language (Butler, 2004b, p. 198).

Achieving the goals and purpose of the pelvic teaching module involved bodies being thought of (and not thought of), spoken about (and not spoke about), in particular normative ways. Within this learning space the body was perpetually made problematic, not only the literal material body (what one ought to do, or not do with "the body", or how one should relate to the body of others, determining whose bodies were 'employable'), but also how one 'spoke' (to/of) the body. Consequently, how to appropriately speak the body (un)intentionally became the central focus of the program. According to Butler, gender arises,

...at the intersection of two elements: a non-discursive element, consisting of practices of corporeal behaviour, gesture, and ritual; and a discursive element, consisting of linguistically articulated norms concerning the meaning of those bodily activities. Gender exists insofar as corporeal activity is structured and performed in accordance with normative ideas concerning its meaning, purpose, and proper direction. As Butler stresses, corporeal activity has long been regulated by the particular constellation of norms that she terms the 'heterosexual matrix' (or, more recently, 'heterosexual hegemony'), according to which bodily behaviour should fall into inversely symmetrical masculine and feminine forms, and sexual behaviour should be heterosexual (Stone, 2005).

It was as though it were a simple process – if medical students could *just* learn to (re)speak the body within the teaching space; the body itself could be (re)made. A body that is both present and absent, or both present and absent simultaneously depending upon the stage of the examination. The following conversation took place between Rosemary, in the role of facilitator, and the students at the outset of a teaching session:

Now you will notice one of the things they emphasized in the video was the use of language. This is a drape, not a sheet. This is an examining table, not a bed. And we try to exclude the use of the word 'feel' in terms of ourselves. I am not going to feel Drew - I am going to assess her, check her, envision, palpate, examine. Just because "feel" is one of those words that can be deemed rather sexual in [this] context. We also use what we term the non-business side of the hand as opposed to the palms.

The emphasis on ‘proper’ language – that was, language that purportedly de-sexualized/neutralized the learning environment/clinic space was central to the dialogue between the medical students and Rosemary. The following table provides additional examples of what terms were improper, what the proper term was, and what the “problem” was in utilizing the ‘improper’ term.

Table 3: How to (not) talk the body

Improper term/phrase	Proper term/phrase	What the problem is
Bed	Table	Sexual connotation
Sheet	Drape	Sexual connotation
Spread your legs	Bring your knees to the back of my hand	Sexual connotation
Looks normal	Looks okay	Won't know anything until results get back
Feel	Find	The patient feels, the doctor finds ... “you might feel”
Pinch	Pressure	Pain connotation
Personal side of hand	Professional Side of hand	Sexual connotation
Enter	Insert	Sexual connotation

Positioning

To demonstrate how (not) to talk the body was accomplished, I have included a section of dialogue between a facilitator and a medical student conducting the exam to represent the extent to which the teaching scene was performed in an attempt to render the body literally and figuratively ‘knowable’ in particular non-sexual ways. Every gesture, every utterance was scripted to ensure the model’s body remained stable as an "object" of investigation, examination and diagnosis. The following teaching scenario re-enacts the act of ‘properly positioning’ the model/patient for the first part of the pelvic examination, which is the examination of the external genitalia. The scene begins with the

model lying on her back, feet outstretched toward the student standing at the foot of the table:

Rosemary: We're going to ask her to just...

Corey: So can you please open your...

Rosemary: Could you just move your legs to...

Corey: Can you move your legs until they touch the back of my hand?

Rosemary: Ok, and just keep her posted as you are going and you'll be fine.

Corey: Ok, so I am going to hand you this sheet so drop it down if you feel uncomfortable.

Rosemary: Just a reminder... *drape*...not sheet

Corey: Oh, sorry...

Rosemary: You can definitely sit. It keeps you more stable and it still keeps you able to have eye contact with your patient.

Corey: So I am just observing for anything that is odd and everything looks healthy. And then, so I start at the top with like, what you said?

Rosemary: You are now going to separate.

Corey: So I'm just going to separate the labia majora and examine, so everything looks normal.

Rosemary: Never tell anybody it looks normal, but everything looks ok.

Corey: Everything looks ok.

Rosemary: Because normal is a very, *one of those words*, if you find something afterwards, they suddenly go but you told me it was normal. Its just one of those, it can be awkward. Now you're just going to insert and you tell her...

As *Positioning* demonstrates, bodies are moved deliberately in this space. Naming and positioning of the bodies choreographs a performance that sets boundaries while simultaneously (re)inscribing norms (Bulter, 1993). When time permitted, some GTAs goaded male students to get on the table and put their legs up in the stirrups – to be positioned as the woman/patient. As Suzanne commented:

I saw one coach who has the males, gives them the opportunity to get positioned on the table so they know what it feels like for the woman, um, how vulnerable and exposed they are in that position, and um, all of them except for one, that last guy that was in our group, cuz there's like five women, everybody else actually kinda pretty eagerly tried it out just to see what it was like and the feedback was that they were actually surprised how uncomfortable or awkward it was, so for us to demonstrate how the patient feels.

While this appeared to be an 'effective' way to encourage empathy, evoking looks of horror on the faces of the male students once they were in the supine position, this was not a routine practice, nor was it suggested to the female medical students – perpetuating the belief that female physicians necessarily offer better care to women than men, and/or already 'know' what it's like to be on their backs for a pelvic examination, or otherwise. These assumptions, beliefs and practices, were taught without appropriate consideration for other possible factors, other than, or in interactions with gender that impact on women's experiences of the pelvic exam. For example, various cultural experiences, beliefs and practices, such as the act of demonstrating respect and attention by *avoiding* eye-contact (Ivey & Ivey, 1999). It is conceivable that topics such as these are addressed at other times within the medical teaching curriculum related to women's health, but I cannot imagine a more appropriate space in which such conversations s/could occur.

Additionally, the various "objects" (e.g. table, drape) in the teaching space were both causes and consequences of this normative performance – that is, by requiring the "object" to be spoken about in terms that did not disrupt the 'body'/object, *all* the pelvic examination participants were (re)made. Through language, the sheet rematerialized as the drape; the bed was transformed into a table. Endeavoring to strip the physical objects utilized in the conducting of pelvic examination of their sexual coding through the act of re-naming 'objects', was a central mechanism by which the body was (re)scripted to

fulfill the primary purpose of offering a site for medical education.

Positioning exemplifies how “... the social body constrains the way the physical body is perceived. The physical body, always modified by the social categories through which it is known, sustains a particular view of society” (Douglas, 1970). However, not only was the model’s body (re)positioned through this scripted performance, so too was the body of the student/practitioner and facilitator. For example, the backs-sides of a student/practitioner’s hands were called the ‘business’ side of the hands, with the palms of the hand representative of the ‘bedroom sides’ of the hand. Touching any part of the model’s/patient’s skin that was not medically warranted was cause for concern, and students were reminded to “make sure the drape always comes between your skin and the skin of the patient”. The (dis)embodied practitioner emerged under the constant surveillance of the facilitator, with the eyes (and ears) of the model and their fellow student witnessing the act of (re)configuring the body through ‘language games’:

It is useful to make the following three observations about language games. The first is that their rules do not carry within themselves their own legitimation, but are the object of a contract, explicit or not, between players (which is not to say that the players invent the rules). The second is that if there are no rules, there is no game, that even an infinitesimal modification of one rule alters the nature of the game, that a “move” or utterance that does not satisfy the rules does not belong to the game they define. The third remark is suggested by what has just been said: every utterance should be thought of as a “move” in a game (Lyotard, 1984, p. 9-10).

Paradoxically, other elements of the exam seemed to enhance the sexuality of the teaching space, within the pelvic examination, for instance, the recommendation to routinely lower the drape between the patient’s knees so that the woman could make eye contact with the student/health care provider. Additionally, within the teaching space, there was a spectatorship element to the act of ‘watching’ the exam either being

performed by your classmate on a GTA, watching yourself being performed on, or orchestrating the movements of others acting on the model's body. The medical gaze circulated between making eye contact with the woman, and peering at/into the woman's vagina.

The “gold standard”

A discourse organized around notions of the ‘normal’ thus has the effect (and is designed to have the effect) of devaluing all phenomena that fall outside or differ from the norm, designating them as modes of being in need of correction. Normality and the normal, therefore, are concepts that represent for the purposes of intervention. The idea of normal is intimately bound with that of a normative intention, a plan and an experience of normalization (Fraser & Greco, 2005, p. 17).

How, then, can one think through the matter of bodies as a kind of materialization governed by regulatory norms in order to ascertain the workings of a heterosexual hegemony in the formation of what qualifies as a viable body? (Butler, 1993, p. 16).

In order to produce the ‘docile body’ (Foucault, 1995) required for student learning, attention needed to be paid to even the smallest details of women's bodies – they must conform in shape and ornamentation (Heyes, 2006). When asked about the ‘types’ of bodies required in order to be eligible to be a GTA, one participant stated, “You have to have your parts”. The GTAs engaged in the transmission of particular types of understanding about the ‘healthy’ and ‘normal’ woman's body. There were references to what women's bodies ‘normally’ look like, and often times they referred to their own body, and their knowledge of their bodies as the ‘gold standard’ –they knew where their various anatomical parts were located, and all those ‘normal parts’ were (usually) present. Their bodies therefore, stood in stark contrast to how women and their bodies were referred to in the community.

The ‘gold standard’ was the phrase used in the program to refer to both the way the examination was conducted by the GTAs in the teaching module, and to the women whose bodies were used as models. The gold standard in the program was a woman who was knowledgeable about her body, and had a complete (or quasi complete) set of ‘parts’. Unlike the GTAs, women in the community were positioned as the inverse – in terms of what they did (not) know about their own bodies, and the indeterminate status of their body. Consider the messages embedded within Rosemary’s advice to students:

I said the thing about this particular exam is practice, practice, practice and I said when you do your rotation and you’ll be doing pelvic exams on many different kinds of women, I said, “we’re the gold standard because we have healthy internal organs”. And it’s one thing that we keep coming back to but I think one of the things I say using myself as their model for this is always remember everybody’s body is a little bit different and again with practice and doing this exam over again. Because that’s another question they’ll ask; but how will I know if I don’t find it the first time? I said “Because you will learn with our bodies as the gold standard, the well body”.

The menstruating body was disqualified from modeling and that was problematic for new GTAs relegated to the role of model:

But then when it’s with your period, like, they don’t, like I have an idea of when it is, I could have told them like last week, I did mention, but they didn’t worry about it – that the last week of the program I wouldn’t be able to be on the table, just like when we had the training four weeks before that, I couldn’t either. But so then the last week I ended up losing a day of work because they had too many models. But why not ask the people and schedule it a little bit better, if some people know, right? (Suzanne)

I know sometimes just because of the way our periods happen that they’re, everybody’s having their period at the same time, it gets a bit tricky sometimes to have enough people who can model. I’m taken right out of the pot immediately due to the fact that if the idea is to insert a speculum, visualize the cervix, I don’t have one to see anymore. So that precludes me from half of the job (Caroline).

GTAs were excluded from participating as ‘the body’ if it diverted from the ‘norm’. That is, if it was missing both ovaries, one ovary is acceptable; however a uterus and cervix

were required even though the emphasis was on the proper approach to conducting the pelvic examination.

‘Other’ women

Women within the broader community were talked about in terms of lacking information about their body and in need of constant education about the importance of the exam. Women in the program often spoke of being motivated to participate in the program as a service to all women – that if they could assist medical students in the(ir) learning of the ‘proper approach’ then women would continue to seek regular pelvic examinations. Their bodies operated as the testing ground, a ‘first’ body for mistakes to be made upon in service to all women. Consequently, supporting the education of medical students manifested not only a personal responsibility, but also a moral obligation for

GTA:

Well I just feel like if they are making mistakes in the exam or stumbling around or saying weird things that I want it to be with me, you know, and not somebody who’s never going to come back because of it. That is where I see the importance of this is that if it is - if a woman's first experience is bad or uncomfortable or you know -then they likely won't come yearly. But if it is good and confident and the doctor is saying appropriate things and – then they will come back. So, I would rather than make mistakes or fumbles with me because I expect it, you know what I mean? (Amanda)

Othering relies on a binary that divides a population into ‘us’ (who belong) and ‘them’ (who do not belong). Othering is an exclusionary practice, working to create ‘power over’ relationships that (re)produce hierarchies of superiority and inferiority amongst groups of human beings. For example the categories: men and women, white and black, able-bodied and disabled people, heterosexual and gay, as well as modes of ‘being’ and ‘doing, order/disorder, pure/impure, clean/dirty (Garner, 2007). Othering presumes the dominant (superior) group is the ‘norm’ that sets the standards whereby

other groups are judged and to which they must conform. Othering is based on the notion that in fact, differences are inherently ‘real’. In the case of the pelvic teaching, *othering* is accomplished through differentiation from the ‘other’ generic women that reside in ‘the community’ (Douglas, 1966; Garner, 2007). Women in the community were understood as lacking sufficient knowledge about the importance of routine examination, their bodies, or skills to ask physicians what they needed in order to make the exam tolerable. GTAs prided themselves on having such ‘knowledge’ about their bodies that other women do not have, allowing them to assume the position of a/the primary person *in the know* in the teaching space:

I’m going to [instruct the students] because I know exactly where mine is located, the insertion is much more than a 45 degrees they tell you in the video and it’s off to their right, my left, and make sure that the angle of insertion is steep. And I can tell them the minute they get of the bills in whether it’s steep enough or not and I tell them that. Most women haven’t got a clue, don’t want to know, and are not going to direct you – they’re not going to talk (Rosemary).

Consider how the following dialogue between a facilitator and a medical student during a teaching session positions the behaviour of women in pelvic examination along normative lines:

Facilitator: It is always nice to offer a mirror [to your patient]. Do they say that in the ...

Model: They don’t say that in the video.

Model: Yeah, I read that in the notes but I’ve never been offered and I think I’d look at the person strangely if they did offer.

Facilitator: No...

Student: A mirror for...?

Facilitator: Um, just offering if they want to use a mirror to...

Student: Watch what is going?

Facilitator: To watch what is going on. It really shows a sign of openness on your part that you are not doing anything that you shouldn't if you are willing to let them see. It is always an opportunity for education if, you know, if you gage it and the woman seems interested in that.

Model: I wonder how often that happens.

Student: Do most clinics have that?

Facilitator: No. I've never seen one.

Model: And I think they would be more willing to with a male than with a female practitioner. Like with a male, I think it is a dynamic.

Facilitator: Yeah, for sure. But it is nice to offer, it does show that you...

Student: It sounds like something that somebody might prefer but...

Facilitator: I think most of the women would turn it down but they might think it nice that you offer. And then you might get the odd woman that's, especially if you've, like if she's a regular patient or something maybe she likes to know more about her anatomy. I like to think that every woman would like to know more about their anatomy but I live in a dream world so...

Model: Unless they're more analytical minded person in the first place and they're just, think it's interesting, hey tell me what you're doing.

Students also participated in the *othering* process:

Medical student: Yeah, I think that it is a very private nature when you are working with someone's genital areas and I think that's why the standardized patient is a good approach because it is a real live approach and you are working with a real person and they can give you great feedback but you don't kind of have the combination of your nervousness for the first time and maybe if you are doing it on a real patient, their nervousness so I think for me that makes me feel better about the situation because you know that they are there to help you and they are not going to judge you. They are going to tell you what you are doing right and what you are doing wrong so it kind of makes the anxiety level decrease.

Even when a GTA had a body with all the 'right bits', there were some bodies that were more productive than others. When a GTAs body failed to produce 'the goods' and a student was unable to visualize the cervix, reassurances were always offered;

unfortunately, there were times when the model's body was problematized in the process. For instance, prior to becoming a GTA, Drew was informed by her physician that she had a retroverted uterus. When a student could not visualize her cervix, Drew apologized for, and problematized her own anatomy. The student's lack of skill was not foregrounded as a cause of this 'failure to view' with Drew – only her anatomy. After all, the GTAs' responsibility was to learn,

...how to deal with the occasional hostile or overly sexual medical student customer. She is there to make the student's trip through the female body comfortable, safe, and enjoyable. But it is her own body, not the metal tray ... that she is presenting to the student [paying customer]. In this sense, the GTA is like Marx's factory labourer who uses his own body. She is getting paid for her body's use-value in the production of a trained medical student (Kapsalis, 1997, p.77).

During a focus group session, Drew shared feeling guilty that medical students could not routinely locate her cervix. In attempting to convey the cadence of her voice and the emotion she was expressing at the time she shared her reflections with the focus group, I took her comments and re-fashioned them into the following poem entitled "*I'm sorry. I'm Broken*".

I'm Broken".

"I'm sorry. I'm broken"

We're already in an interesting position
we're not teachers,
we're not supposed to have this sort of background
- that the doctors do.

They're not up on tables.
But we do have to be able to facilitate
- kinesthetic learning.

A little pang of guilt
just because my uterus is
retroverted.
Often.
And sits off in a different position

So the fact that they couldn't find the os made me feel kinda bad the first day –

“I'm sorry – I'm broken – It's ok”.

...a sense of female shame is related to the extent to which they have internalised standards of bodily acceptability' (Bartky, 1988, p. 68).

The feeling of having 'only' her body to offer, possessing neither the expertise of a physician nor the skill set of a teacher, haunts Drew's (re)presentation. Her 'obligation' to offer kinesthetic learning became equated with offering a 'view'. But the exam is more than meets the eye/"I' – is it not? And herein the confusion rests, tensions emerge and the contradiction, paradoxes and juxtapositions within materialize to produce a destabilized vision of the 'culture' of pelvic teaching. A paradox emerges wherein performing as a GTA holds the possibility, if all goes according to the 'script', of experiencing a “stronger and clearer perception” of self. Yet the means of attaining such feelings may just as likely result in producing feelings of inadequacy and failure – an 'unknowing-ness'. Moreover, as my following field note dated February 25, 2010 demonstrates, while taken up as fixed and unchanging, the body's fluidity and 'aliveness' meant that a particular 'view' could never guaranteed:

It was interesting though that Amanda, when asked where the location of her cervix was, Amanda was able to say 'oh, I'm textbook'. And then when the first speculum insertion went through, they couldn't find the cervix because the cervix was a bit tilted down.

Chapter Seven examines another contradiction (not so) apparent in pelvic teaching. That is, for all the emphasis on language, what to say and not say, in the spaces between, the silence(s) are speaking – they are *telling*.

Chapter Seven
(Silent) space(s)

first love: A reflection

you said i was beautiful
so special
no one could know

"they wouldn't understand"
you whispered,
how someone like you could
love the likes of me

tangerine tits
school-girl kilt
knee socks and dimples
- you couldn't resist

didn't last long-
this "let's just pretend"
bent over, impaled
this school girl became

a body for use/abuse
soiled-
with secrets inside
of shattered dreams
of being special

- Jodi Hall

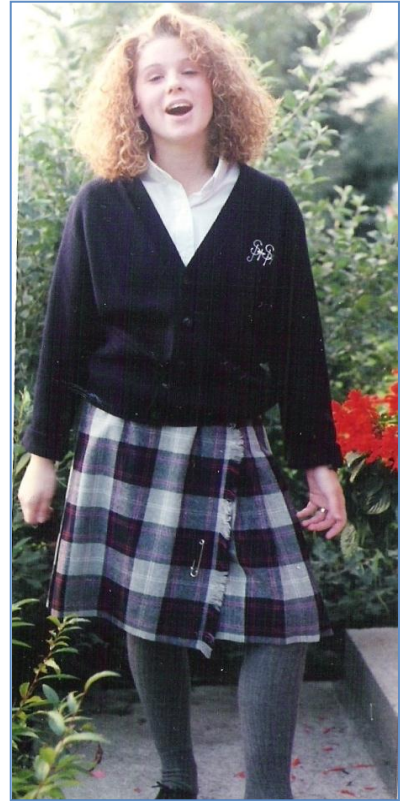


Figure 7: My first day of high school

My 'self' is stolen

My partner was my perpetrator. Wait – let me re-phrase that ... a predator became my partner, became my perpetrator. I was 13 – it was the summer before high school. I feel 'in love' for the first time with a lead actor in a local musical production. I was a dancer in this musical, rehearsing 12 hours a week for three months with the cast. All summer I longed for him to notice me amongst the groupies who circled around him. I'd giggle at his jokes, and linger after rehearsal just to get a last glimpse of him before my ride home would arrive. But who was I? Just a silly girl barely outta grade eight. Untamed, frizzy blond hair that framed cheeks that blushed cherry red at the mere sight of him. I'd lose breath and sensibilities when he looked my way. I was enamoured, infatuated with him – and then he spoke to me...

HE SPOKE TO
ME.

Friday of the long weekend – September 1987. We were post- production and the summer events were winding down. I was babysitting for a neighbour and he asked to stop by. Having never had a male ask to see me, I was speechless, my mouth dried up and I felt like crying I was so nervous. Excited. I described the house I was going to be at, hoping so hard that he would indeed visit me. Oh my god, what will I wear? What will I say? He arrived sometime after 7:00 pm – I remember because the baby was sleeping. Once inside, he fumbled with the LP records of his favourite band –

Genesis. I think he looks nervous too. As the soft sounds of the music enveloped me, my heart beat harder and harder. Was this really happening? Was he really here with me? There are few memories of that evening ... sitting on the stairs that joined the main floor to the bedrooms, him caressing my bare legs. I'm not sure how we ended up in the backyard, but my next memory is of his lips moving over mine. Sweetly. Gently. I was shaking so hard my lips were quivering, and I had to work hard not to chatter my teeth, or bite his tongue as it darted in and out of my mouth. As I recount this memory I can still feel the goose bumps on my arms and the heavy warmth in my chest I experienced at that time. This was my first real kiss. I felt a little unsure of myself – was I doing this right? My friends are gonna be so jealous! I knew something deeply wrong was happening. I'm not sure how I knew, but I did. Maybe it was the timing – why NOW? 'Cuz no one could see us? What would my parents say? What if the parents get home and find us here? I could already feel that I had no power, no voice. He would ask, and I would follow. He would insist, and I would comply. He would take, and I would apologize.

He was 20. I was 13. Four years of this 'relationship' left me bulimic for 15 years, with two hospitalizations, 6 therapists, a fucked-up sex life, and a lifetime of 'surviving' – I spent 20 years trying to figure out what the hell was wrong with me. For two of those years I performed as a GT

Several people told me to not talk about these experiences. When I suggested my own experiences with child sexual abuse as a research topic, one sociologist advised me to investigate the general topic, using my own story as one of my interviews. In other words, he told me to bury it in other data. “Why?” I asked. “Because it might harm your professional career if it were known, and your work might not be taken seriously,” was his response ... Does this imply that there is something wrong with me because I have been through this experience? Should I hide it? (Ronai, 1995, p. 402).

Unspoken

For all the focus on GTAs modeling through their performances the ‘appropriate’ use of language within pelvic teaching, what to speak and not to speak, how to speak, and when to speak – there were notable absences within the program as well. There were significant moments and utterances that occurred during the program that were not scripted for inclusion in the teaching sessions. I was curious whether or not other GTAs noticed that pelvic teaching with medical students did not involve discussions related to sexual violence, particularly given that there was such an emphasis on constructing the space as non-sexual to reportedly reduce women’s shame and embarrassment; however, the conversations stopped short of addressing *why* those feelings might manifest during pelvic examinations –were they simply ‘givens’? Consider the following conversation between Suzanne and myself:

Suzanne: Why are we afraid of talking of it in this module and no other module? Like people hide abuse, they hide sexual – I don’t know, sexual encounters that upset them, things like that. I don’t know how to say it, but those things are private, so is this something that’s supposed to be hidden, and how come we can’t talk about it? You know, like it’s like trying to make it something that’s not clinical again where the whole point is making this clinical so that we can talk about it and deal with it and make it better for the students. How do we make it better for the students if we can’t make it better for ourselves?

Jodi: And it was interesting because when you did your introductory talk, um, I think that you were one of the only women, if not the only one that talked about

well, this language could remind her of rape, so you were making meaning of why the language is so important not just be so that its clinical language but why would clinical language potentially be more comfortable for a woman with a prior history so it, they could make sense of, oh of course, then, that feels like an obvious link for some of us – but it's not necessarily...

Suzanne: Right, you know. And that, those words were things I learned, there's, I heard two other coaches do it, I heard another coach that absolutely will not talk about that, which really surprised me because she didn't say it and I was observing so I threw that in and she did not like having that in the session.

My assumption going into the program was that there would be spaces for such discussions, not only as sexual violence had been cited as a factor impacting on women's 'choice' to obtain a pelvic examination or not (Leerners et al., 2007; Wijma et al., 2003), but given the likelihood that medical students and GTAs alike may also have their own histories of sexual violence which could shape how they performed during the teaching module.

Sexual violence in the lives of women

Sexual violence reaches into the lives of many women. The most extensive study of childhood sexual abuse (CSA) conducted in Canada by the Committee on Sexual Offences Against Children and Youth found that among adult Canadians, 53% of women experience at least one incident of unwanted sexual contact during childhood (Bagdley, 1984). Women survivors of childhood sexual abuse are at significantly higher risk for both physical and sexual revictimization in adulthood (Coid, et al., 2001; Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007; Mezey, Bacchus, Bewley, & White, 2005); compromised physical, psychological, emotional and social functioning (Bohn & Holz, 1996; Kendall-Tackett, 1998); higher rates of chronic pain, anxiety and depression, suicide ideation, decreased self-esteem, rage, post-traumatic stress disorder (PTSD);

and high risk behaviours such as substance use and eating disorders, than women who do not report a history of CSA (Bohn & Holz, 1996; Grimstad & Schei, 1999).

Directly related to the experiences of routine pelvic examination for women who are survivors of childhood sexual abuse, Leeners et al., (2007) and Wijma, et al., (2003) in their separate studies, found women with histories of CSA to have much higher rates of anxiety while seeking gynecological related care. However, health care utilization among survivors of CSA is generally higher than among women who do not disclose abuse (Grimstad & Schei, 1999), or among women who were victimized as adults (Grossman, et al., 2009). However, visits to the gynaecologist often brought back triggers that were reminiscent of their abuse experiences – a space where pain or discomfort, confusion, body position, power differentials and sexuality interfaced. Both studies concluded that the potential existed for health care providers to unknowingly re-victimize women during pelvic exams, for example, when the health care provider inserted their fingers into the vagina while literally standing in a position of authority over their patient. Routine medical procedures often evoke feelings of helplessness, shame and humiliation; themes that are often reminiscent of women’s abuse experiences (Prescott, 2002). Considering this potential then raises the question: beyond ‘interventions’ based at the practice level, was the pelvic teaching program attending to broader, socio-cultural-political issues in the education of medical students?

‘Wilful’ discomfort

GTAs reported the willingness and ability to put the needs of the medical students ahead of one’s own comfort was an integral component of the GTAs’ collective subjectivity. To quote Siwe et al. (2006) “[o]ccasionally the women felt some discomfort

during an examination but tolerated it so as to assist a student to succeed” (p. 892). Such a justification for women tolerating physical pain, coupled with a lack of further exploration or contextualization, raised questions for me as to why GTAs occasionally submitted to not only physical pain, but emotional and/or psychological discomfort. Reaching the conclusion that GTAs submitted to occasional discomfort in order to ensure student success was an oversimplification, and an extension of normative discourse that foregrounds women’s responsibilities to/for caregiving those around her. Such justifications reflect and reify a larger, more pervasive discourse of what it means to be a ‘good girl’, within the larger social context.

My experiences as a GTA problematized the oversimplification of previous researchers’ interpretations. The sensation(s) one derived from feeling capable of enhancing a student’s ability to ‘succeed’ was not the only factor that uncomfortably positioned me, literally and figuratively. My willingness, and I assumed the willingness of other GTAs, to participate in teaching these specific exams was fueled by a complex array of, at times, competing and contradictory interests – including: financial compensation, personal learning, seeking external validation, being resistant and ‘counter’ to normative notions of the “good” girl, healing past trauma, and once I began participating as a GTA, wanting to be accepted and recognized both within myself and the pelvic teaching program as a “women’s health activist”. All of these factors in combination with one another trumped the occasional ‘discomfort’.

I was curious whether or not other women in the program had similar reflections on this whole topic of ‘willful’ discomfort. GTAs were told that they could stop the exam at any time, and in fact, it was written into their script to teach the medical students that

“the woman should be informed that she should drop the drape during any portion of the exam as a signal that something wasn’t going well, and that the exam needed to stop”.

Why then, had I never heard of, nor observed, one teaching scenario wherein the ‘drape had been dropped’? I considered then, how were normative discourse, and by extension, practices set up inside/outside the pelvic teaching program precluding GTAs from dropping the drape, what led GTAs to submit? I was interested in the ‘whys’ for other GTAs – why did *their* need and/or want to offer ‘service’ to others become prioritized over at times, their own sense of wellbeing? What did *they* perceive as the obstacles, if any, to stopping an exam?

To explore how others made meaning out of these questions, I asked other GTAs during individual interviews what the reasons might have been for themselves, or other GTAs, for continuing on with an examination even if they were uncomfortable. I also asked what assumptions GTAs made about other GTAs, not any one particular GTA, but assumptions about what ‘type’ of woman would participate as a GTA. I felt this question would create the space for assumptions to be fleshed out about embodied trauma and the work of GTAs. Such assumptions, I believed, played a role in (re)producing the culture of pelvic teaching along normative lines. This chapter explores the complexities of their responses to my various questions, and concludes with a discussion around the possibilities for enacting resistance to normative discourse within the program.

Dropping the drape

The ritualistic act of gathering the drape between the GTAs knees and handing the drape over to the GTA/patient to ‘control’ throughout the exam presumed that the dropping of the drape would be an un-problematic, easy-to- execute move for the

GTA/woman. Teaching medical students that this shifts *'the power'* over to the woman on the table minimizes the power differential embedded in the gendered aspects of the exam, and the power differentials that circulate between practitioner and patient/client. Yet, even the GTAs had difficulty stopping an exam when they experienced discomfort; perhaps even more so than women in the community due to the complexity of competing interests factored into their decision, e.g. questioning whether or not a disconcerting occurrence or utterance was a *'legitimate'* enough reason to stop. As one GTA shared, *'dropping the drape'* to halt an examination was a complex decision:

... it's not simple at all [no] not a simple situation there's so many factors: from being paid, the wanting to be professional, the wanting to help, the tendency for women to want to help – that's a big one. And to know that this is a learning opportunity for these people and wanting to make sure that they get everything other than that they're supposed to – those are all big factors (Amanda).

The tendency for women to *'want'* to help (help women in the community, help medical students succeed, help each other, help themselves), was a thread that ran through the entire program, indeed it was the very reason that all of the GTAs cited for their involvement with the program. However, was it this same normalized imperative for women to *'help'* that worked against a GTAs *'willingness'* to drop the drape? To drop the drape would be to disrupt the teaching space, and the model would be called to speak to this move. Wanting to help *'others'* succeed was a central feature of the GTAs' gendered *'identity'* enacted in their performances, and reflected and reified in normative discourse.

“Everything that’s required of me is making me stay”: Spaces, expectations and assumptions

We're trying to be really accommodating to everybody else and make sure that we're doing what we're supposed to for the students, which is why you might get that guilt complex if they can't see what they're supposed to see or anything. So we're probably likely to put off much more, anything that we're going through,

because we're worried about accomplishing what we're supposed to, making sure that everybody else doesn't feel that we're weirded out (Drew).

During the time I was conducting this research, there were two particularly poignant examples of how normative discourses shaped the performance space of pelvic teaching. One scenario involved a medical student who was "red flagged" prior to the teaching session, and the other scenario took place off-sight where a selection of GTAs were "borrowed" from the program to assist registered nurses at a sexual assault clinic to obtain skills related to pelvic examination for the purpose of collecting rape kits. While I was not present during either of these teaching sessions, the GTAs and program administrator involved with these teaching sessions chose to share their respective experiences with me during their individual interviews. I first represent the teaching session involving the "red flagged" student from the perspective of Amanda, who performed as the model. I have bolded and italicized sentences that were particularly interesting to me in explicating the relationship between spaces, embodiment, and normative discourse.

If I were a patient of either of those men I would have left

Anna [the program administrator] came in first, and she is like "we are sending you a student who is not doing well". She mentioned to Rosemary to be, you know, really watchful of him. And then she said it was going to be really obvious who it is, when they come into the room. I had no idea which one was the flagged student because they were equally strange and awkward and not engaging and just very weird. ... I don't know how the pairing of medical students even works to be honest before they come to us, but, that was such a bad pairing – like, they basically stood in two corners in the room and looked at the ceiling, wouldn't engage with what Rosemary was saying and whatever. Actually, the mechanics of the exam were totally fine - you know nothing felt weird or hurt or anything. But the one guy was playing with – like sticking his finger in and out of the model of the vagina that was on the table beside him, and that was just really weird. And Rosemary, you know, looked at him like that's not a good thing to be doing – and he kept doing it. And then she finally said something about it, like 'don't do that',

or something. And he also – I don't know if he had an itch - he wasn't masturbating or anything, but he kept touching his genital area. I don't know ... it was just weird. It was just weird energy. I don't know how to talk about that part of it, it is not really a tangible thing but it is like ...

Jodi: How did it make you feel because this is prior to him doing the exam ... even if that mechanically went well? So, set it up how - what were your feelings watching this unfold?

I would rather just leave at this point.

Well, I was thinking to myself 'I would rather just leave at this point.' And I don't often think that – like, I really don't mind doing the modeling, you know, I really don't. But at that time I was thinking that I would really like to leave. *Everything in me* is telling me to leave, but *everything that is required* of me is making me stay. So, yes, if I were a patient of either of those men I would have left.

To me it didn't feel like that kind of nervous.

I mean, a lot was going through my head at that time and actually when I read your experience and – I thought of that, I thought of your experience. And I thought, 'well you know, do we have to stay or?' You know, and that sort of went on in my mind. And I don't even know what the answer is to that. I mean of course there is something - if something is going majorly wrong - I mean I don't even know, because a lot of me wants to give them the benefit of the doubt - okay, you are nervous - okay, this is a really high stress experience, okay. But, that looks different to me than what's in the room, because we have that all the time - you know, everyone is kind of nervous -- some more than others. But, as long as they are listening, they care - that is all I need, you know, to feel comfortable or feel like being there, I guess -- is the willingness to learn to listen, to ask questions, to check in. So, it wasn't that. To me it didn't feel like that [regular] kind of nervous.

...your intuition is telling you to do something and your responsibility is telling you to do another

Well, I think it was because he kept touching his genitals, right? And I mean, I don't know. That is something that we both mentioned to each other afterwards: was he? You know, because you are not sure, you know -- I mean obviously we saw him touch his genitals, but what was it? Why was he doing that? I don't know. So yes, and then our option now is to e-mail the person, the doctor person, who is in charge of that program -- to let them know how we felt. But then actually Rosemary and I -- when we talked about it, I said I would rather go and talk to them because is more of a feeling then something I can write down and I don't know – I don't know how they would receive that. And actually, I don't really care how they receive it. But I feel the need to at least say, you know, at least say

my piece so that if they do want to do anything about it than they can. But if we don't say anything or e-mail anything then - I don't know, you know. You just - for me, I just don't want that – I don't want the responsibility of knowing that these two are a little bit creepy and not telling [anyone]. So, yes it was just weird and -- I mean I feel fine about it now but – yeah, it is a weird thing when your intuition is telling you to do something and your responsibility is telling you to do another. Especially in that scenario, that is a pretty common feeling I think. In that scenario it is just -- I don't know I guess.

Is this valid enough to stop?

I am sure that I have permission to stop whenever I want to actually. It is more of a – I guess for me it was more of a ‘is this valid enough to stop?’ I guess, you know, because it is just a feeling - it is a feeling that I have. Nothing has gone wrong. There has been no physical harm or anything. So, -- yeah I don't know. I mean if something physically wrong happened, I think I would be very comfortable to be like ‘okay guys, you need to leave the room and we will talk about this later’. But when it is a feeling -- I don't know, you know? It just - it is really hard to blame yourself, you know? Even now, even though I stayed in the room, it is hard to say ‘why was it so weird?’ But, I think especially if I had left the room and they didn't get to do that learning part, I would have had a really - I would have probably felt guilty to be honest that they didn't get that experience, and I was the one that made them not have it. Or if it is just nerves and, then, I have misread them or, you know? There is just - I didn't want to - I didn't want that responsibility actually either. So, I don't know.

A critical re-reading of the scenario depicted above demonstrates the assortment of potential questions, concerns, feelings and reactions that a GTA could grapple with during a student's examination: *If I were a patient of either of those men I would have left, I would rather just leave at this point, to me it didn't feel like that kind of nervous, your intuition is telling you to do something and your responsibility is telling you to do another, and is this valid enough to stop?* While this scenario was uncommon, the myriad of feelings, the complexity of the internal negotiations surrounding the perceived competing obligations, (which most often led GTAs to negate their own uncertainties in order to fulfill the obligations of the role), were not uncommon. An aspect of the GTAs role and positionality, after all, was to engage in a form of ‘caregiving’ for the medical

students' emerging professional egos – to bolster their confidence in their capabilities, not diminish them:

It is the particular quality of a caregiver's [GTAs] attention that can bolster the Other's [medical students'] confidence. This attention can take the form of speech, of praise, perhaps for the Other's character and accomplishments, or it can manifest itself in the articulation of a variety of verbal signals (sometimes called 'conversational cheerleading') that incite him [or her] to continue speaking, hence reassuring him [her] of the importance of what he [she] is saying. Or such attention can be expressed nonverbally, e.g. in the forward tilt of the caregiver's [GTA's] body, the maintaining of eye contact, the cocking of her head to the side, the fixing of a smile upon her face. (Bartky, 1990, p. 102)

The concern is not so much that the odd medical student may act in ways to create such discomfort, but as embodied beings with lived experiences beyond the constructed borders of the GTA program; the way researchers, program administrators, and medical educators have traditionally understood the women who comprise the 'pool' of GTAs in pelvic teaching programs; their motivations for participating, and continuing to participate have been overly simplistic and de-contextualized. As researchers Siwe, Wijma and Betero (2006) observed, participating as a GTA had "helped them [GTAs] accept and affirm their femininity" (p. 892). Such an interpretation, in light of the stories shared with me, demands problematizing. What aspects of their "femininity" were previously *unacceptable*?

Various health care professionals who interacted with the GTAs during the program were also implicated in maintaining power relations within which GTAs could not 'drop the drape'. Consider the following statements two male medical students made to me during a post-examination interview:

Student 1: I think the hardest part was just, I thought I was hurting the patient the whole time because it looked, especially with the speculum, it looked like it was pinching and I was worried that it was hurting her. So I was going like very

gently and it was probably a good thing to go gently but maybe I would, because I didn't end up seeing the cervix so maybe I would have been able to see it if I was more, I wouldn't say aggressive, more confident in what I was doing.

Student 2: Yeah for me I, when I was doing the bimanual exam it seemed like she was in pain every once in a while, I could see her wince so that's when I got concerned sort of asked her if it was ok. Of course being an SP [GTA] she said "yes it's fine, so keep going".

The medical students acknowledged that given the expectations of a GTA, even if she was uncomfortable, or indeed in pain, the GTA would continue with their performance. Given the medical students awareness that the GTA was in pain, I was troubled that they did not take it upon themselves to stop the exam. Instead they continued on with the examination even though they were concerned she was in pain. While previous research indicated that medical students had expressed concerns with hurting GTAs (Buckwald, 1979), research does not indicate how or why they managed teaching situations when it was obvious to them that their "practices" were painful. Is there a space for medical to stop an exam, or are they expected to continue on unless the GTA/patient explicitly requests/demands that an exam be stopped? How were medical students expected to perform and how did this preclude them from being able/willing to stop the exam?

Furthermore, as a consequence of GTAs being positioned as the 'ideal test subject', they were at times precluded from acting on their 'instincts, demonstrating a complex relationship between the GTAs 'willingness' to 'transcend' their pain to assist students to succeed, and the obligations GTAs felt compelled to fulfill – not only the role of GTAs, but their role(s) as 'women'. Framing such actions by GTAs as 'choices' to continue with painful or uncomfortable examinations, is detrimental to women – positioning their submission to harm as a vehicle for their self-actualization. The

normalizing discourse of mothering and the ‘duty to care’ inscribed in the ideology of familialism that informs the performances of womanhood, “constitutes women as loving, dutiful (in relation to parents), uncritical (in relation to children), and caring about our appearance, in particular by trying to stay thin” (Kotthoff & Wodak, 1997, p.295). For women, performing gender along normative lines often means fulfilling the expectations of others at the expense of oneself, even to one’s detriment. If GTAs were not enacting a disposition of care toward the students, this was noted by program administrators:

Yeah, this year it seemed more the GTAs were, well that’s maybe another conversation. The students seemed to be a little less cared for this year than the GTAs were caring for themselves. I don’t know if that sounds really ‘judgey’ (Anna).

More than not providing the students with ‘enough care’, was the insinuation that the GTAs were showing themselves *more* care than they were showing the students. I wonder *how so?*

“You need that balance between like freaking them out, but they’re like going to hurt you”

To construct the following scenario, I utilized data from Gloria’s individual interview to further suggest that normative discourse informed the performances of GTAs and the utilizations of their bodies by others. The scene Gloria is recounting took place at a medical clinic where registered nurses who were new to the sexual assault team were being oriented. Part of their orientation was learning how to conduct a “women-centered” pelvic examination on GTAs, which would assist their ability to collect evidence from/for rape kits with victimized persons. Within this scenario, a relationship between space, expectations and exploitation was (re)produced.

I've never been sexually abused but I feel pretty sexually abused right now

Rosemary always talks a lot about how she's gone to the sexual assault clinics and worked with them, and she always talks about how, they're big into sensitivity issues and making sure not to say trigger words that could really upset somebody who's been assaulted and all these things. So that was always my impression of how they handled things over there – that they were just very cautious and I don't know, just sort of very sensitive to a person's, I don't know emotional state or whatever you want to call it. So we went and then they said everybody just grab a room. So that was fine... so we just got ready and waited in our room, and then the doctor who was teaching was Dr. Karen. It was supposed to go from 10:00am to 12:00pm and we were all there on time and we didn't really wait around much before we got started. So, Dr. Karen started in my room and then they had the nurses have pages of all the generals and all the names and diagrams and all that. So she started, she was asking me, she asked me something about whether I'd done a lot of these sorts of things before. And I said "oh yeah we've been doing the pelvic teaching like all month" and she said "oh, so you guys help teach the students how to do it?", and I said "yeah like we teach them and then we model and stuff". So she said "that's great, so why don't you help me and we can kind of like teach the these two together", so I said like "ok, that's fine", whatever because I'd done coaching and all that and even just modeling, all the feedback and all of that, so that was fine. So I was trying to show them, I don't know how they were trying to get me positioned on the table, but it, I may as well been upside down – it was the weirdest way ever, so I was trying to show them how we do the draping. I was basically lying on the table doing the coaching that we do at the university, like for these nurses and there were only two nurses the first time with Dr. Karen.

They wanted to do this external exam, which is a bit different than what they do at the university because there's the palpating and all of that kind of stuff. So it's more just looking for like tears and bruising and all that kind of stuff. So she was showing too where she would look and all this stuff and then she, like they did the speculum exams, so that was fine and then they used the metal speculum with the water because they have to do it like they do in the clinic. And it wasn't that bad, I think just at the university everybody thinks like ooh metal and water is going to be uncomfortable but it was fine, for the insertions and all that stuff when the doctor did it and then she was showing them where they had to get the fluids from for the cultures and all of these things and then like with the sexual assault one, like at the university right, you just open the bills and you see a cervix and then you close the bills and you're done. With the sexual assault one they have to visualize all the walls so they have to pull the speculum out and twist it and put it back in and so it's like being cranked all around and it's not, with all the other ones right it's not bad if it's done gently or if like, yeah, or like slowly carefully all of that. So it was fine when the doctor did it and then the two nurses, like each had a turn practicing or whatever so one of them, well one of them was much better than the other.

The first nurse that did, she was sort of bugging me to start with because when they were draping me she kept putting hands on my knee and my leg. Somebody was saying the nurses are supposed to, or even at the assault center, they're supposed to give you a reassuring touch or something like that, but this wasn't that and I was trying to explain to them that we always use the backs of the hands and we initiate contact and all this stuff. So all of that was sort of in one ear and out the other [laugh]. I don't know, they must have been in there for an hour or something like that and Dr. Karen was really good she kept checking in with me to see like if I was ok and all that. And so I felt comfortable enough and if they, even if students, like if they do something that's off, like I don't always say something because you don't, you need that balance between like freaking them out but they're like going to hurt you and them just figuring out to not be fumbly and stuff like that. So they all finished and then left the room and then I was waiting in the room for a while.

I assumed they still needed us because it was only 11:30am or something like that. But we didn't know what really was going on so, I was sitting there, and I had my door wide open, sitting there because they didn't want to forget I was sitting there. So then the other lady, [she] came in and she had a group of three other nurses, and she said "oh can they just come in and do the external exam?" So I said like "that's fine, like whatever, not a big deal".

So the first nurse literally – like it felt like she was playing piano all up and down my crotch and I said "Ok, what are you trying to do right now because maybe I can help". So I made her come around to the side and I'm like "Ok, if you're trying to palpate this is how you do it", so then she went back, she still couldn't get it. So she moved on then there was one out of three that was less like clumsy or whatever and then the one that couldn't find the urethra she was like totally clueless. Like, I don't know what they were doing; it was just like a comedy of errors. I was starting to get a little bit uncomfortable just because, like well I didn't think anything bad was going to happen but I was just getting tired of like being groped by nurses and they weren't paying attention to whether any of it was like fine with me or not fine with me. So those three are there, and then they were looking at their watches.

So I'd had three insertions with the first set of nurses. So then, so it was 11:50pm, and I figured ok, we're probably done because I don't know what else and then Dr. Karen came in the room where there was still the three clumsy ladies and she said like "Oh has anybody done the speculum exam?" and they said "Oh we've each done two already". So there is only four of us and so she said "Ok well like why don't I show you?" So she asked me if it was ok if I show them. So I figured ok, she's just going to do one more speculum insertion and then show them where to get all the stuff and all these things, like she did for the first two nurses. So that was still fine. So she did the same whole rigmarole that she did the first time around. Then she said to them, why don't you all try to do an insertion. So then there were three more of them that did it.

So I topped out at seven, like speculum exams. I didn't expect that they were all going to do it. Mostly just because of the time. I just figured because of time, she would be the only one doing it and because they'd done two each already, but it was better when the doctor was there to at least supervise them. I think the worst part of it was just when the three were in there like doing god knows what on their own, like a free for all. But I said to the program administrator after – I've never been sexually abused but I feel pretty sexually abused right now. I drove Drew back to the university and the whole day we were just kind of shaking our heads, like what just happened? And so as soon as the other program administrators found out – a lot of phone calls were made.

The above story demonstrates how space is not neutral – it participates in the generation of meaning. Gloria's encounter at the sexual assault clinic highlights how space and expectations coalesced to create a context within which the GTAs were exploited. The sexual assault clinic was not the space that GTAs were used to performing in. Within their 'home' space, GTAs felt a sense of familiarity with their surroundings, a sense of communal ownership that provided them with a modicum of safety and predictability within their performative space. Within the teaching space at the university, there was at least a general understanding of what would transpire, how long they were expected to work, and who would be doing what within the teaching space. Additionally, models had their fellow GTA for assistance and 'protection', which reportedly lessened the power differential between student and GTA because of a more equal distribution of people within the room occupying various positions. Drew, who also participated as a GTA with the clinic nurses, shared the complex emotions she faced while being subjected to repeated 'examinations'

“Taking one for the team”

During that time I was contemplating how the other girls were dealing with it [repeat examinations] and thinking that it was almost like one of those concentration camps situations where you're trying to all take some for the team

so that the rest of you don't have to take the brunt of it. And I found that really strange to have had that sort of experience and feelings run through my head and I managed to shake it within a couple of hours because of the way that I am able to detach, but yeah it was interesting that that surfaced in the first place and then in leaving I pretty much left it because I had to.

...I just did the detachment where [I thought], "you've gotten through a whole month with very few negative experiences and something that you expected to be a little bit more involved, and perhaps more negative than what it was, you have had one bad experience, it's not going to be the fault of anyone that was in charge of this, and this was something you had signed into and you were able to take yourself out of it." I probably could have been more firm myself ... I probably would have kept trying to go except for the fact that I actually clamped shut on that third one, and it could not happen. And then a nurse came in for the fourth, and tried again and then at that point that was the very cool nurse that said "you know what? Let's just sit down and chat for a bit" and then sent me on my way. So I probably would have been wiser to be more firm myself so that was good ...that's something that I need to work on.

... like I said about the sort of taking one for the team concept...if I was able to keep going on I preferred that idea to the others having to deal with another [exam] and they were probably a little bit stronger about being able to say no in the first place because they had had more experience.

I think that a lot of women that have experienced rape it's a common situation that they feel guilty because they should have said no and maybe if they had been more assertive or maybe if they hadn't worn that or whatever and it's very interesting to find that I'm drawing these parallels. So as long as I can keep looking at it on a clinical thing, at clinical level I think I'm actually dealing with it pretty well. Physical healing of course needs to happen. Because I had clamped shut and I kept trying to go anyways I ended up being fairly abraded and I am in a relationship that's fairly new now and we're perfectly sexually healthy and compatible and so again he's one of the gentleman that participate in the rectals and that so he's very understanding, very supportive, great guy all around anyways. But that definitely put a damper [on things] for the month. And especially for the week after this last one, [a damper] on our sex life, because I just physically can't.

The GTAs in both the scenarios shared their experiences with program administrators who provided immediate opportunities to de-brief, and followed up with the appropriate medical school and hospital personal. GTAs were quick to acknowledge the support they received from the program advisors who were suitably horrified by the details of the

training session. However, there was no longer an official space for GTAs to de-brief amongst themselves – a practice that was in place when I was a GTA. Such a space had offered newer GTAs the opportunity to learn from more experienced GTAs, as well as offer a space to process difficult teaching episodes. In lieu of a de-briefing space, GTAs went to program administrators to discuss problems they were having with any aspect of the program; however, sharing their concerns with their employers was not something that all GTAs felt was a viable or wise option:

...the program administrators are the ones who are deciding if you're getting jobs. They're the ones who are choosing people for the next unit. You don't want to be saying, you know that was horrible or I didn't like that, or why did this happen in front of somebody who's going to decide whether you're in the program or not, and especially if you needed the money. I don't need the money, but if you're a student, you know a drama student and a lot of them are. You don't want to be saying anything negative in front of somebody that's deciding if you're getting the next gig. You know they've got four/five hundred people to choose from they don't have to choose you and some people are making part of their necessary income doing this. So no, I would definitely not (Caroline).

Discursive (re)constructions in history-taking

Misogynist thought has commonly found a convenient self-justification for women's secondary social positions by containing them within bodies that are represented, even constructed, as frail, imperfect, unruly, and unreliable, subject to various intrusions which are not under conscious control (Grosz, 1994, p.13)

So let's rewind back for a moment – if not within the pelvic teaching module, then I expected to find issues related to sexual violence located in the history-taking portion of the training module. However, instead of discussing the myriad of possible health impacts of sexual violence on women's health, their utilization patterns, and experiences with health care providers, the four main scenarios enacted between medical students and the standardized patients were of women who had: (1) lost their sexual desire; (2) were experiencing pre-menstrual syndrome; (3) had post-menopausal bleeding; and (4)

received a cervical swab that came back positive for a Chlamydia infection. While these may be important points of discussion between patients and their physicians, a closer reading of how these scenarios performed as per the instructions from The Department of Obstetrics & Gynecology, demonstrated how medical ‘conditions’ determined worthy of focus were no less ‘sensitive’, but reified dominant discourses regarding women. For instance, in the first scenario where the standardized patient performs a lack of sexual desire, she does so by reporting that she used to like sex, but now dreads it. She felt the pressure of her “biological clock” ticking (she is 30), and as a result of her “lack of desire” the relationship with her husband was in trouble. The second scenario positions the woman’s premenstrual syndrome [PMSs] as so severe that she has slapped her children and bitten her husband in a PMS rage. Her husband was worried about her lack of control with her children because of her “uncontrollable cycle of anger and guilt”. The standardized patient “should be honest” if asked about her treatment of her children, and should ask immediately if the student (aka physician) will be calling the child protection agency. The third scenario depicts an older woman who began bleeding intermittently, after starting a sexual relationship with a new partner, three years after the death of her husband. She is uncertain if intercourse is causing the bleeding and feels guilty despite the pleasure she has found with her new partner. She will be informed at a follow-up appointment that she has cancer. The students’ “Mission” during the fourth and final scenario is to provide the patient with information on how to prevent getting Chlamydia again, and addressing her concerns that her boyfriend will leave her if he was to find out. She is also concerned about her chances of having children in the future.

To raise concern here is not to dismiss the importance of these topics outright, but I am problematizing the choices to include these scenarios as *the* predetermined performances during the pelvic teaching module between the students and standardized patients, the instructions the standardized patients were given regarding their performances, and how the women’s “problems” were situated. Such scenarios reified not only heteronormative understandings about women, but also depicted women’s physiology as inherently pathological and ‘risky’ (Maine, 2000). “The linearity of questioning presumes heterosexuality and nonmonogamy; as such it reinforces a heteronormative, patriarchal and pathology based system of medicine” (Silverman, Araujo, & Nicolson, 2012, p. 2-3). To me, it was one of the biggest disconnects – the emphasis on creating a positive patient experience, but reifying problematic constructs of women in the process. In a teaching space wherein medical students were randomly assigned to participate in either the history-taking role ‘plays’ of the aforementioned scenarios, or in a pelvic examination with GTAs, and then rotate to the other exercise the following week, the content of the role-plays demands critical re-consideration. Learning to conduct a pelvic examination was firmly situated within the performance of normative gender discourse. Only normatively defined ‘women’s problems’ were ‘rehearsed’. Why do history-taking at all only to create a discursive and non-physical ‘context’ that supports the same gender norms imbued in the physical exam? What does this ‘play acting’ say about women if these are the (only) kinds of conversations they are being trained to have? There is the *how (not) to talk to the body*, and then how (not) to talk to the ‘actual’ women unless (re)enacting normative assumptions in regards to ‘women’.

“You do *what?!?*”

While each GTA who participated in the pelvic teaching program shared feeling a sense of pride in working for a program that prepared medical students for conducting pelvic examinations, there was an element of stigma to their work that precluded many of the GTAs from sharing with friends and family the nature of their involvement with the program. This element of managing their identity has not been documented previously in the research literature. I was interested in this apparent disconnect between the GTAs performance of pride and empowerment within the teaching space, and their reluctance to engage in conversations with their loved ones about their work. I asked participants whether or not family and friends were aware of their involvement with the program, and here were a selection of their varied responses from a focus group:

Suzanne: Like, there is some people you just don't tell. Me, I tell everybody everything and I have like very few boundaries, I don't know. But I've said it to people and they're like you do what?!, and they make that face and tilt their head. But I'm like “yeah because this is why ...”, and I tell them why and how important it is, and all this sort of stuff and then eventually they understand what we're doing and by then they're “oh, ok”. But like a lot of people once they see the face they stop and they just let it go and they feel bad. So I don't know, I just back it up with why.

Caroline: I have a number of friends that say, “You do what?!” I mean I knew you were a show off but really ... you do what?!”

Gloria: But I find that too, when I recruit people, it's not for everyone. You can kind of get a feel of who may be interested and getting involved, and the first thing they obviously say is, "Oh I would never do the pelvic." Like that's the first thing, “I wouldn't be interested in that”. And I said “well you'd be surprised, you know if you want to sit in on a session to check it out and go from there”.

Rosemary: But you occasionally have the one who says, "That sounds kind of interesting, what do you exactly have to do apart from the obvious." Meaning you know if you are going have to have the pelvic exam the obvious if you're going to be on the examining table, but when you explain that it is also a teaching unit and that you get training and that you learn by observing as well as doing. It's like you said, if they're interested you can tell.

Gloria: Well and they don't realize that you know that first of all they say, "Well how come you do a pelvic exam, you're not a doctor or you're not a nurse, or you don't have any medical background do you?" And I go no, we're obviously taught how to do a pelvic exam, we have to actually do a, perform a pelvic exam ourselves you know. And that kind of freaks them out, and that would just you know regular people doing pelvic exam you know, like something that a trained physician does, kind of freaks them out.

Rosemary: I also think we have a flair for showmanship if you will. We're not ashamed to be here ... I'm always a little cautious as to who I tell that to, because there are some people that I'm not going to say it to. They would condemn you off hand.

The participants dealt with the "stigma" of their work by using a combination of techniques and strategies that ranged from avoiding the topic with people outside the program, to minimizing their role in the program, and/or justifying the requirements of the job because of its benefit to medical students, and by extension, women in the community:

Jodi: What have people's reactions been to your involvement in a program?

Amanda: Like, my outside...?

Jodi: In your own ...yes.

Amanda: I have actually become really a lot more open about it than the past couple of years. Definitely, my dad doesn't know. But my mom knows and she doesn't really say much about it.

Jodi: Why wouldn't your dad know, or why wouldn't you tell your dad?

Amanda: I just don't think he wants to know. And that is fine with me. Yes, and actually my partner knows now that the first time that I did it while we were dating – did this program -I didn't say what it was, because I don't know - it was early on and I thought 'I don't really want you to know that I am doing this'.

Jodi: And what was the motivation behind not wanting him to know?

Amanda: I was thinking that he might not fully understand why, or he might feel jealous, or... yes, those are the two things.

Compensation

Whores, too, are something that women are not only not supposed [*sic*] to *be*, but not be *mistaken* for. This division translates into a mandate to not only be virtuous, but also to *appear* virtuous, to again demonstrate our affiliation with the privileged half of the good girl/bad girl binary (Nagle, 1997, p.5, emphasis in original).

I have been asked several times while I was involved in the program-- why in the world any one, for any amount of money want to subject themselves to teaching medical students about pelvic exams using their own body as the "dummy". Main reason – I became involved in this program because I needed the money. My partner and I had a small child to support and I was in midwifery school, commuting 200km once a week to Ryerson for class. It was during one of these commutes that a classmate started talking about a pelvic teaching program she was involved with in Kingston. My classmate shared that being involved in the pelvic teaching was a great way to earn some money while also acquiring some skills that would serve me well as a midwifery student. I initially had a lot of questions about the program: does it hurt? Do you get embarrassed? What if you were menstruating? But bottom line, I needed to find some way of making a little money without paying for childcare or interfering with my partner's work-hours. I already felt guilty that I was causing a considerable amount of strain on our family by returning to school. It was the perfect opportunity to make money while learning appropriate clinical skills I would later use in practice. In Ontario, where the average part-time worker makes \$13.98/hour (Statistics Canada, 2007), the incentive of \$25.00/hour working as a GTA was enough to overcome any lingering apprehensions I was having. After all, I've given away my vagina for much less desirable, and not at all noble causes in the past. "This is a coup!" I thought to myself,

just lie on a table –spread'em and there you have it. And it was legal. And no one would expect me to love them afterwards. Sure I'm likely to feel a little embarrassed, aren't I? And surely there would be some discomfort, but nothing I couldn't handle. This was a good for me, convenient for my family, a valuable learning opportunity for medical students, and I would be helping future women by being involved in training medical students to be competent at providing women-centered pelvic exams.

Looking at body work as an aspect of employment relations draws attention to the experiences of others' bodies that emerge from or are enjoined upon many workers as a condition of their employment. While it has been argued that the dispersal of 'affective neutrality' means that we subject our own bodies to surveillance for signs of illness ... the dispersal of a medicalizing touch is equally relevant to forms of paid employment... (Wolkowitz, 2002, p. 503).

For those whom I talk to about the work of the GTAs, including health care professions, one of the most difficult issues to reconcile about the pelvic teaching module – is the compensation GTAs receive for their work. Pay ranges widely depending on whether GTAs are compensated hourly or by the session – hourly wages range from 20 to 55 USD an hour, and between 100 and 160 USD when paid by the 2-3 hour session (Underman, 2011). How does one conceptualize work that operates at the elusive boundary between body work that is constructed as legitimate, and body work constructed as illegitimate? GTAs took exception to being conceptualized as a type of sex worker, even though the original pelvic teaching models were sex workers. During focus group interviews, this topic was brought up by a few GTAs:

My own family doctor when I told her I was doing this started to laugh and I said what's funny. She said, "Well 1985," I think she said Toronto, not sure about that, "me, five male medical students all in a room with a hooker, that's who did it then." [Laughs] So this program is as you can see, has come a long way since where it was twenty years ago (Caroline).

I'm finding that I need to shut my mouth more often than not or for comfort sake because I started blathering about it to somebody too and they're immediate response was "so, you're just a step away from a stripper". Well, no, not really actually, I don't think the stripper is going to give an anatomical breakdown while she stripper dances [laughing] (Suzanne).

Not only did GTAs police the boundaries between their work and sex work, program administrators played the role of gate-keeper, deciding who was motivated to participate

as a GTA for the ‘right’ reasons:

Like we have a great group of women and I was... would say that all, at the very least most of them are doing it for the “right reasons” but I don’t think any of them would do it for free...I wish I could advertise it being one price and then secretly pay them more once they’ve agreed to do it for what I consider to be a reasonable amount. Because if it were up to me they would get paid a lot more because I think it is worth an awful lot. What they’re doing is worth an awful lot. I just don’t want anyone to be doing it because it’s worth a lot; I want them to be doing it because it’s easy for them. I want them to be doing it because it’s not a hardship. If someone’s doing something that’s a hardship because they’re getting paid a lot of money that worries me... I don’t have a worry if she’s doing it solely to be compensated, [as long as] she’s doing it with ease, right. I don’t expect them to enjoy it, there is no requirement that this be, and in fact I would say that there are some women in our program who are doing it solely, but they’re doing it with ease. The trouble is that if your motivation is money that that might overcome some discomfort, but discomfort stills underlying and then do I have a role in taking advantage of you and do we as a program, are we taking advantage of you because sometimes people need money. Right, it’s not a choice, I’m doing this because I want to go on a trip or I want, but I need money this is the only thing I can currently see in front of me so I must do this (Anna).

However, program administrators did acknowledge that money was a motivating factor for the amount of sessions a GTA would sign-up for:

In theory the goal would be to have enough GTAs that we would only use a GTA twice a week. The problem with that is that they want to do all the dates, right, because of money. And I don’t want to tell somebody that they shouldn’t, right, and because for some of them it’s not that big of deal, for others it is and yet you still see them signing up and who am I to tell them they shouldn’t do that. And sometimes you read people wrong to and that’s, I never want to make assumptions, it’s a really tricky line to walk (Anna).

Informed by my experiences as a volunteer outreach worker for/with sex-workers, I wondered what really were the fundamental differences between what GTAs were performing in their role as models, and what women engaged in sex work were doing to earn a living? I wondered how their pasts, need for income, and available choices

made/make this work appear, or actually be, the best available option? Consider the comment from Amanda:

... at the time, I'd been in, well I was in three car accidents so I couldn't work so it paid really well and so that was a big motivation to because I can get a lot of days and then I could go and work in the morning and not have the stress of trying to slug my guts out for like \$10 an hour for the day. So the money was a big part of it at first but then I don't know, its kind, I've found that it's kind of fun when you do it, like you just get to know everybody and for me I always like shock value for things so like most people you tell them that you do it and they're all like "oh my god I can't believe you do that.

Who then, gets to define sex work? Where do the distinctions lie? If it is based on the location in which the service is provided, if it is based on services, like sex work, the pelvic teaching program utilizes the vagina to meet the needs of the 'consumer', be it a 'John' or a medical student. This then leads me to wonder how getting paid as a GTA continues to perpetuate a dichotomy between women who do 'good/right' work with their vaginas, and women who do 'bad/wrong' work with their vaginas? Consider Rosemary's statement:

I started out answering an ad in the community classifieds and it seemed like a lot of money at the time. Fifteen dollars an hour, like minimum wage was like five and so that was some of the motivation but also I kind of felt it was one of those rebellious out of conformity type of jobs that would be kind of fun and I had had two babies and thought well if I can do that then this would be just fine.

Or perhaps it is a stereotype about who accesses the services of a sex worker? Is it about demonizing this group of people, while sanctioning the status, privilege, and good intention of the biomedical system? Is it about who can afford access to women's bodies, and who can't? Is it about the motivations behind wanting/needing access? It is about the women who provide the services?

Collectively, Chapter Six and Seven raise several questions about the

(re)performance of normative discourses in the representations of the ‘right woman’, ‘ideal body’, ‘proper motivations’ and ‘duty to care’. Partnered sex, with a man, of course, is ‘good sex(ual) work’ stripping; particular ways of dressing, and pornography for male consumption is ‘good work’ – although, they are both lauded and vilified; i.e. ‘I’ll watch it, but would not want my partner/wife/daughter/friend to be a ‘porn star’. The women who ‘teach’ as GTAs and those that ‘come in regularly’ for pelvic examination and Pap screenings are serving the(ir) and the states biopolitical health impetus – they are doing ‘good work’. The women that ‘avoid’ these exams, even if it is for their own good, are ‘bad’, deviant, and/or ignorant. Then, of course, there are all the assumptions that are made about women’s sexuality and how they are demonstrated within the history-taking portion of the module: woman as ‘breeder’ with a biological clock ticking away, time is running out. She is going to anger her husband because she was not offering up her sexuality to/for him. Then there is that pesky PMS – those crazy ladies at ‘that time of the month’. The sexuality of older women is presented as risky and negative; only young and aesthetically pleasing women are to be sexual. Then, the final woman; she has ‘the clap, which is often equated with promiscuity. She fears she is going to be ‘punished’ by her boyfriend. The sexuality in pelvic teaching is ‘included by its explicit exclusion’ – it is the elephant in the room they keep trying to throw sheets (or drapes, perhaps) over, but the more that happens – the more obvious it gets. Is this because women’s bodies can ‘only be’ sexual? There are issues within gynecology, I would think, that go beyond sex; yet, all the teaching scenarios touch on heteronormative sex to some degree, e.g. the woman who has cancer – why could she not just randomly notice more bleeding, not in the context of a new heterosexual relationship? The physical teaching space produces the

very space it attempts to efface because of how much they try and ‘keep it out’. Why do women’s bodies need to be ‘healthy’, what purposes does this and other ways of utilizing ‘female bodies’, serve? If it was ‘for the women only’, would the questions and approaches not be different? Would they be asking different questions, *differently*?

Chapter Eight

Lost(*ness*)



Figure 8: Wandering

“Lost really has two disparate meanings. Losing things is about the familiar falling away, getting lost is about the unfamiliar appearing. There are objects and people that disappear from your sight or knowledge or possession; you lose a bracelet, a friend, the key. You still know where you are. Everything is familiar except there is one less item, one missing element. Or you get lost, in which the world has become larger than your knowledge of it”

- *A Field Guide to Getting Lost*, 2005, Rebecca Solnit

I conclude my thesis with this chapter entitled “Lostness”. The feeling of lostness permeated my research experience, to the extent that lostness became a participant, a quiet passenger on my travels helping me make new(er) meanings out of the space of pelvic teaching. In this chapter, I use the concept of lostness to frame ‘struck’ moments during the research process, those moments of ‘bliss’ – “...moving from pleasurable repetition of that which is already known to the moment of bliss where the pleasurable surface is punctured with another way of knowing” (Davies et al., 2004, p.

356). Researchers are often confronted with the questions, “So what did you *learn*, what *new* insights did you generate conducting your research?” For me, attending to the thoughts and feelings created when lostness (re)appeared provided me with the space to contemplate the answers to “so what?” – what (im)possible conversations were ignited during the research process, and why do they matter?

Hey guys,

I feel in need of de-briefing. I had my first session 'in the field' today, which was wonderful, as in all the GTAs consented to participate, and I was able to observe a teaching session today and conduct brief interviews before and after with the two medical students.

I must say though, it was difficult, very difficult to stay in an observation role during the examination. The younger (first time) woman was noticeably uncomfortable, and even once winced in pain, and the doula in me longed to pull my chair up next to her and guide her to breathe with me. She was staring at the ceiling, biting her lip and holding her breath. She apologized several times to the students because they couldn't locate her cervix because her uterus was inverted.

So ... that's where I am at. Feeling like the lone researcher personified. I head back in tomorrow, and then Tuesdays - Fridays for the rest of the month, when the program will end.

Wish we were sitting back in the coffee shop making plans to take over the world....

Jodi
Email correspondence
February 2, 2010

The above email was sent to a tight-knit group of fellow classmates after my first day of ‘in the field’ data collection. We met in our first year qualitative methods course and fell quickly into a ‘support’ group for emerging scholars. Our twice-monthly meetings provided the space for peer mentorship through the sharing of mutual challenges and resources, evolving into enduring friendships and writing partnerships. As

the email suggests, I was very much grappling with lingering feelings associated with a scene I witnessed during my first day as a ‘researcher’, and I reached out to my peers through this email to de-brief. Trying to find the words to articulate the feelings this scene stirred in me was difficult, but I was able to get closer to an authentic representation through poetry. I have entitled this poem, *breath(e)* and have partnered it with a picture of myself in a supportive hold of a laboring woman.



photo used with permission

breath(e)

i feel helpless when i watch her in pain
when i think i know
'I' can assist.

like labour, women wincing in pain
and afraid that breathing
will hurt the hurt *more*,
who hold their breath
when nothing else seems within grasp.

i think this is how i feel when i watch her
wincing in pain.

helpless.

or worse, that i am holding out on her.
the ‘participant’ in me feels suffocated
by the ‘observer’

so i can't catch my breath
to say loudly enough
to the woman holding her breath:
breathe.

While writing the above poem, I did not know that the feeling of (my) 'being' suffocated would reoccur throughout data collection. Negotiating how to 'behave', and when not to, was a constant feeling throughout fieldwork, leaving me at times, with the dizzying feeling of lostness. It was one thing to obtain ethics approval; it was an entirely different process to find oneself confronted with in-the-moment decisions about which aspect of your 'self' will be foregrounded, if a choice is even capable of being made in the moment. Rather, which 'position(s)' will be enacted, and toward what end? Residual feelings of haunting inadequacy and being immobilized, of being caught between research expectations and internal obligations, are depicted in this poem. I made, what felt to me in the moment, the safe(est) choice, the choice to stay quiet for fear that I would somehow be overstepping boundaries if I spoke out – if I 'disrupted' the scene. In those moments, the knowledge that I was already disrupting the scene with my mere presence slipped out of concrete awareness. The activist, the women's studies 'grad', the mother – the identities within which I found the strength to 'speak' did not (re)materialize. Retracting into my plastic seat, the participant in me slunk away and I let the scene unfold 'uninterrupted'. *Lostness*.

Reflecting back, ironically, my moments of lostness connected me to my research participants. Concerns about breaking from the script, meeting external and internally imposed expectations, disrupting the scene by interjecting 'oneself(s)' into the space of pelvic teaching were familiar feelings shared by and between the research participants and myself, as a fully embodied researcher. Normative discourses (re)shaped not only the space of pelvic teaching, but also my role as a 'researcher' researching the culture of pelvic teaching.

(Re)creating space(s)

Within the context of this thesis, Butler's notion of gender as performed/ a performance offered space to consider how gender, as it is *now* performed during pelvic examinations, could be performed differently. The aim therefore, "...is to make visible the tenuousness of gender 'reality' in order to counter the violence performed by gender norms" (Butler, 1990, p. xxiv) and to (re)create the possibilities for something other, something more. By troubling the ways in which gender is (per)formed within the context of pelvic teaching, attention is drawn to how such performances are situated within dominant discourses, leading us to consider how and why this matters.

Reflecting on the research questions that guided my research, I remind myself that I intended to situate the pelvic teaching module within the larger socio-political context, specifically as it (re)performed normative discourse. I was interested in exploring how various participants positioned themselves within the teaching space, how they conceptualized the purposes of the pelvic teaching program and understood their role within it. I sought deeper and newer meanings to how participants interacted with one another within the space to accomplish the goals of the program, (re)forming the 'culture' of pelvic teaching along normative discourses of gender performance within the context of biomedical education.

In the following sections, I gather together the threads weaved throughout my thesis pertaining to normative discourse in pelvic teaching, language and performance. I introduce the notion of a 'discourse-in-use' to draw attention to the possible disjuncture between what the espoused purposes of the pelvic teaching were and participants' performances. I consider the ways in which the space of pelvic teaching offered a place

for GTAs to utilize their roles to perform against biomedical discourse. I will then introduce methodological considerations, including a consideration of the disruptive role my presence had on the space of pelvic teaching. I believe the methodological challenges I encountered contribute to on-going conversations concerning a range of methodological approaches that seek to engage, provoke, examine, and ultimately create spaces where alternative ways of thinking about one's being in the world, and one's implication(s) on/in the world, are thoughtfully challenged. I conclude my thesis by revisiting the intentions of my research according to the broader aims of my autoethnographic methodology.

As the last chapter in my thesis, consistent with the framing of my autoethnography methodology, I will not use this space to resolve the tensions I have highlighted in the performances of pelvic teaching. I sought explication, illumination, new representations, and dialogue that could spark new possibilities to be imagined through a critical engagement with the space(s) (per)formed in the 'culture' of pelvic teaching. Indeed, the research/writing of my thesis was:

...compelled by many forces. Especially salient are anger, curiosity, and gratitude. It is surely not a new thing for an author-editor [researcher] to be motivated by righteous rage at discourses, systems, or movements that inflict silence, pain, or injustice. Nor is it uncommon to create a work to quench one's own intellectual thirst – curiosity is a canny catalyst (Nagle, 1997, preface).

Discourses pertaining to women's genitalia

My intention is to contest the authority and apparent certainty of the real, not in order to deny materiality, but to insist that there is never direct, unmediated access to some 'pure' corporeal state (Shildrick, 1997, p.14).

As introduced in Chapter Two, women's genitalia has been constructed through normative discourse as: (1) an anatomical space separate from the woman herself (2) the signifier of what a woman is, and what she is predetermined to become (3) something to be enjoyed by men for the purpose of men's pleasure only (4) something that can be commodified, packaged, bought and sold (5) the space of temptation, and should be feared and engaged with only to service reproductive purposes and (6) when left to the discretion of its' owner to decide its own boundaries – criminalized and/or pathologized. They were the very discourses enacted in the history-taking scenarios.

My interpretations demonstrate the way that these various discourses did not operate in isolation, as discrete and tidy categories, indeed the GTA experience and the examinations more generally 'took up' or, touched upon, all of these categories. Normative discourses were taken up within pelvic teaching in what was done and not done, said and unsaid, and how bodies moved or did not move with 'objects' and one another. Moreover, the notion that to be 'the body' was the easier of the two roles, what does this say about women's 'other' subject positions – expected and 'accepted' roles that 'being a piece of meat, a slab on the table', being poked, prodded and 'exposed' is considered 'less uncomfortable', is it 'more natural', perhaps, than teaching/instructing, leading, and talking in front of others? Why is it 'more understandable' to be 'less comfortable' about coaching, but not being splayed-out and for the most part, silent?

In the following section, I borrow from theories of (in)action to engage critically with the disjuncture between what it is that participants in the space were saying about their actions, intentions, motivations, and what they performed – 'discourse-in-use'.

‘Discourse-in-use’

During data-collection and interpretation, in addition to making sense out of the learning space through a lens of performativity, I began to note differences in what I perceived to be the goals of the program, what participants themselves shared and thought were the goals of the program, and the performances that were enacted with the pelvic teaching space. I found it useful to understand these differences by applying theories of action to performance theory: “There are two kinds of theories of action. Espoused theories are those that an individual claims to follow. Theories-in-use are those that can be inferred from action (Argyris, Putnam, & Smith, 1985, p. 82). Espoused theories are what a person believes they do – an idealized account of their actions, and the rationale for why they ‘do it’. Theories-in-use are said to be the ‘real’ theory that underpins an individual’s actions and determines their behaviour (Jones, 2009). Individuals are often unaware of the theories-in-use within their ‘practice’. While research into the difference between what we say and what we do has a long history (Argyris & Schon, 1974; Jones, 2009; Polyanyi, 1966), I extend my understanding of both espoused theories and theories-in-use to be enactments of normative discourses, that is what we think we ‘know’ to say within the context of disciplinary boundaries and epistemic communities (Jones, 2009), and what we think we should “do” according to the normative discourses that (re)constitute our actions. This adaption of theories-of-action extends itself beyond a way of understanding the individual, toward an analysis of espoused actions and theories-in-use as socially sanctioned performances situated within webs of power relations. Within pelvic teaching there were several examples of the gap between what were the ‘espoused purposes’ of the program according to the various

participants, and the actual performance(s) of pelvic teaching: teaching in the supine position, the disembodied, segmented representation of women in the training materials, exclusive, albeit unintentional, employment of GTAs who self-identified as Caucasian.

Positioning. The disconnect between what was espoused and was enacted is exemplified by the practice of not actually teaching students how to do the exam in an upright position. Although students were informed that the upright position for the examination might be preferred for some women, particularly pregnant and older women, this was not an option for the GTAs performing in the role of model. If a student was not actually offered the opportunity to practice such skills in a teaching context, it is surely less likely that they will adopt them in ‘real’ practice. As the exchange in Chapter Seven between the two medical students and myself indicated, medical students have to negotiate their own positions of power(lessness) in ‘real’ practice. Medical students face disciplinary traditions that equates respect with silence and deferring to more senior practitioners. If students do not have the opportunity to practice methods during their education that work against the status quo, then even the chance of the smallest of changes, such as the ‘position’ of the patient’s body within the immediate context of the pelvic examination, will remain limited.

Words that (re)wound

The problem of injurious speech raises the question of which words wound, which representations offend, suggesting that we focus on those parts of language that are uttered, utterable, and explicit. And yet, linguistic injury appears to be the effect only of the words by which one is addressed but the mode of address itself, a mode – a disposition or conversational bearing – that interpolates and constitutes a subject. (Butler, 1997, p.2).

In addition to the aforementioned examples, within the printed materials provided

to GTAs there was further confirmation of the disconnect between the *espoused* aims of the program and *practice(d)* values of the program. There was a total absence of information on the contextual factors that have been said to influence a woman's experience of the pelvic exam, such as: age, trauma history, mental health, physical ability, previous experiences seeking health care, and sexual orientation/identification. Not one diagram was there one picture of the genitalia connected to a woman, and the training video reified the 'hairless' ideal (for a complete discussion of the history of representation in gynecology see: Kapsalis, 1997). This is reminiscent, again, of mainstream pornography and the 'close up' shot, wherein women's genitalia are the site/sight for consumption rather than attached to a woman for her health, pleasure, part and/or of the(ir) broader context and 'selves'. Do these images then, also contribute to the sexual undertones of the exam and what 'female bodies' are and can be? That is, they try to de-sexualize the exam context, and yet, in the video and literature their vaginas are presented as the hairless ideal found in mainstream pornography. I wonder then, do older training videos and manuals have hair, since the hairless ideal has not always been with us, and that the new training video and manuals are reflective of more current normative discourse?

Previous research conducted on the use of GTAs in pelvic teaching has noted the mechanisms by which GTAs attempt to (re)script the performance of the examination. A fundamental vehicle through which the space is reconstructed is language – “talk before touch” and no language that connotes (sex)uality (Kapsalis, 1997, p.73) Language itself is not troubled – language just is. However,

The very notion of “dialogue” is culturally specific and historically bound, and

while one speaker may feel secure that a conversation is happening, another may be sure that it is not. The power relations that continue and limit dialogic possibilities need first to be interrogated. Otherwise, the model of dialogue risks relapsing into a liberal model that assumes that speaking agents occupy equal positions of power and speak with the same presuppositions about what constitutes “agreement” and “unity” and, indeed, that those are the goals to be sought. It would be wrong to assume in advance that there is a category of “woman” that simply needs to be filled in with various components of race, class, age, ethnicity, and sexuality in order to become complete (Butler, 1990, p. 20).

In addition to assuming the transparency and universality of language and dialogue, objects in the teaching space, integral to the examination (im)possibilities, were treated as ‘givens’. For instance, the examination table required bodies to be positioned in particular ways.

‘Right’ kind of woman

Among the GTAs themselves, there was a pervasive desire to conform to the pro-‘labia warrior’ culture. Women who were not yet ‘labia warriors’ idealized the GTAs’ capacity to apparently transcend culturally determined inhibitions in order to be of service to the medical community. Except in private space, problematizing aspects of the program was difficult, lest you be positioned as perhaps not suitable for work in the program. Ironically, each woman was expected to offer their own personal touch, according to their own personal experiences with seeking care, unless that ‘personal’ touch was being uncomfortable with aspects of the program, asking for better preparation and de-briefing.

Recruitment for women ‘willing’ to perform as a GTA often relied upon word of mouth (Underman, 2011). This recruitment strategy has produced a ‘culture’ wherein normative gender, class and racial discourse remain unchallenged. The lack of cultural diversity within the pelvic teaching program is deeply concerning as research has

indicated that medical students and health care professionals alike have demonstrated implicit preferences for white persons and the more economically privileged (Haider et al., 2011).

There was also an idealized notion regarding the ‘proper’ motivations for participating as a GTA. There was a policing of the boundaries of acceptable behaviours, and acceptable motivations for participating as a GTA. Within the research literature, women performing as GTA were predominately from ‘helping’ professions, e.g. teachers, secretaries, social workers. (Siwe et al., 2006; Underman, 2011) – Professions that aligned with the ‘duty to care’ exemplified in the GTA performances. . Herein an interesting tension is created: the work of ensuring that GTAs are motivated to participate for the ‘right reasons’, while the questions of ‘what type of women’ would participate still lingers on the lips. This tension is the ‘inverse’ of sex work; if she, the sex worker, is desperate – well she is a victim of circumstance – abuse – inequality – patriarchy, and ‘we understand’. Yet, if she enjoys the work, finds it empowering and/or wants to ‘have sex for cash’, then there is something wrong (Nagle, 1997). With so many other similarities to pornography and other forms of sex work, I wonder why there is an inverse here, when it comes to all the right/wrong reasons to perform.

(Non)sexual

...[as] feminist teachers pointed out decades ago and as my experiences have occasionally confirmed, it may be impossible to educate medical students properly within the medical institution given unacknowledged cultural attitudes about female bodies and female sexuality (Kapsalis, 1997, p.78)

The pelvic teaching program had to contend with an inherent paradox – the discursive construction of the female body as always, already (non)sexual and available.

While I risk subjecting the space to ‘sexual reductionism’, there were so many

similarities with other normative consumption practices of women's sexualized bodies and sexuality that it warrants further deliberation. Pelvic examinations are performed on parts of bodies constructed as 'inherently' (always) sexual, but without a discernible sexuality. Does 'avoiding sex(uality) at all costs' make the examination even more sexual, through their 'non-use'? By ignoring discussions around female sexuality, and insisting that the pelvic examination is devoid of this element, erroneous beliefs about the vagina are perpetuated, because as Diana Fuss states (1989), "The body is "always already" culturally mapped; it never exists in a pure or uncoded state" (p. 6). Others argue that it is precisely the marginalization of women's sexuality that is at the centre of our oppression (Few, 1997). Furthermore, if participants within pelvic teaching programs insist on making such claims as, "the situation was never sexually or otherwise charged" (Siwe et al., 2006, p. 890), what does this say about women's connection to their bodies, to their sexuality? How can we be at once connected to our body enough to offer instruction and feedback on what is safe and comfortable in the pelvic teaching program, but at the same time, be removed from, disembodied from, the feelings of our vagina? Whose needs are met by making such assertions? Whose voices are excluded from the conversation if we are told that nothing about this exam is sexual?

By admonishing any sexual component to the process, women become artificially compartmentalized, reinforcing the notion of a body-mind split that has plagued Western medicine since the *Enlightenment*, when other forms of 'knowing' became inferior to the scientific method (Flaming, 2001). Our own intuitive, embodied, experiential knowledge was no longer valued as 'real' knowledge at all (Flaming, 2001). Because biomedicine does not make room for such embodiment, women are once again denied the space to

experience their vaginas as sexual (or not). What does this say to women who experience a sexual response to the examination? Is this a pathological response? And what about the examiner, is this an arousing process? Can we talk about how students and health care providers may feel sexual; can we create spaces for practitioners to learn how to manage these feelings? Or as my research documented, are these “disagreeable” emotions so forbidden to express that if a student dares to speak the silences, they risk personal and professional persecution?

Enacting resistance to biomedical discourse

“Medical power relations are relational and productive, not merely repressive. Power relations produce bodies that are disciplined and resistant through the manner in which knowledge/power moves between shifting positions/statuses” (Lorentzen, 2008, p.52).

Where there were differences that existed, behind ‘closed’ doors, perhaps that is where the possibilities for something other to be (per)formed live(d) – “teaching the pelvic exam the best” way they thought how. Where the healing space(s), the sites for resistance emerge(d) – a (more) humble position(ality) that does not attempt to speak for/from the position of all women, but foregrounds the efforts of themselves, ‘ordinary’ women occupying hybrid space(s) replete with various knowledges vying for attention and competing obligations, compulsions and commitments.

[If you could make improvements to the program?] I don’t know its tough to say because the first year I was really, like the thing that I noticed the most is just that every single room, like we’re supposed to be standardized but we couldn’t be farther from the standardized if you tried and you’ve probably seen that being in everybody’s rooms. So for me the first year that really bothered me because I kept thinking like why are we pushing so hard to be the same and, why is everybody so different? And everybody’s going to be different to a degree but I felt that everybody is vastly different. And so at the end of the first year I went and I talked to Anna

and I said look you know I've been in all these different rooms and like everybody's really, really different and so I said like I don't really know if that's how it's supposed to be or not because I was new to it all and so like I've just sort of accepted it at this point... So as much as we want to be standardized I think we're not standardized at all, we're just teaching them how to do the pelvic exam like the best way we think we know how (Amanda).

Is standardization and 'text-book-ish-ness' then, a form of space? Is it a non-healing space, a limited space? Does such a limiting space *produce* possibilities for reading GTA performances differently?

Healing space(s)

"My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. So my position leads not to apathy but to hyper- and pessimistic activism." (Foucault, 1983)

I argue that not all forms of embodiment that draw from objectifying understanding of the female body necessarily reduce the female body to docility and passivity. Rather, social actors can reframe these forms of objectification in pursuit of social change (Underman, 2011).

When I entered the pelvic teaching program part of my rationalization for doing the work was my belief and intention that I would be contributing to a meaningful change in the current medical practices, while making an income, and gathering some professional expertise related to midwifery practice. As a survivor of abuse, and a counselor for women who have experienced childhood sexual abuse, sexual violence and woman abuse, it was also important to me that medical students understood the complex, contextual factors that influence a woman's experience of a pelvic exam. Furthermore, I was concerned about the GTAs in the program, who like me, had prior embodied experiences of trauma that spilled into the teaching space. For instance, Amanda had a

‘feeling’ that something had happened in her childhood, and those embodied experiences were starting to surface:

Jodi: So tell me about what some of those assumptions [about GTAs] were or are?

Amanda: Probably at the outset I would have had an assumption that everyone who was involved would have some level of comfort with their body, now I think that that probably isn't the case ... for me there's always been a uncertainty as to whether I personally suffered sexual abuse as a child myself. There was some indication that that was the case but that indication didn't have any tangible evidence connected to it and I know that some people have a crystal clear mental memory of the experiences that they might have gone through that were unpleasant, and some don't ... But that the fact that there's any indication makes me strongly suspicious that there's a likelihood that something happened.

Jodi: And that's the interesting piece is that particularly in terms of childhood sexual abuse or childhood trauma - is it isn't often a very tangible memory. Either the age of when it has happened, or the conditions in which the trauma took place, or simply the brain has decided to not make that retrievable, and so you might as a consequence, women 'live' out those experiences in very different ways.

Amanda: It's a lot of emotion coming up as we're sitting here speaking [*participant starting to cry*].

It is important for health care providers to know that children learn to cope with the unpredictable and frightening nature of sexual abuse in ways that assist them in maintaining some sense of safety, and for some children, the abuse is so profound that they learn to dissociate from their bodies in order to cope with the physical and/or emotional pain they are experiencing (Kendell-Tackett, 1998). These once adaptive responses to abuse, such as aggression, later become viewed as maladaptive by health care providers (Anderson, 2006). Given the numbers of women who experience sexual violence, and children who experience CSA, it is likely that other participants in the program, (GTAs, medical students, and program administrators) have their own 'experiences'. As such, program administrators, clinical instructors, and the Dean for

that matter, have an obligation to provide resources to attend to such issues, if only through normalizing that such experiences occur, and not silencing the discussion.

Bodies that matter

Remnants of valuing (particular kinds of) women's experiences as a source of insight could be found within pelvic teaching as the experience(s) that GTAs brought to teaching was central to the legitimacy of the teaching space – both the knowledge that a GTA possessed as a consequence of “being a woman”, but also her experiences of the examination itself:

Caroline: The only thing that I found is that as a patient I mean, especially with the breast exam and other things that most of those exams I've had my entire life were never done properly or extensively enough to learn anything. And even just the little things like for the pelvic exam that you can have the table raised at the back, that's never been an option given to me in my life you know you think okay. I just feel much more informed as a patient going and saying that.

Furthermore, Anna was attempting to make changes to who ‘qualified’ as the GTA body. However, in her following comments, at least part of the reason why the program has not been pro-active about recruiting women who have had hysterectomies was because of a lack of support from obstetricians involved in the program:

Something that we have talked about and we've tried is to also include GTAs who've had hysterectomies and don't have cervixes. I certainly fall on the side of the argument that we shouldn't [exclude these women]. It doesn't matter if you see a cervix or not, it's the process and there are others who very much think that the cervix is important and the students will feel like they've missed out on something. So some of that comes from obstetricians and I haven't been told not to recruit people but yeah, we don't have a huge number of SPs who are willing to do it who've had hysterectomies. There are some side effects; vaginal dryness for example does make the exam a little less comfortable sometimes so it doesn't come up too often. But we do, this year we had one SP, two who had partial hysterectomies. So their cervix is sometimes harder to find, looks a little different, I think that's a step in the right direction.

(Re)constituting the qualifications of ‘bodies that matter’ in pelvic teaching would work

toward troubling the notion of the elusive 'gold standard'. The gold standard as a metaphor excluded women from participating as GTAs when their bodies deviated from socially sanctioned norm. The following comment from Rosemary demonstrated the power of how women/GTAs position(s) were wrapped-up in their bodies being 'useful':

Rosemary: My feelings about the program have changed drastically over the fifteen years and I've used it as part of life, I used what my experiences here to gain more insight into life and how it works and has become truly empowered partially because of the program.

Jodi: Can you speak to me a little bit more about what you mean by that?

Rosemary: I ended up with an extremely distorted body image, going the opposite way. I thought my body was much better than probably what other people thought, because I was using my body as a tool for teaching...it really changed my perspective that my body was functional, it was working fairly well, well enough to actually be used as a teacher and therefore came to this acceptance of my body to the point where I didn't even realize if I was sort of gaining weight, no body image issues whatsoever because my body was just another part at that point, instead of being all of my personality. All positive, all positive.

This 'mattering' to medical students, to women in the community, overshadowed other types of 'how the female body matters' most in society, re: being thin, not gaining weight. Though Rosemary's quote demonstrates how it was through the position of being an object for medical education that her subjectivity was redefined against normative discourses related to the female body, it does come from the same 'place' – 'my body is only worthy if it can function as a GTA, or as a pleasing object, as a lover, as a caretaker etc. Yet, while problematic, it can also be simultaneously positive and healing. Weedon (1987) outlines how the poststructuralist "decentering of the subject" proposes a subjectivity which is "precarious, contradictory and in process" (p. 33) and opens up the possibility for change by 'offering' alternative ways of ascribing meaning to our experience. An example she gives is the potential opened up by 'feminist' discourses for

women to re-ascribe what they had perhaps previously internalised as personal inadequacies and failings to a recognition of the socially constructed 'nature' of experience; through a process described as 'consciousness-raising' in the 1970s by second-wave feminists (or in contemporary jargon 'deconstructing' the 'positioned subjectivity' that may be experienced as 'oppressive'), such that:

What had been experienced as personal failings are socially produced conflicts and contradictions shared by many women in similar social positions. This process of discovery can lead to a rewriting of personal experience in terms which give it social, changeable causes (Weedon, 1987, p. 33).

For other women, performing as a GTA provided the space for prior embodied memories to be released and (re)explored:

There's a lot of things that you don't think of day to day, that start coming to the surface when you do this, and I did find that there were a lot of transitions that were far more emotional than I expected them to be and I'm really glad that I have done this because that probably wouldn't have any reason or any intensity behind facing some of those issues (Drew).

I feel that there's been a deeper connection with what it is to be female, really a lot deeper connection than that. Definitely an even deeper comfort level with my body and what my body is capable of and especially given my recent experiences a heightened respect for my boundaries and my own comfort which is kind of part of the picture that I've been kind of moving towards that part in general the last year or so, couple of years or few years. So this recent experience has just heightened that. There's been a lot of really valuable learning in those ways at least. Also its been very rewarding in many ways because of the fact that we see over and over again the relief and the gratitude from these students, the majority of them, there's the occasional one who's not quite connecting with it or doesn't want to be there or obviously is not any kind of an area that they're going to go into in their medical career (Amanda).

When asked if participation in the program had changed how she thought about her extensive, and invasive experiences with the medical system. Caroline responded with the following:

Completely, of course it does. Of course it does. I wouldn't say that the experience has changed me. It just it employs part of me that I like and I that I think is important and it's reassures me that all those things are still true about me because retirement is wonderful but it's also, now what am I going to do and it's good to feel that I'm contributing something and I feel that I am. So I don't think that it's improved me in anyway but it has, it has given me a whole new experience of something I already thought was important.

I see these as potential sites of resistance within the program against powerful discourses that have had the power to create (ab)normal bodies. By incorporating the 'aged' body and the 'partially' complete female body, the pelvic teaching program moves closer to a space wherein participants learn to move with/on previously marked, yet marginalized bodies.

I continue to hope for a coalition of sexual minorities that will transcend the simple categories of identity, that will refuse the erasure of bisexuality, that will counter and dissipate the violence imposed by restrictive bodily norms. (Butler, 1999, p. xxvii)

Within the history of Western medicine, feminist scholars have long drawn attention to how women's sexuality in particular has been conceptualized as "...submissive, naturally passive and sexually masochistic" (Few, 1997), a site for medical intervention, particularly in the areas of menstruation, reproduction, and menopause, and more recently, pharmaceutical interventions to treat 'low libido', sexual transmitted cancers (HPV) and a host of other dysfunctions associated with female physiology and anatomy (Moynihan, 2003). Through a (re)consideration of 'dropping the drape' I wonder whether or not this performative space further produced in GTAs feelings riddled with 'must please', 'must be helpful tensions', informed by normative discourse which positions women as inherently more nurturing. Such notions have contributed to the disproportionate amount of unpaid and invisible labour carried out by

women, in their homes and in their communities (Donelan, Falik, & DesRoches, 2001). How was the performance of GTAs an extension of this normative discourse of familial obligation?

Specifically, this program provided a space for women to explore not only their own bodies, but also the bodies of other women; establishing a space to touch other women's vaginas offers us a political and cultural site of resistance against the social construction of heterosexuality rampant in medicine (Few, 1997). By coming to view our bodies as something other than *not-male*, there is the potential to defy dominant messaging around women's vaginas. Just talking openly about women's vaginas defies current mores around the appropriate places for such discussion for "when it comes to polite conversation and proper public behaviour, the vagina has been erased almost completely from the visible and speakable female body" (Hammers, 2006, p. 220).

Because of this taboo, or despite this taboo of talking about the vagina, we have seen the success of Eve Ensler's *The Vagina Monologues*, to the point of now being at the center of a "worldwide social movement to end violence against women and girls" (Hammers, 2006, p. 221). The connection? How can we ever hope to change the oppressive, violent practices waged against women, if we cannot, or refuse to, talk about the vagina "openly, respectfully, and publicly?" (Hammers, 2006, p. 221). *Silence perpetuates violence* (Hammers, 2006). I know for me, this was an exhilarating aspect of the program. I found it fascinating to talk about, to touch, and be touched by other women in the teaching program. What healing possibilities could there be for women who had learned to disconnect from their bodies, if they found spaces where their bodies

experienced intimate, but safe touching? Could such teaching programs offer women the opportunity to re-establish physical and emotional boundaries? As Rosemary shared:

I think when we work as partners too it's very clear that there is a purpose, like I don't think there's any sexual issues because we're all working for the same purpose of teaching and it is sort of a medical context, we're performing an exam and I thought I'd have a lot more trouble because I was actually sexually abused in my childhood by my female babysitter and so I thought this would be particularly difficult for me and it actually turned out to be sort of helpful in that because I never realized that someone could look at the reproductive organs in a non-sexual way and that's what we're doing, we're actually touching these organs in a non-sexual context.

While I problematized aspects of the teaching space that reify normative understanding regarding women, I do not want to ignore that participants also found the space of pelvic teaching to offer the possibilities of healing, to challenge existing constructs of what 'proper women' ought to do, offered insights into their own bodies that they previously did not possess. I do not wish to deny or repress such experiences; I only wish to add to them, to make richer our understandings about the variety of stories that remain untold, and to question why.

Request for the space(s) that went missing

For all the talk about creating a particular space for students to learn, new GTAs lacked such a space. I asked each GTA if they could make changes to the program, to aid in their own feelings of *Lostness*, what, if any changes, would they make? Newer GTAs wanted the opportunity to de-brief with their fellow GTAs, the opportunity to 'make normal' the performances enacted once the 'doorknob twisted'. To demonstrate, here are a few responses to their responses to question, "What if any, changes would you make to the program?" Drew answered with the following:

It sounds like the debriefing was a lot more helpful and lengthy before and that

even just the physical side of things you had a bit more recovery times so it was probably nowhere near as intense and as much to process than... Everybody involved is still really great and the fact that you're doing this interviewing session is also probably going to be giving us a lot more access to these talks that we need if people plan on, if the school plans on doing it this way again.

Drew's comments are particularly poignant as she links the need to debrief with the new pacing of the program. The intensity of multiple, frequent exams is connected with the needs to process more frequently; the embodied nature of the experience of being a GTA model is clearly articulated. It's also notable that she sees my presence as a researcher in the space as a catalyst toward change, toward "a lot more access to these talks". This is both positive to the extent to which the research space offered her the opportunity to reflect and process, to question and challenge the existing program framework. Yet, it also raises a potentially problematic issue, that is, why did it take 'a researcher' to create the space? Or rather, perhaps it was a particular type of researcher that was both (in the past and presently) a subject, object and 'observer' of the GTA program?

Caroline addressed the issue of de-briefing as well, not going by the assumption that all GTAs will feel able to seek someone out for this purpose:

They should have one day to just watch that [exam with students] and yes I think there should be some kind of debriefing, at least for the newer people and it might not have to be everybody but it should be [a] definite program set up. So let's say, you know these three people who have been doing it forever are going to be staying on Wednesday and Friday and that newer people who want to, they'll be there for fifteen minutes or they'll be there until 11 instead of everybody's leaving at 10:30. Just so that anybody who has a question or just wants to talk about it, or "boy that was weird" or "what do you do about this and there"? I mean as I say, I just asked but you might not want to, you might not seek out somebody, so yes that's two things: observation for everybody, debriefing available.

Rosemary contemplated how the tight time block of the program might have necessitated

even more need for de-briefing. She drew attention to the fact that this was a staple of the program's past, but wondered if it was not happening due to competing time demands:

... because this time block has become a very tight time block of four days a week for four weeks in a row as opposed to way back when we used to debrief and it once a week I think forever. [Laughs] I don't remember how long it lasted. But for the people who are on the table many times a week, that... I do think that it's probably particularly important for them to be able to say something about having this exam done. ... if they're not staying and they just want to go home because we've got another [laughs] job to go to this afternoon this debriefing business is just not happening and maybe for the ones who are getting the exam done several times a week maybe they do need to.

My interpretation of this research demonstrates that the positive experiences are created through the time it takes to conduct a pelvic examination with the GTA, and the partnership, hopefully of, a trusted ally – time that is NOT made available in a practice setting. Further, with all the research directed at understanding mechanisms by which pelvic examinations could be experienced as more 'tolerable', there has not been a significant shift in attainment rates, in fact rates of routine Pap screening in the United States have steadily declined since 2000 (National Center for Health Statistics, 2009). Such knowledge helped me to understand the situations wherein GTAs experienced (dis)comfort.

“The unseen guest”: Methodological considerations

There is no one-way to do interpretive, qualitative inquiry. We are all interpretive bricoleurs stuck in the present working against the past as we move into a politically charged and challenging future (Guba & Lincoln, 2005, p. xv).

"Why do you have to go and make things so complicated?"

The above quote is taken from Avril Lavigne's 2002 hit song "Complicated".

This one line swirled around in my head during data collection and analysis as I came to

realize I was not the only one impacted by feelings of lostness generated by ‘unexpected’ moments precipitated by my research. The program managers were confronted with responses from some GTAs that were unanticipated as a consequence of my ‘asking around’. I asked one program administrator about the experiences of having me present as a researcher during the module, and this was a portion of her response to me:

We are keenly aware that because of our multiple perspectives, or our multiple priorities rather and our perspective as administrators, that well, in theory there are best practices – usually the day is just whatever we can make it be. And the program has been around for a long time and things, routines can get stale so we really like the idea of a fresh set of eyes and critical look at what we’re doing. That, we’re fine with. Absolutely fine with. What has been challenging is and I don’t mean, its been challenging, its not a bad thing but it’s been challenging – is I think that your presence is in part responsible for some of the debriefing that has been required of the SPs, and not what I was expecting. I was expecting a lot more, a lot more, probably a lot more of what you’ve been getting. I assume the emotional stuff is brought up, “oh my god something came up today I need to tell you about”, and the emotional kind of outpouring. I haven’t been getting any of that. What I have been getting, well I get a little bit but not a lot – nothing more than normal. What I have been getting are a lot of criticisms about how we run the program; we should do this better and SPs being, and maybe its just this year and its not you but this idea that they’re not trained well enough, that has been a recurring theme and frankly I’ve had enough of [it].

It was interesting to me that the program administrator was expecting my research to bring up “emotional stuff”, but instead she was finding GTAs’ criticizing elements of the program, such as training, and that she had had enough of the criticism of the program. While a GTA’s skill and expertise was said to be valued and the contribution to the medical education was seen as invaluable, program administrators shared feeling sometimes frustrated about the attitudes of the GTAs – that they felt that they were something ‘special’, and entitled to praise over and above what was offered to others working as standardized patients within the larger clinical skills teaching program.

By sharing my story with research participants, a space was created for other GTAs to consider elements of their work that they may not have articulated aloud, particularly in the company of their fellow GTAs. I felt that such a space was crucial so that GTAs could hear the assumptions about the(ir) work, and learn from the experiences of other GTAs. The intentional act of performing “The doorknob twists” at the end of both focus groups was a gesture on my part to demonstrate my willingness to take the ‘risk’ alongside them, to share what could have been perceived as ‘unshareable’. Indeed, the sharing created such a space, as depicted in the following conversation after the performance:

Gloria: That’s exactly how it is.

Suzanne: Exactly.

Gloria: We’re nuts eh? Aren’t we crazy?

Rosemary: That would totally describe my beginning of my experiences.

Jodi: In what ways?

Rosemary: Just the whole thing, what you felt here is exactly what we’ve all felt you know. The sexual arousal, the too much lube...the everything. You try to keep the bedroom out of it but sometimes, yeah.

Jodi: It’s a presence.

Rosemary: It inserts it’s [*pause*] presence whether we want it or not. It’s there; it’s sort of the unseen guest.

Jodi: Or the unacknowledged, that isn’t a presence but is a presence.

Gloria: See I managed to separate that after.

Rosemary: I think it takes a while though to get over that feeling.

Gloria: Because we are used to things going in our vagina when we are sexually enjoying it.

Such choices within autoethnographic research work to undermine the conventions of academic writing that breeds “hierarchy and division” (Ellis & Bochner, 2006, 436), neat and tidy accounts of what is the messiness of our lives. To this end, autoethnography pulls on the conventions of deconstruction – with “its multiplicities without end ... [proliferating without apology in the] tensions between postepistemic refusals of presence and foundations and subaltern calls for a restoration of self and voice” (Lather, 2006, p. 43). Drawing on the work of Claude Levi-Strauss, the word bricoleur is used to describe a handyperson who makes use of what is available to them in any given moment. For critical researchers, the term can be used to push the boundaries of research towards new conceptual terrains, seeking insight from the margins on sources of domination, and allowing circumstance to dictate methods of action (Kincheloe & McLaren, 2005).

How does one (re)learn to live in such tentative spaces, where mastery and authority are relinquished in pursuit of research practices that work against their/our own knowing: a philosophy of knowledge that *knows it does not know*? (Lather, 2007). I suggest that driving the road ahead requires circumspect navigational moves toward/against the dominant(s), daring to defy boundaries, while mapping our complicity along the journey, driving towards a “double(d) science in order to capture the vitality of the deviations that elude taxonomies in addressing the question of practices of sciences within a postfoundational context” (Lather, 2007, p.19). These are the spaces and places in which we can endeavor to find the as not-yet (imagined) possibilities of what’s possible (Lather, 2007).

The goal of autoethnography is to open up spaces for conversations, rather than closing them down with “definitive description and analytic statements about the world

as it truly exists outside the contingencies of language and culture” (Ellis & Bochner, 2006, 435). And, my research did create such spaces as reflected in the focus group comments, and as Gloria shared with me, my having been a GTA was important for the research process as experienced by the GTAs:

I think that if you had been someone who hadn't been part of the program it might have put a different twist on it. You've been very much the fly on the wall. Not intrusive, invasive and I think by virtue of the fact that you've been through this program yourself I think adds to your sense of how not impose yourself at all in the room, you literally been working quietly on the side, listening and [laughs] I'm sure you're taking in all kinds of things. But the way you've handled the recordings situation and informing us about that. So I think it's been done in a very professional way from that perspective. But knowing that you've been part of the program, you know been there done that ... I wasn't at any point worried about you at all.

However, as discussed in Chapter Three, my familiarity with the program and the participants presented me with (un)anticipated feelings of concern with representation.

And not all GTAs were happy that I had the prior experience as a GTA, or chose to share it or the timing of my sharing.

I find, the story, your review, very negative, for a lot of reasons, like there's very little positives coming out of that at all and where as I, I find, I feel this program is a very positive thing. So, some of it's hard to take in that, ah, I feel that in that experience, you were already expecting it to go bad and I, I do a lot of quotes and why I feel that way, throughout this and that's what I'm worried about that other new SP cuz she's had so many bad experiences, like, [slight pause], see I only caught her in the second week, I wasn't there in her first week so I don't know if she was like that right from the start or if it's because of the experiences she had so maybe if all of you were like [negative] that it [the program] would end right now. So, I haven't had those experiences (Suzanne).

However, just as there is a danger when GTAs knowledge is treated as representative of all women, when their experiences are positioned as “uncontestable evidence” – whose experiences can be counted – did my story count, even if it wasn't the story others wanted to be told?:

Experience is taken as that which explains, not that which needs to be explained, thereby failing to historicize the “workings of the ideological system itself” that make different experiences possible ... claims to speak for [from] experience take as self-evident the identities of those whose experiences are being represented. In other words, when using the evidence of experience, we should keep in mind the subject positions are constituted, and not just spoken for, when experience is called on” (Murphy, 2004, p.119).

I was deeply concerned about the relationships I had with the GTAs – the relationships that (re)formed during my time with them, in very intimate spaces as a consequence of doing research differently. The research participants had let me into a space where few others in their lives would ever share with them, and where few researchers had been. I felt honored, privileged and yet burdened by the care I developed throughout my time there. This was yet another connection to my research participants – finding myself undertaking a caregiving role. I believe this is an intrinsic aspect of qualitative work that seeks to engage with participants rather than on, and in particular within ethnographic work that involves prolonged engagement over time with people who invest their ‘selves’ endeavor to produce better, more humane spaces for us to all co-exist within: alongside you in the

... friendship and fieldwork are similar endeavors. Both involve being in the work with others. To friendship and fieldwork communities, we must gain *entrée*. We negotiate roles (e.g., student, confidant, and advocate), shifting from one to another as the relational context warrants ... [As researchers] [w]e navigate membership, participating, observing, and observing our participation ... negotiating how candid we will be, how separate and how together, how stable and how in flux. One day, finite projects – and lives – come to an end, and we must “leave the field” (Tillmann-Healy, 2003, p. 732).

I intended to conduct a second focus group to follow-up with research participants, to ‘check-in’ and invite them to comment on the initial interpretations. As interpretations were made, I decided this would not be consistent with the conduct of my critical

autoethnography. However, I do wonder what conversations might have emerged had I gone forward with the second focus group. Additionally, I wonder how the sharing of my personal reflection shaped the data I ‘collected’? Different GTAs felt differently about this choice; however, I feel sharing my story demonstrated my willingness to be vulnerable with them. So as these wonderings reveal, while I have left the ‘field’, the field has not left me. So I move forward carrying the stories of my participants, revisiting the intentions of my work, haunted by a ‘real’ tension in feminist work “between giving voice and authority to our narrators and using our feminist lens and categories of understanding to try and effect positive social change” (Hesse-Biber & Leavy, 2006, p.169).

Intentions of my research

The practice of gynecology itself is speculation. Built into its very structure is a dependence on spectatorship and the speculum. But the performance of gynecology also incorporates the notion of speculation in terms of speculating the future, a speculation indebted to past and present performances. In the many performances of gynecology new futures are imagined. (Kapsalis, 1997, p. 180)

Drawing upon my own experiences as a GTA, the purpose of my research was to explore the ‘silences’ and taken-for-granted assumptions embedded within the performance of pelvic teaching with GTAs, to consider how the ‘culture’ of pelvic teaching potentially (re)produced, while simultaneously resisting, particular normative understandings about women through the transmission of various pedagogical practices, and as such, to consider how these understandings were reified practices of larger social-political and biomedical discourses. I considered what newer understandings might be gained by exploring and critically examining the broader context in which pelvic teaching

was taking place. Such an understanding was developed through an examination of my experiences as a GTA, and to consider how similar or divergent the experiences of other GTAs were from my own. The unique role we/they played in both reifying traditional medical educational practices and resisting it is of particular interest to those of us concerned with shifting the landscape of gynecological educational discourse and practice. For indeed,

Gynecology is not a sealed entity. It is leaky. Its practices and representations are indebted and productive of greater cultural attitudes about female bodies and sexualities. I have no desire to police the boundaries that lie so precariously between gynecology and other cultural forms. Rather, I wish to recognize the fluidity across boundaries and to use that discovery in order to encourage and support the creation of new performances (Kapsalis, 1997, p. 181).

While the teaching of pelvic exams is said to have important implications for medical students' future practices, the (re)positioning of women in pelvic teaching says something to us about the (re)positioning of women in a more general context. Rather than difference between GTAs and women in the community, I saw *similarities*. Not exceptional, not some kind of super women capable of transcending their embodiedness to be in service of/for others, but 'just' women – with similar vulnerabilities, and susceptibilities to being hurt, to feeling disappointed (also empowered, and connected), and wanting to feel worthwhile in their role(s). Is this a/the insight? That in spite of their commitment to the program, their own stories *also* shed some insight into what many women might be faced with when making the 'choice' to seek gynecological care – feelings of embarrassment, expectation, obligation, having to live up to conflicting notions of what it means to be an idealized 'responsible' woman/citizen?

The program, attempting to disrupt biomedical ‘business’ as usual through the use of GTAs, inadvertently reproduced the very understanding of/about women, and their health care providers, that contribute to women’s ‘reluctance’ to obtain pelvic examinations. More than (re)positioning, more than (re)dressing the body, more than (re)scripting the pelvic examination space is called for to effect new performances. To this end, performing the role of GTAs was not so unlike performing the role of ‘woman’. Teaching pelvic examinations was not outside normative discourses, but occupied an in-between-space where tensions and struggles to ‘do’ the examination ‘differently’ collide with the fact that GTAs and women alike need to be “nice” while presenting their bodies, costumed with a smile, and a well-defined cultural script, and a uniform (Kapsalis, 1997, p.76). Perhaps Gloria’s comments are the most telling:

I’ve only been to a gynecologist once and yeah, it was a while ago, well ok. I only went for a PAP or whatever once a long time ago, now I just figure I have so many [as a GTA model] that if something’s wrong somebody will pick something up along the way but I still, I don’t know, I still don’t want to go to the gynecologist. And like I’ve gone about like other issues but that didn’t require like pelvic exams or whatever and the most recent time I went the doctor said like oh do you want me to do like an exam or whatever I just like, I don’t think you need to, kind of why bother? But, yeah, I don’t know, I still have that same [concerns] like every other woman, like I’d rather have like four strange medical students do pelvic exams on me, than go to the doctor and have it done. I don’t know why.

I wonder what about the pelvic teaching space made this safe(r) for Gloria than obtaining ‘care’ from her own health care provider? Indeed, many questions remain about the possibilities within the performance of pelvic teaching. Based on my interpretations, my research invites us to consider the pelvic examination as a performative, pedagogical site underpinned by a host of personal, social, political and cultural assumptions or ‘givens’ that compete and contest to inform its teaching

methodology. Such a conceptualizing of the space raising critical questions about how normative understandings about women, in relationship with their health professionals, are reified within the education of health care professionals, and to consider the potential consequences.

The intention of my research was to present a far more complex representation of GTAs than the Pollyannaish representation often found in the biomedical education literature. Within the teaching space, GTAs performed from a far more complicated position than an altruist, self-sacrificing instruments of medical teaching. As discussed in *(Per)forming the practice(d) body*, there seemed to be frustration (on the part of both students and GTAs/facilitators (perhaps mostly the students, but then ‘guilt’ perhaps on the part of the GTAs?) when the ‘body didn’t cooperate’, wasn’t ‘normal enough’, or (pre)formed improperly, to meet the ‘needs’ of the students, that was, to see the cervix.

My research draws attention to how GTAs’ bodies and students’ bodies were both problematized as text and utilized as text. *Both*. It was not just the coming together of different forms of professional practice, but the paradoxes within each participants’ enactment of their ‘practice’/performance. In a sense, GTAs became the quintessential woman – teacher and text, learner and learned, knowledgeable but self-sacrificing, sexual but able to compartmentalize their embodied reactions to serve a higher purpose, performer and *performed on* - their roles required them to constantly and fluidly shift across and between subject positions.

Sharing my work with others

...once that journey into the other’s experience has been taken, we cannot return “home”. We can only create a new home, one furnished with the understandings of them and of ourselves that we have developed in the course of our research. Research of this type not only changes the audience, moving them from stillness

to action, it also alters where we dwell as scholars and as beings-in-the-world (Lockford, 2002, p.85).

Newer methods of inquiry necessitate new(er) modes of representation and dissemination. While I have attempted to write against ‘the grain’, having to commit my interpretations to written text has its limitations. I have had several opportunities to present various aspects of this work, and it is in that ‘live’ performative space where I have felt the impact of this particular piece of work. One time in particular, I presented some initial interpretations to an all-female group of graduate students gathered together at a doctoral intensive. Even though we were from a diverse array of backgrounds, there were such similarities in the stories I had shared, that we spent more time de-briefing the scenes I shared, than my presentation lasted. Such a space is where I see the potential for this mode of critical research. Future dissemination practices will necessitate strategies that are mindful in order to support women who hear their stories recounted through the narratives of my participants.

Closure

Every way of seeing is also a way of not seeing (Burke, 1935, p. 90)

To know now, how to end this thesis – well that was a daunting task. I know that with the passage of time, and even as I read back over what I’ve written now, “The points that are deemed most important in one time period [will] pale in relation to different points in a new era” (Kincheloe & McLaren, 2005). Indeed, if I were to return and begin again, within a different space, time and place, I can only assume how differently this story would have unfolded. For all I have learned through the literature I have read, and the interpretations I have made, I am left with many questions: (1) what does pelvic teaching look like outside the walls of a medical school, in locations where feminist

ideologies are inscribed into the very mortar of these community-based practices (personal communication, 2012) ?; (2) would the curriculum be different, differently performed, if the composition of GTAs reflected women across a range of socio-cultural locations?; (3) how might theories of embodiment add to the discussion, bringing together theories of ‘in-the-body’ with ‘on-the-body’; (4) what other discourses may be at ‘play’ in the performances of the GTA, e.g. what it means to be the ‘good worker’; (5) how were the performances different within programs that utilized one GTA performing as both model and facilitator; and (6) what would other theoretical lenses add to the discussion, specifically actor network theory and/or delving more deeply into the sociology of the body. Undoubtedly, there are many paths that could be forged based on this work.

At the end of all ‘this’, I just want you to ask yourself – from wherever you are ‘positioned’- from where were women re-claiming their bodies? Where did they go? Who took them? What experiences might happen to women, or don’t happen for that matter, that necessitated participating in a pelvic teaching program to acquire knowledge about the bodies of other women, their own bodies? Why did I find participating in the program the only space in which exploring our bodies and *other* women’s bodies was encouraged? How does the pelvic teaching program legitimize the work of women’s bodies in one context, yet (un)intentionally make liminal the work of the women’s bodies in other contexts?

Possibilities

With her elbow
she glides down my thigh.
Ever so gently
she spreads my knees –
quiet, but present,
anxious, but eager.

Her and I.

I am comforted by the nervousness
of a new medical student
approaching me
with a tentativeness, a humbleness
too soon eroded
in the process of becoming
a *knower*.

And then her fingers move over me,
in me,
parting me –
she reaches cavernous spaces
that I cannot.

And I am grateful for her patience,
her slowness,
I take pleasure in this process
no longer afraid –
there are possibilities in this space.

So my body responds.
I feel warmth –
wetness.
Her gentle motions are medicinal,
and I close my eyes
and exhale.

Afterward

Deep sigh. I'm tired. This was a tiring process: I can see it in the black under my eyes, feel it in the burning of my shoulders. The worry, and knot in my stomach, coupled with my diet of coffee and donuts has caught up with me. Five years distilled down into 269 pages. Have I done enough? Too much of this, and not enough of that? Was I convincing? (*Did I aim to be?*) Was I moving? (*Like I aimed to be*). As others before me, I feel the anxiousness of dancing outside, between, beneath and beyond the beat of the master drummer. Is this a/the toll of writing the self into the text? One is left wondering. Nights I lay awake with phrases like messy text and 'so what' rolling around in my head, ricocheting off the inside of my skull like ping pong balls. 'Dissertation anxieties' competed for time with numerous other 'to do's' – the tasks associated with parenting three young children, being a partner, and a woman abuse counselor (not to mention the friendships that have fallen by the wayside in the meantime), a novice researcher. It's a tricky 'balance', and inevitably there were points where things toppled.

Life happened anyways.

... after standing and holding the hand of my dad's broken body, watching him scream silently with sedated pain, and days of wondering if he'd ever know me again ... through a damaged throat and a lingering haze produced by an injured brain, my dad said so very slowly with a deep raspy voice "I love you too pumpkin" - it was like hearing the epitome of all that's beautiful. This, my father's nickname for me. (email, March 10, 2012)

February 28, 2012 my dad had a near fatal fall from the roof of our family home in North Bay, ON. A northern winter storm was brewing and he'd made his seasonal climb onto the roof to ensure the weight of an ice-build-up wouldn't cause a ceiling collapse in the kitchen if the anticipated amount of snow arrived. This story finds it's way into my afterward as the bulk of my writing occurred in a Critical Care Unit waiting room

surrounded by other family members sitting there filling the spaces between visits. There was a young nurse who was 'working on' my dad in the Critical Care Unit that first and second night we (my brother, mother and I) arrived to be with my dad. I was sobbing over my dad. Just sobbing. As Wendy, his nurse, flushed an IV line, she suddenly stopped, looked at me across his sedated body, and shared with me that she understood what I was feeling, as a 'daughter'. Her dad would be going for surgery the next day - he was pre-cancerous and needed his large intestine removed as a consequence – a preventative measure. The next day her dad arrested on the table, and the following day they had to make the final decision to remove his care. We were with her and her family as they too became a part of the CCU 'family'. As my brother, mother and I stood with her and her family in the hallway crying and hugging, I told her that her sharing, her moment of "being there" with me as a daughter, instead of 'only' the nurse, was a transformational moment for me in that unit. I trusted her to *care* for my dad. My trust was based on the/her/mine position of having 'been there' (thematic in my dissertation), and in this space with *this* nurse, reminded me again how the choices we make in representing others is as much an ethical choice as it is a methodological choice. I'll digress though, and for now, I will end here, "Autoethnography is ... making a text present. Demanding attention and participation. Implicating all involved. Refusing closure or categorization... Witnessing experience and testifying about power without foreclosure – of pleasure, of difference, of efficacy" (Homan Jones, 2005, p. 7650).

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Appendices

Appendix A



Letter of Information GTAs

Re: Embodied knowledges, discursive performances and pelvic teaching: A critical ethnographic study

Introduction and Purpose of the Study

Hello. My name is Jodi Hall and I am a doctoral candidate in Health and Rehabilitation Sciences – Health Professional Education Stream. From 2001-2003 I participated as a standardized patient in a pelvic teaching program. Since returning to school to pursue my PhD, I have been interested in exploring in more detail the various experiences of other standardized patients in the pelvic teaching program, and the thoughts and feelings of the medical students and program administrators that also participate in the program.

Therefore, this letter is to invite you to consider participating in a study about pelvic teaching programs using standardized patients.

Up until the 1960's pelvic teaching programs relied heavily on a combination of teaching and simulation techniques. These included plastic pelvic models, manikins, cadavours, and most controversial, anesthetised women who most often were subjected to exams by students unknowingly without providing informed consent. These approaches, which still continue today, are often characterized as unethical and ineffective. In response to these concerns, various medical schools began employing professional, standardized patients in the mid-1960s with an aim to improve the skill set and behaviors of future practitioners.

Standardized patients in pelvic teaching programs are women from the community trained to teach pelvic examinations to medical students, usually working in pairs with one performing as the patient and the other as the instructor. Yet despite becoming an integral component of the current pelvic examination teaching curriculum, and despite the growing prevalence of such teaching programs in the USA, Australia, Sweden, Great Britain and Canada research into these programs remains virtually absent. Therefore, this study intends to explore how standardized patients, medical students and program administrators view their role in pelvic teaching and what their thoughts and feelings are regarding their respective roles.

It is anticipated that the research findings will have relevance to similar standardized patient programs, and provide critical insights to be used in the programming and development of training modules within other medical education settings.

Research Procedures

As a standardized patient employed in the pelvic teaching clinical skills module, you are being invited to participate in a research study exploring how standardized patients, medical students and program administrators interact with one another in the pelvic teaching clinical skills program, and what your thoughts and feelings are regarding these various roles.

You are being asked to take part in three different types of research methods. You may consent to each method individually by indicating with a checkmark (✓) on the consent form.

(1) Participant Observation

I will be observing verbal and nonverbal expressions and interactions between and among standardized patients, medical students and program administrators. Participant observation will assist me to gain a deeper understanding of the pelvic teaching culture by observing how the various participants interact with one another. I will observe these interactions before the teaching begins, in the clinic room while the teaching occurs with the medical students, and after the teaching module has finished. Participant observation will occur throughout the duration of the pelvic teaching module this term, which is between February 2 – 26th, 2009, from approximately 8:30am – 12:30pm.

(2) Focus Groups

A focus group will be conducted with the standardized patients at the outset of the program in February and also when the program ends, in March. Each focus group will last between 1-2 hours. The purpose of the first focus group is so that I may learn about how you came to be a standardized patient and what some of your experiences have been. The second focus group will allow the group members to share with one another the thoughts, feelings and experiences you had during the teaching module.

At the end of the first focus group I will provide you with a copy of my own storied reflection of one teaching session as a point of departure for the individual interviews.

(3) Individual Interview

You are invited to participate in an individual interview once the pelvic teaching module has finished for this term. The purpose of this interview is to explore in more detail your thoughts and feelings about participating as a standardized patient. I will utilize my own storied reflection provided to you at the end of the first focus group as a possible starting point for the interview.

The interviews will take place in a location that is convenient and comfortable for you. I will collect demographic data, including your age, education, employment history, length of time involved with the program and marital status. I will use an interview guide in a flexible manner, and you may choose to answer only those questions you feel comfortable with. The interview will last approximately 1-2 hours, will be digitally recorded with your permission, and will be transcribed verbatim.

Voluntary Participation

Participation in this study is completely voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time. You may also withdraw the information collected about you during the individual interview for six months after the data has been collected without any negative consequences. Participant observation data and focus group data may not be withdrawn after it has been collected.

Please note: Your future employment within the standardized patient teaching program will not be impacted by whether or not you participate in this study.

Privacy and Confidentiality

All information is treated in a completely confidential manner. Your name will not appear in any report resulting from this study. In fact, the information you provide will be combined with information from all other participants. Focus group members are asked to keep everything they hear confidential and not to discuss it outside of the meeting. However, I cannot guarantee that confidentiality will be maintained by focus group members. Data collected during this study will be retained for 7 years in a locked office. Only researchers associated with this project will have access to the information. Representatives of The University of Western Ontario Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research. No information you share with me will be shared with your fellow standardized patients, program administrators or medical students.

Risk and Benefit of Participation in the Study

The anticipated risk to participants is extremely low. As in all research, it is possible that talking about your role as a standardized patient may bring up thoughts and feelings that you find distressing. Should this occur, we will stop the interview until you feel comfortable continuing, cease the interview all together, or re-book the interview for another time. I also have available a list of possible community resources should you wish to speak with someone further about these emotions or memories.

If you participate in any aspect of the study you will be provided with a \$40.00 honorarium at the end of your respective data collection period (i.e. at the end of the interview, focus group, or at the end of the study). If you wish to withdraw from the study at any point you will receive partial compensation of \$20.00. If you have any

questions about this study, or would prefer more information to assist you in your decision about participating, please contact me at xxx-xxx-xxxx or by email at:

You do not waive any of your legal rights by signing the consent form. If you have any comments or concerns resulting from your participation in this study, please contact the Office of Research Ethics at the University of Western Ontario by phoning xxx-xxx-xxxx or by email at:.

I look forward to speaking to you about this project and thank you in advance for your assistance. This letter is yours to keep.

Sincerely,

Jodi Hall, PhD(c)
Health and Rehabilitation Program
Faculty of Health Sciences

CONSENT FORM STANDARDIZED PATIENTS

Participation Consent Form

Topic: Embodied knowledges, discursive performances and pelvic teaching: A critical ethnographic study

I have read the letter of information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction. I consent to participate in the following:

- (1) Participant Observation _____
- (2) Focus Groups _____
- (3) Individual Interviews _____

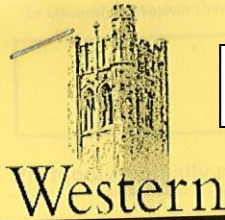
Participant Name: _____ (please print)

Participant Signature: _____

Person obtaining consent : _____ (please print)

Person obtaining consent signature: _____

Date: _____



Office of Research Ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. H. Berman

Review Number: 16818E

Review Date: January 27, 2010

Review Level: Expedited

Approved Local # of Participants: 49

Protocol Title: Embodied knowledges, discursive performances and pelvic teaching: A critical ethnographic study

Department and Institution: Nursing, University of Western Ontario

Sponsor:

Ethics Approval Date: January 29, 2010

Expiry Date: August 31, 2010

Documents Reviewed and Approved: UWO Protocol, Letter of Information and Consent (standard patient), Letter of Information and Consent (medical student), Letter of Information and Consent (program admin).

Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

- a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- b) all adverse and unexpected experiences or events that are both serious and unexpected;
- c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

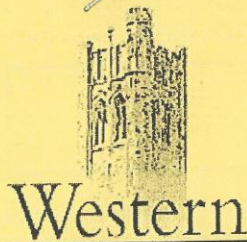
Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert
FDA Ref. #: IRB 0000940

Ethics Officer to Contact for Further Information

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cc: ORE File



Office of Research Ethics

Use of Human Subjects - Ethics Approval Notice

Principal Investigator: Dr. H. Berman

Review Level: Expedited

Review Number: 16818E

Revision Number: 1

Review Date: March 05, 2010

Approved Local # of Participants: 55

Protocol Title: Embodied knowledges, discursive performances and pelvic teaching: A critical ethnographic study

Department and Institution: Nursing, University of Western Ontario

Sponsor:

Ethics Approval Date: March 10, 2010

Expiry Date: August 31, 2010

Documents Reviewed and Approved: Revised study instruments, study design, participant recruitment, number of study participants and eligibility of subjects. Demographics Information Sheet, Interview Guide for clinical instructors and Letter of Information and Consent for Clinical Instructors.

Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

- a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- b) all adverse and unexpected experiences or events that are both serious and unexpected;
- c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Joseph Gilbert
FDA Ref. #: IRB 00000940

Ethics Officer to Contact for Further Information

This is an official document. Please retain the original in your files.

Appendix D

Focus Group Interview Guide

At the start of the focus group interview, questions about the study will be addressed, a Letter of Information will be given to each participant and written Informed Consent will be obtained where possible. Issues of unique importance to focus groups will be covered, such as the limits of confidentiality and anonymity.

INTRODUCTION

I am interested in hearing your thoughts and feelings about your role performing as standardized patients within the pelvic teaching program. Perhaps you can begin by each telling me your name and how long you have been involved with the pelvic teaching program.

1. Can you share with me the process of becoming a standardized patient? (recruitment, intake, training)

- Are there issues that you felt you could have used more instruction around prior to starting as a standardized patient?
- What was the most useful part of your training experience?

Can you tell me about your experiences working with the medical students who come through the pelvic teaching program?

Are there shifts that you notice in the students' thoughts and feelings prior to the examination and then after the examination?

Can you tell me about the relationships between standardized patients?

- What makes for a good teaching partnership?
- What are some of the challenges?

Can you describe a scenario to me where the importance the relationship between you and your teaching partner was essential?

Generally speaking, can you tell me about the treatment you receive from the medical students?

Can you share with me an experience in which you didn't feel comfortable during an examination (either physically or emotionally)?

- How did you or your partner handle the situation?
- Did you share the experience with the other standardized patients? With program administrators? Why or why not?

What do you think are the greatest benefits of the pelvic teaching program?

Appendix E

Interview Guide for GTAs

This interview guide will be used in a dialogic fashion and will be directed by the flow of conversation between the participant and myself. Prior to the start of interviews, all participants will receive a Letter of Information and be given the opportunity to ask any questions. After questions are answered to their satisfaction, the women will give written Informed Consent.

INTRODUCTION

I am interested in hearing your thoughts and feelings about your role performing as a standardized patient within the pelvic teaching program. You are welcome to begin where you like, for instance with your reflections on my own narrative that I provided you with, or I can get us started with some questions that I would be interested in exploring with you.

- 1) Can you tell me how you first became involved with the pelvic teaching program?
- 2) Can you tell me what your experiences have been like working with the other standardized patients?
- 3) Can you tell me what your experiences have been like working with the medical students?
- 4) Can you walk me through the process of being recruited and trained to perform as a standardized patient?
 - what sorts of training materials were involved?
 - how long in duration was the training?
 - how were the goals of the program explained to you?
- 5) Can you walk me through a typical day that you have a training session, from when you arrive, to when you leave?
 - are there any rituals you undertake to prepare yourself emotionally or physically for teaching? Prior to arriving, during the teaching session, or afterwards?
- 6) Thinking back to before you started performing as a standardized patient, can you tell me about your own experiences seeking gynecological care?
- 7) Have those experiences shifted since being involved with the program? If so, how?
- 8) Can you share with me some of the initial thoughts or feelings you had prior to beginning as a standardized patient?
- 9) Have your thoughts about being involved in the program shifted over time? If so, how?

10) Can you tell me how friends, family or others in your life have responded to your role as a standardized patient?

11) Can you tell me how you think this program contributes to the medical students' learning experience?

As you read in my own narrative, sometimes our experience with medical students can be filled with mixed thoughts, feelings & reactions, positive and negative experiences:

11) Can you share with me an experience working with a medical student that you felt wasn't optimal or an experience where you left with negative thoughts and feelings?

- Did you share these thoughts with the other women standardized patients? Did you share these feelings with the program administrator(s)?
- What were their responses like?
- Have there been experiences with the other standardized patients that haven't been what you would have hoped for (for instance, do you feel that there are enough opportunities to share?)

12) Can you tell me about the experiences with the students that you generally find most rewarding?

13) What do you think are the most important aspects of the standardized patient pelvic teaching training program?

- For yourself?
- For women in general?

14) If you had the opportunity to make changes to the current program, what might they be?

Appendix F

Demographic Information Sheet

Code: _____

What is your age? _____

Gender: _____

Would you identify yourself as:

Asian ___ South Asian (e.g. East Indian, Pakistani) ___ Black ___ Filipino ___
 Latin American ___ Arab ___ West Asian (e.g. Iranian, Afghan) ___ Korean ___
 Japanese ___ Caucasian ___ Other (please specify) ___

What is your current marital status? _____

Married ___

Separated ___

Divorced ___

Other ___

What role do you play in the pelvic teaching program:

- a) standardized patient
- b) medical student
- c) program administrator

Highest level of education: (circle highest level completed)\

- a) Primary School 1 2 3 4 5 6 7 8
- b) Secondary School 9 10 11 12 13
- c) Post-Secondary 1 2 3 4 5 6 7 8
- d) Other _____

Employment Status:

- a) Full time (30 hours or more per week)
- b) Part time
- c) Unemployed
- c) Other (e.g. casual, contract) _____

If employed, what is your profession?: _____

Appendix G

Interview Guide for Medical Students

This interview guide will be used in a dialogic fashion and will be directed by the flow of conversation between the participant and myself. Prior to the start of interviews, all participants will receive a Letter of Information and be given the opportunity to ask any questions. After questions are answered to their satisfaction, the participants will give written Informed Consent.

Prior to examination

INTRODUCTION

I am interested in hearing your thoughts and feelings about your role learning to perform your first pelvic exam within the pelvic teaching program. You are welcome to begin where you like, for instance your reasons for wanting to become a physician, or I can begin by asking you some of the questions I have prepared.

- 1) Can you tell me how you were prepared to conduct this examination?
 - what sorts of training materials were involved?
 - how long in duration was the training?
 - how were the goals of the program explained to you?
- 2) Have you ever performed a pelvic examination before?
- 3) As you're getting ready to perform the examination, what are your thoughts and feelings at this moment?
- 4) Can you tell me what your first thoughts/feelings were when you found out that you would be performing a pelvic examination this term?
- 5) How do you think your classmates are feeling? Have you been talking amongst yourself about today?
- 6) What do you think are the biggest concerns with learning to perform a pelvic exam?
- 7) Why do you think it is important to learn how to perform pelvic examinations with standardized patients?
- 8) What is your understanding of the role of the standardized patient within the pelvic teaching session?

After examination

- 1) Can you tell me how you are feeling now that you have completed the examination?
- 2) Can you tell me what your experiences were like working with the standardized patients?
- 3) What were some of your thoughts and feelings as you were going through the examination?
- 4) Can you tell me how you think this program contributes to your learning as a medical student?
- 5) What do you think are the most important aspects of the standardized patient pelvic teaching training program?
- 6) What did you find most surprising about learning to conduct the pelvic examination with the standardized patients?
- 7) Based on your own experiences, if you had the opportunity to make changes to the current program, what might they be?

Appendix H



Letter of Information Medical Students

Re: Embodied knowledges, discursive performances and pelvic teaching: A critical ethnographic study

Introduction and Purpose of the Study

Hello. My name is Jodi Hall and I am a doctoral candidate in Health and Rehabilitation Sciences – Health Professional Education Stream. From 2001-2003 I participated as a standardized patient in a pelvic teaching program. Since returning to school to pursue my PhD, I have been interested in exploring in more detail the various experiences of other standardized patients in the pelvic teaching program, and the thoughts and feelings of the medical students and program administrators that also participate in the program.

Therefore, this letter is to invite you to consider participating in a study about pelvic teaching programs using standardized patients.

Up until the 1960's pelvic teaching programs relied heavily on a combination of teaching and simulation techniques. These included plastic pelvic models, manikins, cadavours, and most controversial, anesthetised women who most often were subjected to exams by students unknowingly without providing informed consent. These approaches, which still continue today, are often characterized as unethical and ineffective. In response to these concerns, various medical schools began employing professional, standardized patients in the mid-1960s with an aim to improve the skill set and behaviors of future practitioners.

Standardized patients in pelvic teaching programs are women from the community trained to teach pelvic examinations to medical students, usually working in pairs with one performing as the patient and the other as the instructor. Yet despite becoming an integral component of the current pelvic examination teaching curriculum, and despite the growing prevalence of such teaching programs in the USA, Australia, Sweden, Great Britain and Canada research into these programs remains virtually absent. Therefore, this study intends to explore how standardized patients, medical students and program administrators view their role in pelvic teaching and what their thoughts and feelings are regarding their respective roles.

It is anticipated that the research findings will have relevance to similar standardized patient programs, and provide critical insights to be used in the programming and development of training modules within other medical education settings.

Research Procedures

As a second year medical student enrolled in the pelvic teaching clinical skills module this term, you are being invited to participate in a research study exploring the interactions between standardized patients, program administrators and medical students. You are being invited to participate in two different data collection methods. You may indicate your consent to participate by making a checkmark (✓) on the consent form next to the method(s) to which you are agreeing.

(1) Participant Observation

I will be observing verbal and nonverbal expressions and interactions between and among standardized patients, medical students and program administrators. Participant observation will assist me to gain a deeper understanding of the pelvic teaching culture by observing how the various participants interact with one another. I will observe these interactions before the teaching begins, in the clinic room while the teaching occurs between yourself and the standardized patient, and after the teaching module has finished. Participant observation will occur once you have signed the consent form and will continue until your teaching session has concluded and you exit the clinical skills teaching building.

(2) Interviews

For feasibility, interviews will be conducted in groups of two prior to and just after the pelvic teaching session with the standardized patients. Each interview will last approximately 15 minutes, will be digitally recorded with your permission, and will be transcribed verbatim. The purpose of these brief interviews is to capture your immediate thoughts and feelings before and after your first experience learning a pelvic examination. You are also invited to meet with me for a separate interview, which would allow for greater anonymity and confidentiality.

Students are being purposefully chosen based on a variety of factors, such as: age, gender and race, to maximize the possibility for variation within the research sample.

Voluntary Participation

Participation in this study is completely voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time. You may also withdraw the information collected about you for six months after the data has been collected without any negative consequences. You may also withdraw the information collected about you during the individual interview for six months after the data has been collected without any negative consequences. Participant observation may not be withdrawn after it

has been collected. Whether or not you participate in this study, there will be no impact on your course grades.

Privacy and Confidentiality

All information is treated in a completely confidential manner. Your name will not appear in any report resulting from this study. In fact, the information you provide will be combined with information from all other participants. Co-participants are asked to keep everything they hear confidential (as you are being co-interviewed) and not to discuss it outside of the interview with others. However, I cannot guarantee that confidentiality will be maintained by a co-participant. Data collected during this study will be retained for 7 years in a locked office. Only researchers associated with this project will have access to the information.

No information you share with me will be shared with fellow students, standardized patients, your clinical instructors or program administrators except where required by law.

Risk and Benefit of Participation in the Study

There is no anticipated risk to you for having participated in this study. Additionally, your participation may contribute to a greater understanding of the purposes, benefits and challenges you experience as a medical student in learning to perform pelvic examination within a pelvic teaching utilizing standardized patients.

You will receive \$10.00 as an honorarium in appreciation for your time, which will be provided at the start of data collection. If you wish to withdraw from the study will receive partial compensation of \$5.00. If you have any questions about this study, or would prefer more information to assist you in your decision about participating, please contact me at xxx-xxx-xxxx or by email at:

You do not waive any of your legal rights by signing the consent form. If you have any comments or concerns resulting from your participation in this study, please contact the Office of Research Ethics at the University of Western Ontario by phoning xxx-xxx-xxxx or by email:

I look forward to speaking to you about this project and thank you in advance for your assistance. This letter is yours to keep.

Sincerely,

Jodi Hall, PhD(c)
Health and Rehabilitation Program
Faculty of Health Sciences

CONSENT FORM MEDICAL STUDENTS

Research Participation Consent Form

Topic: Embodied knowledges, discursive performances and pelvic teaching: A critical ethnographic study

I have read the letter of information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction. I consent to the participate in the following:

- (1) Participant Observation _____
- (2) Pre and Post session Interview _____

Participant Name: _____(please print)

Participant Signature: _____

Person obtaining consent : _____(please print)

Person obtaining consent signature: _____

Date: _____

Appendix I

Interview Guide for Program Administrators

This interview guide will be used in a dialogic fashion and will be directed by the flow of conversation between the participant and myself. Prior to the start of interviews, all participants will receive a Letter of Information and be given the opportunity to ask any questions. After questions are answered to their satisfaction, the participants will give written Informed Consent.

INTRODUCTION

I am interested in hearing your thoughts and feelings about the purpose, goals, challenges and successes you have experiences in your role as a [insert role] You are welcome to begin where you like, for instance how you came to be involved with the pelvic teaching program, or I can get us started with some questions that I would be interested in exploring with you.

- 1) Can you tell me how you first became involved with the pelvic teaching program?
- 2) Can you tell me what your experiences have been like working with the standardized patients and the medical students?
- 3) Can you walk me through the process of recruiting and training standardized patients to perform in the pelvic teaching program:
 - what sorts of training materials are involved?
 - how long in duration is the training?
- 4) Have your thoughts about being involved in the program shifted over time? If so, how?
- 5) What makes for a good standardized patient in the pelvic teaching program?
- 6) Can you tell me how you think this program contributes to the medical students' learning experience?
- 7) Can you share with me an experience a standardized patient had working with a medical student that they felt wasn't optimal? How was the situation managed?
- 8) What do you think are the most important aspects of the standardized patient pelvic teaching training program?
 - For yourself?
 - For women in general?
- 9) If you had the opportunity to make changes to the current program, what might they be?

Appendix J



Letter of Information Program Administrators

Re: Embodied knowledges, discursive performances and pelvic teaching: A critical ethnographic study

Introduction and Purpose of the Study

Hello. My name is Jodi Hall and I am a doctoral candidate in Health and Rehabilitation Sciences –Health Professional Education Stream. From 2001-2003 I participated as a standardized patient in a pelvic teaching program. Since returning to school to pursue my PhD, I have been interested in exploring in more detail the various experiences of other standardized patients in the pelvic teaching program, and the thoughts and feelings of the medical students and program administrators that also participate in the program.

Therefore, this letter is to invite you to consider participating in a study about pelvic teaching programs using standardized patients.

Up until the 1960's pelvic teaching programs relied heavily on a combination of teaching and simulation techniques. These included plastic pelvic models, manikins, cadavours, and most controversial, anesthetised women who most often were subjected to exams by students unknowingly without providing informed consent. These approaches, which still continue today, are often characterized as unethical and ineffective. In response to these concerns, various medical schools began employing professional, standardized patients in the mid-1960s with an aim to improve the skill set and behaviors of future practitioners.

Standardized patients in pelvic teaching programs are women from the community trained to teach pelvic examinations to medical students, usually working in pairs with one performing as the patient and the other as the instructor. Yet despite becoming an integral component of the current pelvic examination teaching curriculum, and despite the growing prevalence of such teaching programs in the USA, Australia, Sweden, Great Britain and Canada research into these programs remains virtually absent. Therefore, this study intends to explore how standardized patients, medical students and program administrators view their role in pelvic teaching and what their thoughts and feelings are regarding their respective roles.

It is anticipated that the research findings will have relevance to similar standardized patient programs, and provide critical insights to be used in the programming and development of training modules within other medical education settings.

Research Procedures

As a program administrator, you are being invited to participate in two different data collection methods. You may indicate your consent to participate by making a checkmark (✓) on the consent form next to the method(s) to which you are agreeing.

(1) Participant Observation

I will be observing verbal and nonverbal expressions and interactions between and among standardized patients, medical students and program administrators. Participant observation will assist me to gain a deeper understanding of the pelvic teaching culture by observing how the various participants interact with one another. I will observe these interactions before the teaching begins, in the clinic room while the teaching occurs between yourself and the standardized patient, and after the teaching module has finished. Participant observation will occur once you have signed the consent form and will continue for the duration of your involvement in the module.

(2) Interview

You are being invited to participate in an individual interview about your experiences in the pelvic teaching clinical skills module. I will follow an interview guide, which will be used with flexibility. This interview will take place at a location of your choosing during a time that is convenient for you. Each interview will last approximately 1 hour, will be digitally recorded with your permission, and will be transcribed verbatim. The purpose of this interview is to gather your perspectives on the purposes of the program, the benefits and potential challenges.

Voluntary Participation

Participation in this study is completely voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time. You may also withdraw the information collected about you for six months after the data has been collected without any negative consequences.

Privacy and Confidentiality

All information is treated in a completely confidential manner. Your name will not appear in any report resulting from this study. In fact, the information you provide will be combined with information from all other participants. Data collected during this study will be retained for 7 years in a locked office. Only researchers associated with this project will have access to the information.

Risk and Benefit of Participation in the Study

The anticipated risk to participants is extremely low. Additionally, your participation may contribute to a greater understanding of the purposes, benefits and challenges you experience as a program administrator of the pelvic teaching clinical skills module.

If you have any questions about this study, or would prefer more information to assist you in your decision about participating, please contact me at xxx-xxx-xxxx, or by email at:

You do not waive any of your legal rights by signing the consent form. If you have any comments or concerns resulting from your participation in this study, please contact the Office of Research Ethics at the University of Western Ontario by phoning xxx-xxx-xxxx or by email at:

I look forward to speaking to you about this project and thank you in advance for your assistance. This letter is yours to keep.

Sincerely,

Jodi Hall, PhD(c)
Health and Rehabilitation Program
Faculty of Health Sciences

CONSENT FORM PROGRAM ADMINISTRATORS

Research Participation Consent Form

Topic: Embodied knowledges, discursive performances and pelvic teaching: A critical ethnographic study

I have read the letter of information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

(1) Participant Observation _____

(2) Interview _____

Participant Name: _____(please print)

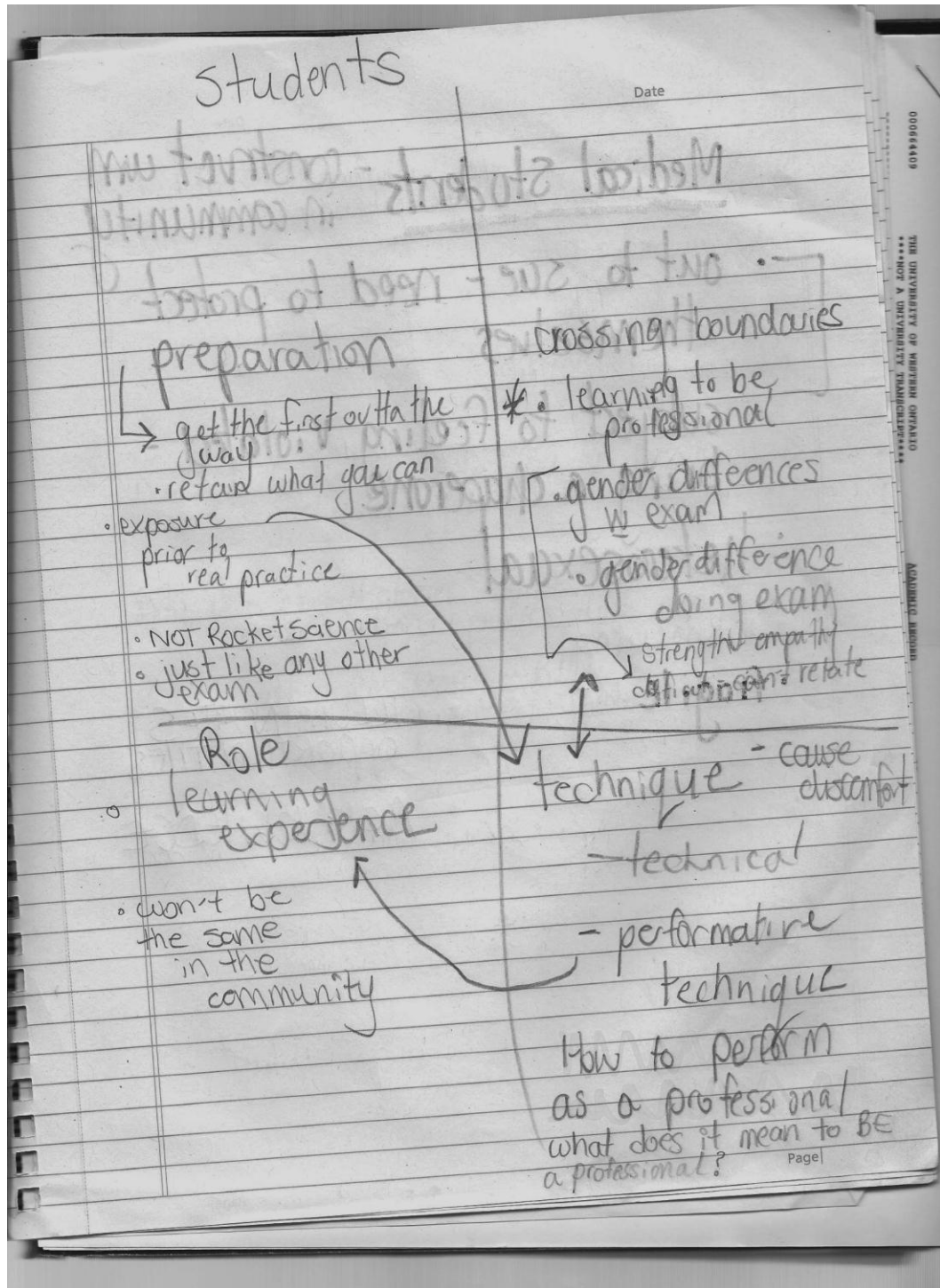
Participant Signature: _____

Person obtaining consent : _____(please print)

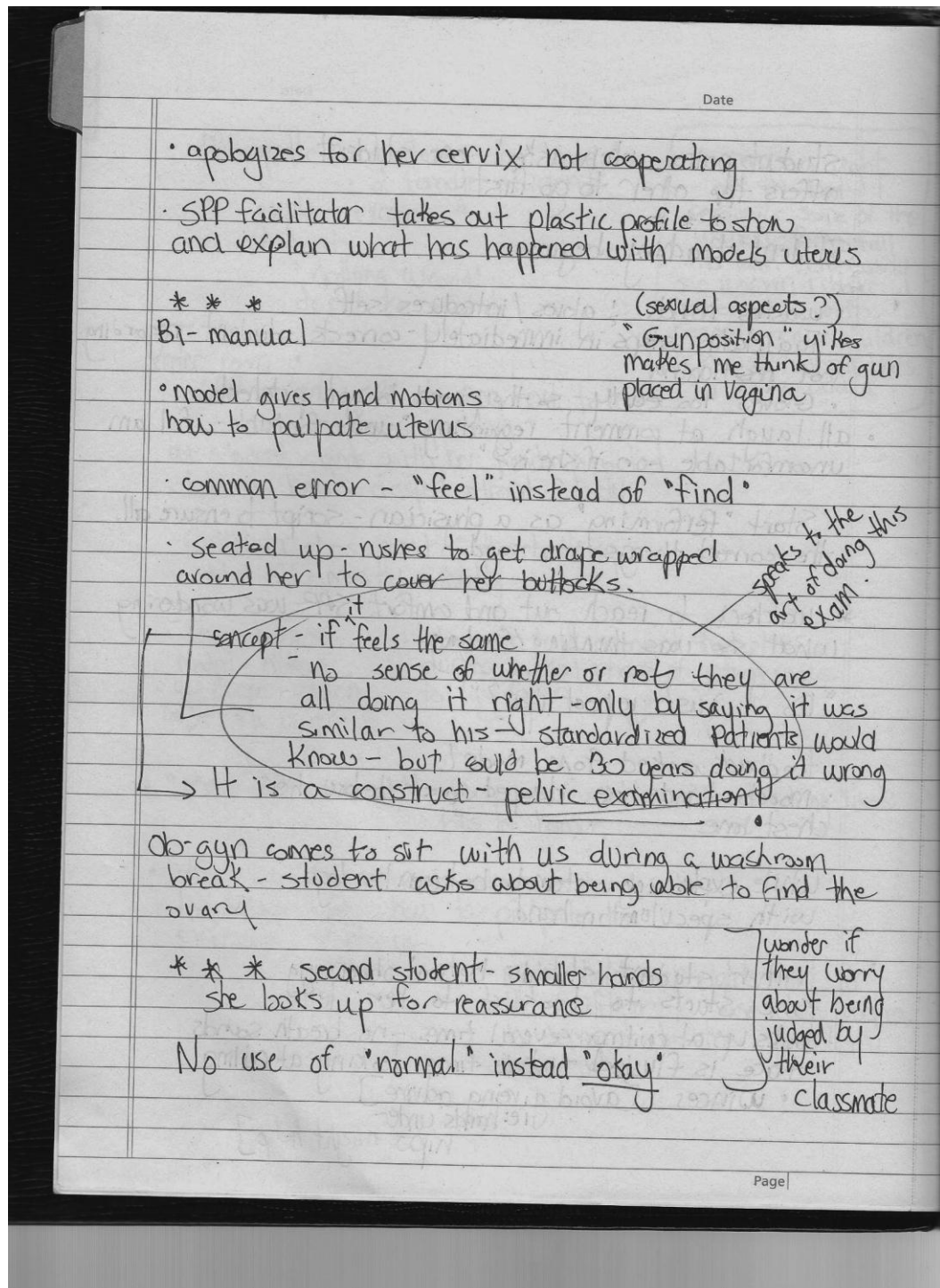
Person obtaining consent signature: _____

Date: _____

Appendix K



Appendix L



Curriculum Vitae

Name:	Jodi. C. Hall
Post-secondary Education and Degrees:	Western University London, Ontario, Canada 1993-1994, B.A. Combined Honors Sociology and Women's Studies Doctoral candidate Health Professional Education Health and Rehabilitation Sciences The University of Western Ontario
Awards	1997 Gold Medal Highest academic achievement (Women's Studies and Sociology) 2009 Alzheimer's Society/Canadian Institutes for Health Research trainee award (\$5000) 2010 Interdisciplinary Professional Education Team Development Grant (\$1500), Interdisciplinary Network for Scholarship in Professions' Research in Education (INSPiRE) 2010 International Doctoral Institute: Researching Professional Practice, Charles Stuart University, Wagga, Wagga, Australia, December 6-10, 2010
Related Teaching Experience	2007 Health Promotion 306a, Teaching Assistant, Winter term, 2008 2011 Health Service Delivery in Rural and Remote Communities 3011b, Teaching Assistant, Winter term 2011

Publications

Peer Reviewed – Journal Publications

1. **Hall, J., & Donelle, L.** (2008) Researching women serving court mandated probation or parole orders. *Canadian Journal of Nursing Research*, 41(2), 37-53.

2. **DeForge, R., van Wyk, P. Hall, J. & Salmoni, A.** (2010). Afraid to care; unable to care: A critical ethnography within a long-term care home. *Journal of Aging Studies, 24*, 415-426.
3. **Ward-Griffin, C., Hall, J., DeForge, R., St-Amant, O., McWilliam, C., Oudshoorn, A., Forbes, D., & Kloseek, M.** (2012). Dementia home care resources: How are we managing? *Journal of Aging Research*, 11 pages. doi:10.1155/2012/590724
4. **Donelle, L. & Hall, J.** (2011). A pilot investigation of health literacy and health promotion with women in conflict with the law. *Social Work and Health*
5. **St-Amant, O., Ward-Griffin, C., DeForge, R., McWilliam, C., Forbes, D., Kloseek, M., & Hall, J.** (2012). Making care decisions in home-based dementia care: Why context matters. *Canadian Journal on Aging, 31*(4).

Accepted

1. **Hall, J.** (forthcoming). Body/Practice: The Body in Professional Practice, Learning and Education, edited by Bill Green & Nick Hopwood: Springer Publishing Company.

Under review

1. **Benbow, S., Hall, J., Heard, K., & Donelle, L.** (under review). "...and I will need your straw back": Researchers experiences of data collection in an incarcerated setting with criminalized women. *Canadian Journal of Nursing Research*.
2. **Carranza, L. Alzoubi, F., & Hall, J.** (under review). I cried all the way home: Emotional labor and the experiences of emergent researchers conducting interviews with women survivors of trauma. *Qualitative Sociological Review*.

Peer Reviewed Papers Presented at Conferences

1. **Hall, J.** And then I was pregnant. Western Research Forum, Western University, Ontario, London, Ontario, March 2008.
2. **Hall, J.** More than meets the eye?: (Re) conceptualizing the use of standardized patients within pelvic teaching programs. Oral Presentation (First place award winner – Oral presentation) Western Research Forum, Western University, London Ontario, February 2009.
3. **Hall, J., & DeForge, R.** Muddying the waters: The complexities of engaging with/in relational critical reflexivity (Roundtable). Engaging Reflection Conference, London, Ontario, May 2009.

4. **Bickford, J., Hall, J., & DeForge, R.** (2009) Reflections on relational scholarship: Negotiating the complexities with/in a group of seven doctoral students (Roundtable). Engaging Reflection Conference, London, Ontario, May 2009.
5. **DeForge, R., & Hall, J.** Muddying the waters: The complexities of engaging with/in relational critical reflexivity. 15th Annual Health Research Conference. International Institute for Qualitative Methodology, Vancouver, British Columbia, October 2009.
6. **Ward-Griffin, C., McWilliam, C., Forbes, D., St-Amant, O, Hall, J, DeForge, R., Oudshoorn, A., Kloosek, M., Bol, N., Mowat, J.** Resource management in dementia homecare: Merging divergent perspectives. *Canadian Association on Gerontology 39th Annual Scientific & Education Meeting*. Winnipeg, Manitoba, October 2009.
7. **DeForge, R. & Hall, J.** "Dictribing": Our experiences in using voice-recognition software in dictating our qualitative data transcriptions and analysis. 5th Annual Health and Rehabilitation Sciences Graduate Research Forum, Western University. London, Ontario. February, 2010.
8. **DeForge, R. & Hall, J.** "Dictribing": Our experiences in using voice-recognition software in dictating our qualitative data transcriptions and analysis. Western Research Forum, London, Ontario. February, 2010.
9. **Shaw, J., DeForge, R., & Hall, J.** From Solid Boxes to Fluid Bricolage: Paradigm Proliferation in Mixed Methods Research. The 27th Annual Qualitative Analysis Conference: Social Pragmatism as a Conceptual Foundation. Wilfred Laurier University, May 2010.
10. **Hall, J.** Supporting women survivors of abuse during the transition to mothering within a primary health care setting, 20th IUHPE World Conference, International Union for Health Promotion and Education, Workshop, Geneva, July 2010.
11. **Alvernaz Mulcahy, G. & Hall, J.** Seeing, Listening and Speaking Through Our Stories: Preparing For the Feminist Research Interview With Trauma Survivors, Symposium - The Transition to Motherhood in the Aftermath of Trauma: Research Ethics, Issues, and Conundrums, The CIHR Institute of Gender and Health presents: *Innovations in Gender, Sex, and Health Research: Every Cell is Sexed, Every Person is Gendered*, Toronto, Ontario, November 22-23, 2010
12. **Hall, J.** Practice(d) Bodies, The 28th Annual Qualitative Analysis Conference: Contemporary Issues in Qualitative Research, Brantford, Ontario, May 2011.
13. **Carranza, L, Hall, J., & Alzoubi, F.** "I don't feel I'm alone no more": Lessons

learned conducting interviews with pregnant & parenting women survivors of trauma, The 28th Annual Qualitative Analysis Conference: Contemporary Issues in Qualitative Research, Brantford Ontario, May 2011.

14. **Hall, J., Donelle, L. Benbow, S., & Heard, K.** "... and I will need your straw back": Researchers' experiences of data collection with women offenders in an incarcerated setting, The 28th Annual Qualitative Analysis Conference: Contemporary Issues in Qualitative Research, Brantford Ontario, May 2011.
15. **Hall, J. & Donelle, L.** Body Mapping: An emergent arts-based method. The 28th Annual Qualitative Analysis Conference: Contemporary Issues in Qualitative Research, Brantford Ontario, May 2011.
16. **Berman, H., Mason, R., Carranza, L., Classen, C., Evans, M., Hall, J., Mulcahy, G., Rodger, S., & Ross, L., & Al-Zoubi, F.** The Transition to Motherhood in the Aftermath of Childhood Sexual Abuse. Paper presentation at the 18th Conference of the Nursing Network on Violence against Women International. Charlottesville, Virginia. March 4-6, 2012.

Peer Reviewed Poster Presentations

1. **Hall, J.** And then I was pregnant (First place award winner, Proposal and Literature Search Category), Health and Rehabilitation Sciences Research Forum, The University of Western Ontario, London, Ontario, March, 2008.
2. **DeForge, R., & Hall, J.** The place for autoethnography in the evaluation of knowledge translation. *Annual NICE (National Initiative for the Care of the Elderly) Knowledge Exchange*, Toronto, Ontario, May, 2009.
3. **Hall, J., & DeForge, R.** Storied methods of our negotiations of selves in the practice of "relational critical reflexivity". *Advances in Qualitative Methods*. International Institute for Qualitative Methodology, Vancouver, British Columbia, October 2009.
4. **DeForge, R., Hall, J., Szudy, N., Bickford, J., Lencuch, R., Shaw, J., & Cullion, C.** This is not a poster: It's a hypertextual re-presentation of relational critical reflexivity. *Advances in Qualitative Methods*. International Institute for Qualitative Methodology, Vancouver, British Columbia, October 2009.
5. **Hall, J., DeForge, R., van Wyk, P., & Salmoni, A.** Afraid to care; unable to care: a critical long-term care home ethnography. *Annual NICE (National Initiative for the Care of the Elderly) Knowledge Exchange*, Toronto, Ontario, June 2010.

6. **Donelle, L. & Hall, J.** Health promotion and health literacy of women in conflict with the law: A pilot study. 20th IUHPE World Conference, International Union for Health Promotion and Education, Workshop, Geneva, July 2010
7. **Donelle, L. & Hall, J.** Body Mapping with Incarcerated Women, 3rd Annual Health Literacy Research Conference, Chicago, Illinois, Oct. 2011

Research and Investigation

Principle Investigator's Name Appears in Bold

1. A pilot study of health promotion and health literacy of women offenders. **Donelle, L.**, Hall, J., & Haleem, F.: The University of Western Ontario. SSHRC, (January 2008), Graduate Research Assistant.
2. Embodied trauma: The impacts of trauma on women's transition to mothering. **Berman, H., & Mason, R.**: The University of Western Ontario and Women's College Hospital, Toronto On, Canadian Institute of Health Research, (September 2008), Research Coordinator.
3. Examining the Adequacy of Community Mental Health Services In Meeting the Needs of Aging Londoners Prior to Entry into Long Term Care Homes. **Salmoni, A.**, Hall, J., DeForge, R., vWyk, P., & Sogbesan, F.: The University of Western Ontario and The City of London, The City of London (50,000 July 2009), Graduate Research Assistant.
4. An Investigation of Health Promotion and Health Literacy with Women in Conflict with the Law. **Donelle, L. & Hall, J.** The University of Western Ontario. " Internal SSHCR, (September 2009), Graduate Research Assistant.
5. An Investigation of Health Promotion and Health Literacy with Women in Conflict with the Law: A pilot study. **Donelle, L. & Hall, J.** The University of Western Ontario. Internal SSHCR, (September 2009), Graduate Research Assistant.
6. Client-Caregiver-Provider Relationships in Home-Based Dementia Care: A Critical Analysis. **Ward-Griffith, C., et al.**, Canadian Institute of Health Research Traineeship.

Presentations

Invited Speaker/ Workshop Facilitator– National and International Conferences

1. National Summit for Ensuring the Rights of Pregnant and Birthing Women, Atlanta, Georgia, January 2007. *How can we ensure the health and humanity of*

pregnant and birthing women when violence is so pervasive in the lives of women? Panel presentation Hall, J.

2. Celebrating the Health of Our Children, Families and Communities, Canadian Prenatal Nutrition Program's Provincial Conference, Vancouver, BC, April 2007. *A Safe Passage: Supporting Women Survivors of Abuse through the Childbearing Years.* Workshop facilitator Hall, J.
3. Sensitive Midwifery Symposium, Pretoria, South Africa, May 2009. *Negotiating the transition to mothering within the context of birth trauma: Support strategies for care providers,* Key Note Hall, J.
4. Sensitive Midwifery Symposium, Cape Town, South Africa, June 2009. *Negotiating the transition to mothering within the context of birth trauma: Support strategies for care providers,* Key Note Hall, J.
5. Perinatal Challenges and Opportunities: Childbirth and Postpartum in Canada, Childbirth and Postpartum Professional Association Annual Conference, November 13-14, Toronto, On. *How the impacts of abuse shape the experiences of women during the transition to mothering,* Key Note Hall, J.
6. Best Start Resource Centre: 2010 Annual Conference, February 2010, Toronto, ON. *Creating Safer Space for Women Who Have Experienced Trauma as They Transition to Mothering.* Workshop facilitator Hall, J.

Scholarly Activities

Co-editor, *Auto-ethnography in health and social care* ed. Sense: The Netherlands.

Professional Affiliations

Member Scholar - International Institute for Qualitative Methodology, University of Alberta

Invited Peer Reviewer - Manuscript

1. Forum Qualitative Social Research Winter 2011

Abstract Reviewer – Peer Reviewed Journal

1. Engaging Reflection through the Arts in Health and Social Care, special edition of Reflective Practice: International and Multidisciplinary Perspectives

Abstract Reviewer – Peer Reviewed Conference

1. Abstract Reviewer, Engaging Reflection in Health Professional Education and Practice International Conference, May 2009, London ON.

Invited Lecturer

1. Feminist Philosophies, Philosophical Foundations Methodologies Round, Health and Rehabilitations Sciences, The University of Western Ontario February 2009
2. Fanshawe College Ontario School of Naturapathic Medicine, “Supporting women survivors of abuse”, Staff: Rebecca Liston
3. Health Communication, “The use of newer technologies in the promotion of health” December 2009, Professor Lorie Donelle
4. Fanshawe College Ontario School of Naturopathic Medicine, Screening for Abuse in the Childbearing Year, Staff: Rebecca Liston
5. Foundations of Feminist Research and Practice, Philosophical Foundations Advanced Methods Round, Health and Rehabilitation Sciences, Western University. London, Ontario, February 2010, Professor Anne Kinsella