Chapter 12
(Per)forming the Practice(d) Body: Gynecological Teaching Associates in Medical Education

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> *Now you will notice one of the things they emphasized in the pelvic teaching 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 (Gynecological Teaching Associate, speaking to medical students – pelvic teaching module)*

Background

This chapter is based on excerpts from my doctoral research, which utilized an autoethnographic methodology to critically explore the taken-for-granted assumptions embedded in the performances of Gynecological Teaching Associates (GTA) in pelvic teaching within medical education (Hall 2012). Gynecological Teaching Associates (referred elsewhere in the literature as professional patients) 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, sometimes working alone, otherwise in pairs, with one GTA performing as the 'patient', while the other facilitates the teaching session (Pickard et al. 2003; Siwe et al. 2006). Theoretically informed by (post)critical feminist theories, my research broadly considered how the 'culture' of pelvic teaching, as enacted within this specific teaching setting, (re)produced particular normative discourses about women (while simultaneously resisting such

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discourses), and how the performances of GTAs, medical students and program administrators reified larger social-political and biomedical discourses.

I situate my research within the growing body of work that critically examines the processes implicated in the (re)shaping of women's bodies through biomedical practice(s) and education (see Grosz 1994; Lippman 1999; Sawicki 1991; Shildrick 1997). A critical examination of the professional practice of GTAs in pelvic teaching contributes to on-going discussions related to the (re)production and reification of normative discourses in the education and practice of biomedical health professionals. While 'practice' has been summarized as '… purposive, embodied, situated ("emplaced"), and dialogical, or co-produced, as well as being emergent and necessarily sociomaterial' (Green and Hopwood, Chap. 2, this volume), there is a rich body of feminist literature questioning how what we take as 'embodiment' and 'co-production(s)' may in fact be performances based on gendered/classed/racialized power relations. Such work addresses the history of biomedicine's role in constructing and representing the female body in very particular, objectified, (dis)embodied ways that have normalized how we collectively make meaning of, and experience, the female body (Grosz 1994; Shildrick 1997). Such literature invites us to re-consider what elements of practice are purposive (and why), embodied, and dialogical, what is '*co'*, and what exactly is *'produced*'.

In this chapter, I (re)present a selection of the performance practice(s) of GTAs, who operate as both model and 'teacher/text', to show how professional practice as enacted in, and outside of, the pelvic teaching space by GTAs required them to (re)perform stylizations of (supposed) disembodiment. Furthermore, GTAs were expected to draw upon their own embodiment as a 'site' and producer/production of 'knowing' while their bodies were engaged intimately with and by bodies of others in the teaching context.

Throughout this chapter, I draw upon my own storied reflections of working as a GTA to give a distinctive, often-unarticulated voice to the practice/performance of a GTA (*in italics*) – a voice that questions the (re)positioning of women through a language that speaks us into being, drawing attention to how we come to be *known* in particular ways as a consequence. I raise up to question – What does it mean to be/become a practice(d) body in pelvic teaching from the perspective of GTAs? Furthermore, what are the possible consequences for (the practice of) GTAs whose bodies operate as sites where medical students' practice is practiced upon, and from where practice(d) knowledge is (re)generated through (not) 'talking' the body. Such questioning invites us to consider how notions of professional(ization), as taken up within medical education, exist and participate in the creation of other bodies – caught-up in a normative feedback loop where 'one's' practices (re)create the very body one sets out to find.

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 possibly an 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 partner's 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 student's 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...' 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 Kegel exercises done by me to keep toned. 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' heterosexual 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 performed as a GTA within a pelvic teaching program from 2001 to 2003. *The Tour* is a reflection I wrote based on a composite of experiences I had as a GTA. This 'scene', scripted 2 years prior to data collection, was shared with research participants prior to data collection to give a voice to experiences that were made liminal within the program, to open up the space to talk about aspects of the GTAs' practice experiences that rarely circulate aloud among the GTAs (e.g. disgust, revulsion, arousal). This scene also called attention to embodiment in the practice of pelvic teaching. An awareness of how *my* professional(ized)body ebbed

and flowed between presence and absence, of knowing and wanting to un-know, opened space(s) to access and dialogue about the possibilities of the body-mind link with others.

Asking Different Questions, *Differently:* An Autoethnographic Approach

'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 (not) been asked, and how. I came to the topic of pelvic teaching in a graduate course, but during my review of the literature I was astounded by the lack of research literature on the topic from the perspective of GTAs, and further by how uncritical the existing published literature was. Therefore, the body of published scholarly work was the provocation for my dissertation. 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 pelvic teaching programs. I felt strongly that my own stories would have resonance with other women who performed as GTAs in the program, and that our stories could say something (critically) important about the complexity of the experience of being a GTA, the tensions that arise in performing pelvic examinations and being performed on, and of having one's body worked on intimately in service of medical education.

Research/Writing as Practice

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

By using an autoethnographic research and writing approach, I intended to make room for the body – my body, in the production of knowledge. 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. 299; 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).

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 and Bochner 2006, p. 434). As Jones (2005, p. 765) 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'. Autoethnography appears on the scene as 'part of a corrective moment against colonizing ethnographic practices that erased the subjectivity of the researcher while granting him or her absolute authority for representing "the other" of the research' (Gannon 2006, p. 475).

In addition to the singular voice of the researcher, there is often on-going dialogue between other 'participants' in the text, such as research participants (as in autoethnography that includes interviewing), other texts (such as books and journal articles), and the reader (Ellis 2004). 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' (Denzin and Lincoln 2005, p. xvi): 'A certain identity is never possible; the ethnographer must always ask, "not "*who* am I?"" but "*when, where, how* am I?"' (Trinh, as quoted in Denzin and Lincoln 2005).

An autoethnographer often discloses intimate aspects of one's personal life, and requires 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. Autoethnographies are counter-narratives aiming to 'disrupt and disturb discourse by exposing the complexities and contradictions that exist under official history' (Multua and Swadener, as quoted in Denzin and 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 and deChant, as cited in Ellis and Bochner 2006, p. 439).

In my autoethnography, 12 out of 15 GTAs employed within the program participated in individual interviews and one of two available focus groups depending 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 consent forms 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 to 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.

My work is informed by Michel Foucault's conceptualization of discourse, particularly as taken up by scholars in health studies (e.g.: Cheek 2004; Grosz

1994; Petersen and Lupton 1996). Discourses 'order reality in a certain way. They both enable and constrain the production of knowledge, in that they allow for certainways of thinking about reality while excluding others' (Cheek 2004, p. 1142). 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 et al. 2003; Cheek 2004).

The work of Judith Butler informs my theorizing throughout this chapter, particularly as I attend to the activities of preparing to practice as a GTA, and the 'scripted' performance between medical students and GTAs during pelvic teaching. The view that gender is *performative* seeks 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 instead one that we anticipate and produce through certain bodily acts, at an extreme, an hallucinatory effect of naturalized gestures' (Butler 1990, pp. xv–xvi). Performativity has been defined by Butler (1993, p. 2) as '... that reiterative power of discourse to produce the phenomena that it regulates and constrains'.

Butler (1993, p. xi) suggests that the way we perform ourselves perpetually (re)*constitutes* our identities – our bodies. To this end, performing gender is not an innocent practice; rather, it is a performance of (dis)(em)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' (Butler 1993, p. 2). By troubling gender through drawing attention to its performative nature, 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).

The Inception of Pelvic Teaching Programs Utilizing Gynecological Teaching Associates Within Medical Education

Despite the presumed 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 et al. 2009; Seehusen et al. 2006; Yanikkerem et al. 2009). Indeed, many women do not seek or receive regular 'screening', particularly older women (van Til et al. 2003), poorer women, criminalized women (Sered and Norton-Hawk 2008), indigenous, and visible minority women (Ackerson et al. 2008; O'Brien et al. 2009).

The collective response to low rates of routine pelvic examinations in particular, and negative examination experiences in general, has been to implement pelvic teaching programs utilizing GTAs as an 'intervention' in medical education – attempting to (re)script the pelvic examination space as one that is not hostile to/toward women. 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 et al. 2003; Hendrickx et al. 2006; Kapsalis 1997). Such methods of teaching reflected the dominance of the body/mind dichotomy. One need not have the 'mind' of the patient (as it is the mind of the professional that matters) present to perfect one's technical craft when the body alone would do – whether simulated or disembodied in some other way. Over time, because of 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 et al. 2003; Ubel et al. 2003), new programs were developed in the late 60s-early 70s utilizing live women who were not patients (Hopwood et al. 2014).

Although similar programs/practices were developed elsewhere, 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, consequently; the program became 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. 1992; Kapsalis 1997; Siwe et al. 2006).

Today, GTA programs generally operate as distinct units umbrellaed under larger standardized patient programs that provide a broad range of clinical methods training to health professionals using hired 'laymen'. 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. Generally GTAs undergo at least a half-day training program to learn how to provide basic instruction to medical students, and 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).

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 results in improved skill acquisition and greater communication efficiency in practice, and thus to more competent care of women in the wider community (Lane and Rollnick 2007; Robertson et al. 2003). With more competent and sensitive care for women in the community, then presumably screening rates of routine gynecological care would be improved. The ability to link this presumption to enhanced 'quality of care' depends upon the recognition that there needs to be a connection between the body/mind, and the body/minds of the different professionals within a/the educational context.

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 research that does exist primarily documents the perspectives of program administrators and of medical students with a focus on comparing the utility, validity, and effectiveness of GTAs with other types of simulators.

Past studies have demonstrated how GTAs have framed their work as fundamentally self-affirming (Siwe et al. 2006; Underman 2011); however their sense of 'self' in this context was interwoven with assisting students to achieve their learning goals, and their desire to improve examination experiences for women in the broader community. Collectively, such research also questions how the process of placing 'lay' people in the position of instructor/'knower', as with GTAs, potentially destabilizes biomedical practices and cultures, given that GTAs are positioned as the 'knower'/professional directing the learning of medical students as themselves prospective 'knowers'/professionals. However, previous explorations of the practices of GTAs have overlooked how normative discourses inform the assumptions underpinning the professional practice(s) of GTAs enacted within teaching spaces. Instead, researchers have produced interpretations of data that do not account for the broader socio-political, historical context within which GTAs develop, refine, and perform their practice(s).

Throughout the remainder of the chapter, I demonstrate how the practice(d) body and the practice(s) of the GTA, were (re)made through the performance of normative discourses to advocate for a re-worked theory of practice that *situates* the 'bodily sayings' and 'bodily doings' of professional practice(s) in a historical context.

(Per)forming the Practice(d) Body

> I 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. (Jodi – 'Getting ready for [body] work)

As my above reflection describes, carrying out the purpose of the pelvic teaching module involved bodies to be thought of, or not thought of, in particular normative ways. Accordingly, an integral aspect of the work of the GTA body was the work *on* the body – before, during, and after the teaching session(s). The preparatory activities of GTAs were invisible aspects of the work of being/becoming a GTA – shaping, reducing and (re)inscribing possibilities for interactions among participants within the teaching space. The manner in which the body was utilized as resource (Green and Hopwood, Chap. 2, this volume) is exemplified in this reflection. Working on the body brought about the changes necessary to perform one's (professional) practice. GTAs' body-work, as both resource and background, were routinized by GTAs, to the extent that the enactment of these aspects of their professional role remained non-problematized nor questioned (Shotter 2011).

Prior to enacting the role of model with students present, processes were undertaken that seeped into very intimate aspects of the GTAs' lives. Participants shared with me aspects of their preparatory/self-surveillance work that assisted with the emotional and physical dimensions of the model role – from avoiding heterosexual intercourse without a condom, shaving legs and external genitalia and bathing, to managing possible negative judgments from significant others in their lives. Consider the comment made by Susanne to the question I asked: '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].

Rather than educating medical students on how to manage pubic hair during insertions, GTAs, manage their varied forms of discomfort by preparing or even eliminating the hair in advance of the training session. The repeated representation of the pubic hair as shaved and trimmed (re)produces normative ideas about the aesthetics of genitalia that are 'imported' from elsewhere. The female body within pelvic teaching is analogous to public consumption in pornography, in a different way, but at the same time the sanitized version of the body is the same. In both spaces, a disservice is done to women in trying to (re)present bodies as 'all the same' (bare) bodies.

Rosemary, an older adult in the program, shared further comments that were reflective of normative discourses 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.

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. As the preceding quotes illustrate, rituals were undertaken to prepare one physically, in order to be prepared emotionally, for the practice of 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.

These disciplinary practices reflect the embodiment of ideas about the ideal body, and the sanctioned processes of becoming (or 'being' and 'having') the ideal female body (Heyes 2006), and invite us to consider how the female body as a resource, is established as such. 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. 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.

While I did not intend to elicit data related to attitudes regarding hair removal specifically, 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 presented themselves as 'women in the know', confident with their bodies and committed to educating medical students about the variety of female bodies, yet conforming to normative femininity in the production of the model role; and (2) By conforming to the hairless (or hair reduction) ideal, GTAs were (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.

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:

> I would definitely wash, clean. I contemplated at first waxing, just because of the video. And I thought 'you know what, no. This [the video] is not real. This is real life.'

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 and Lewis 2004, p. 381). In addition to (per)forming the hairless ideal, Gloria's comments below demonstrated how the performance of normative femininity informed, and is informed by, a 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 ...

Power circulated through the disciplinary practices enacted to (pre)form the idealized GTA, (re)producing particular individuals, institutions and cultural arrangements. However, disciplining the body was not 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.

'Okay, So Just Repeat After Me': How to (Not) Talk the Body

> 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 2004, 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 spoken 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), 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. It was as though it were a simple process – if medical students could 'just' (un)learn to (re)speak the body within the teaching space, the body itself, and its various representation(s) could be (re)made. A body that was both present (to instruct) and absent (to be practiced upon), or both present and absent simultaneously, depending upon the stage of the examination.

The scripted nature of the teaching space, particularly how to (not) talk 'the body', assisted the GTAs in accomplishing this practice/performance. 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 professional '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 expert-amateur performance(s). For example, they would use medical terminology for female anatomy (labia, rather than 'lay' language lips) and then in the next utterance use a term like 'smoogy'.

The emphasis on 'proper' language – that is, language that was purportedly de-sexualized and/or neutralized – in the learning environment/clinic space was central to the dialogue between the medical students and the GTAs. To demonstrate how (not) to talk the body was instructed, I present a section of dialogue, entitled 'Positioning', which exemplifies a typical exchanged between a facilitator and a medical student conducting the exam. 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 . . .

As *Positioning* demonstrates, (re)naming and positioning of the bodies choreographs a performance that sets boundaries while simultaneously (re)inscribing norms (Butler 1993). This discursive/linguistic 'dance' takes place between GTA and student in order to reimagine the body in front of them as not a naked woman of a sexualized nature, but as 'resource'. Making meaning out of the female body in particular normative ways required those in interaction with the female body to (per)form themselves accordingly. In the context of pelvic teaching, the physical configurations of the apparatus that worked with/on the bodies of GTAs, and the physical properties of the actual clinic space, required all bodies moving within the teaching space (GTAs, medical students, possible observers) to acquire 'knowledge' of the 'other' through institutionally-sanctioned, pre-choreographed series of movements (Hopwood et al. 2014) and the sanitized terminology that accompanied such movements. It was through language that the sheet rematerialized as the drape; the bed transformed into a table. The (dis)embodied GTA 'escorts' the medical student through the pelvic examination under the constant surveillance of the facilitator, with the eyes (and ears) of the model and their fellow students witnessing the act of (re)configuring the practice(d) body.

The 'Gold Standard'

> 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)

How the body was taken up as a metaphor was evidenced in conversations with GTAs about what constituted the 'healthy' and 'normal' female body – framed as 'the gold standard', and the criteria for participating in the program. The 'gold standard' was the phrase used by GTAs to refer, literally, to the women whose bodies were used as models, and to instructional methods utilized to demonstrate the exam components:

> 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'. [. . .] 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'.

GTAs could be excluded from participating as 'the body' if their body diverted from the 'norm'. That is, if it was missing both ovaries, one ovary was acceptable; however a uterus and cervix were required, even though the emphasis was on the proper approach to conducting the pelvic examination. Even when a GTA possessed a body with all the 'right bits', there were some bodies that were more productive than others. When a GTA's body failed to produce 'the goods' and a student was unable to visualize the cervix, reassurances from the GTAs to students were always offered; unfortunately, models' bodies could be problematized in the process. For instance, when a student could not visualize Drew's (a novice GTA) cervix, she apologized for, and problematized, her own anatomy: '*I'm sorry. I'm broken*'.

'Dropping the Drape'

The practice of teaching medical students to gather the drape between the GTAs' knees, hand the drape over to the GTA/patient to 'control' throughout the exam, and drop if discomfort arose, was based upon the assumption that dropping the drape would be an un-problematic, easy-to-execute move for the GTA/woman. However, 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).

A central feature of the GTAs' gendered 'identity' enacted in their performances, embedded in their practice, reflected and reified in normative discourse, was wanting to help 'others' succeed. Again, the space where bodies and minds in the medical education context meet is not neutral. As a consequence of GTAs positioning as the 'ideal test object/subject', at times they were precluded from acting on their 'instincts', demonstrating a complex relationship between GTAs' 'willingness' to 'transcend' their pain to assist students to succeed, and obligations GTAs felt compelled to fulfill – not only the role of GTAs, but as 'good 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. Consider the following quote from Amanda, commenting on a session she wanted to stop, but did not:

> 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 (Amanda)

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' (Coates 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, and persisted as an element of the practice of a GTA. The body is no longer 'only' theirs, because it's a site/source of work.

A Body of Bodies

In a sense, GTAs become 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 (medical) purpose, performer and *performed on* – their roles required them to fluidly shift across and between subject positions. The professional(ized) body does not exist in a vacuum. It is impacted on, shaped by and has tensions with other 'professional' and 'practised' bodies and social roles. Others' bodies heavily influence the practice(d) and professionalized bodies within an educational setting – motherly/caring bodies, available, 'owed' and sexual bodies, submissive yet 'knowing'/knowledgeable bodies.

What are the *bodies* in professional practice? That is, are there a multitude of 'other female bodies' acting as ideals and (re)sources – a 'body of bodies'?, which coalesce to form the ideal GTA and/or woman's body. Such questions draw attention to the idea that practice(d) bodies are reifications, (re)constituted through the repetitions of gendered, classed, heteronormative 'rules of engagement', to the extent that these very practice(d) bodies themselves become embodied manifestations of larger social, political, historical emplacements.

The GTA must enact their particular professional languages and positions (not to mention instructing the student while feeling and knowing with her body); the student in turn must repress and/or alter potential bodily/embodied responses – shock, repulsion, arousal, etc., and demonstrate his or her own professionalism through appropriate contact with 'the other body', as well as speaking the body accordingly. However, bodies, even professional bodies, in an educational setting have all sorts of shadows about (cast, of course, from bodies – both present and absent – and 'light'; light as a way/a metaphor of looking at things) that intervene on and in, and problematize the body(bodies) within a particular context.

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' collided with the lived reality that GTAs and women alike are obligated to be self-sacrificing and 'nice' while presenting their bodies, 'costumed with a smile, and a well-defined cultural script, and a uniform' (Kapsalis 1997, p. 76) to/for the benefit of others.

The acts of 'learn[ing] to be bodies in a certain way . . . ' (Reckwitz, as quoted by Green and Hopwood, Chap. 2, this volume) did not begin or end with GTA training (or any other educational context). What I have argued throughout this chapter is for consideration of the multiple other possible (normative) practices that may have informed the professionalization of body practices. In taking up the challenge of asking the question of 'What is the body in professional practice, learning and education?', I mean to challenge conceptions of practice as 'open-ended, spatially-temporally dispersed nexus of doings and sayings' (Schatzki 2012, p. 14). Instead, I ask: *Whose* sayings and doings? And why *these* sayings and doings, and not others? Who benefits at this particular 'moment' from such sayings and doings? Whose 'practice' is one really practising? And (just) what practice is being practised? I believe grappling with the answers to such questions is crucial if we are to think critically about the place of 'the body' in professional learning, education, and practice.

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