

# **Exchanging Hats: A Gendered Perspective on Teaching Clinical Medical Anthropology**

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## ***Word Count***

Abstract:

Text: 4000

References: 659

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Unfunny uncles who insist  
In trying on a lady's hat,  
--oh, even if the joke falls flat,  
we share your slight transvestite twist.

In spite of our embarrassment.  
Costume and custom are complex.  
The headgear of the other sex  
Inspires us to experiment.

Elizabeth Bishop, 1956

This article explores the way in which gender can be given intellectual relief against the backdrop of a class in clinical medical anthropology. Through the use of ethnographies of the clinical spaces that make up the world of high-tech biomedicine, students are introduced into alternate realities where moral authority is enacted out through sacrosanct medical protocols. Using the notion of contested gender to challenge the inscribed moral order and authority of the biomedical institution, students are led through a critical reasoning process. Ethnography, fiction, poetry and medical texts are all used as texts for analyzing. This class is targeted to a multidisciplinary group of senior undergraduates and masters students of the social and clinical sciences.

The students work through the texts, analyzing them both for content and differences with respect to gender, ethnicity and socio-economic status. While highlighting gender in this discussion, ethnicity and socio-economic status are also integral axes of analysis. The class first moves through a discussion of illness narratives and conversation analysis of doctor-patient communication. We then address the theoretical issues of stigmatization and the cultural construction of risk—emphasizing how gender contributes to both of these processes. Expanding out from the focus on the patient, we begin to examine the clinical reality of medical doctors, questioning how clinicians are trained and the ramifications of the training regimen on how they ultimately work with their patients. Ethnographies and social analysis of birthing are used to highlight the culturally constructed nature of biological events—events that could be seen as “normal” and “healthy” or as “abnormal” and “pathological,” depending on the perspective of the beholder. The last sections of the class deal with specific illnesses such as AIDS and cancer, highlighting disparities in the illness trajectory from genetic testing, to scenarios of diagnosis and treatment, to dealing with the eventual outcome of death.

I include transcripts of class discussions and excerpts of students’ written works in order to show the multiple interpretations of the literature. While teaching this class during the Fall of 2001, I enlisted the participation of the students in contributing to this article. Several of the class sessions were tape-recorded and segments of those transcriptions as well as short excerpts from weekly written memos are included in the following discussion of teaching gender.

## **Beginning with their stories**

Patient's stories provide an excellent entrée into exploring the meaning of clinical spaces. Illness stories have the power to engage and illustrate how we construct our selves differently, in different social situations. Patients and clinicians alike tell stories of illnesses and clinical encounters in order to make meaning out of difficult events (Becker 1997). These stories are told again and again in order to establish not so much what "really" happened, but what sense we can make of it (LeGuin 1981, Polanyi 1981). Illness narratives are constructed to emphasize who was right and who was wrong (Price 1987). They point out blame for what can be interpreted retrospectively as clinical errors, misjudgments and outright mistakes, and they are deeply reflective of the local cultural moral order. By beginning with clinical narratives, the alternate logic of clinical spaces can begin to emerge as the background for the semester's class discussions.

Anthropology highlights local logics. Seen from outside, the progression of events in hospitals and clinics often appears to be arbitrary and capricious. Taking an emic or insider's point of view, clinical medical anthropologists try to see why these institutions function as they do. As anthropologists, using the emic point of view, we question why the "naturalized" social order exists as it does. To question this can be threatening for students. The pedagogical question becomes, how do we get our students to try on these different spectacles, these different hats, especially when they fear how they might make the world look or feel?

I'm sitting in a cardiologist's waiting room filling out my intake forms. The tip of my pen hovers above the ubiquitous binary boxes. Female or Male? I was born female-bodied and I identify as female—as a lesbian butch. However, some people see me as a feminine male. And whether they guess male or female, I am always perceived as “queer” because my gender expression is very fluid and complex. I am transgender. Which box do I check to get the medical attention I need so badly right now? (Feinberg 2001:897)

I expect that it is when we catch the students just a touch off-guard that we make the most difference. We tuck something in that challenges preconceived ideas and allows students space to listen and to glimpse what being in another way might really be like. But we do this with the urgency of things clinical. It is the patient in the waiting room, with the difficult-to-diagnose disease or the raging infection, who needs help now. The clinical frenzy that surrounds Urgent Care Clinics and Emergency Rooms generates enough adrenaline to get practitioners through the day; its addictive qualities make sure that they'll be back for another shift in the morning. That infective energy also can drive the compassion that we want to tap for our students.

Most good cultural anthropology conducted in clinical settings includes some sort of participant-observation or ethnographic description. The best of these ethnographic writings give us the imaginative distance needed to begin to see patterns of practice and interaction and to question the hegemonic institution of biomedicine.

Starting with the mysteries of birth, this class moves through the clinical maze of curing bodies both culturally wrought and institutionally controlled (Foucault 1973, Davis-Floyd 1992, DeVries et al 2001). Highlighting the cultural construction of the physiological process of birth demonstrates how women and their bodies articulate with institutions, how they are defined as normal or abnormal, and whether they are allowed more or less control over their birthing experiences. The notion that the physical process of birth can be defined as a medical event or a natural process lies at the root of a gendered reading of the medical system. It decenters the biomedical reality that defines what is dangerous, wild, and in need of control. It also challenges what we take for granted as the “biomedical truth”.

If we can challenge the notion that healthy women belong in institutions when they are birthing, then all the events surrounding a normal birth in an institution become cultural artifacts reflective of deeply held societal values. The cultural events that either put or do not put a birthing woman under the control of a biomedical practitioner are rich in analytical potential with respect to gender power hierarchies in the clinic and in the wider societal context (e.g. DeVries et al 2001).

## **Conversation Analysis in the Clinical Setting**

In order to take apart the then-apparently culturally constructed power hierarchies, we turn to an analysis of doctor-patient communication. Using works that include transcripts of actual practitioner-patient conversations, the class examines how the world of biomedicine and the lifeworld of the patient are often very different and how that

difference makes even the most simple exchange of information quite difficult at times (Habermas 1984, Mishler 1984, Barry et al. 2001). How do doctors talk to patients? Who is in control of the information? Who gets to express their point of view?

Based on the early works of Sacks, Schegeloff and Jefferson (1974), the analysis of turns at talk in the clinical encounter precisely describes what goes on when doctors talk to patients. Who has the conversational floor? How are turns at talk manipulated to the advantage of the doctor or the patient? How are encounters influenced by others present and by cultural expectations of verbal exchanges (Moerman 1988)? Once understood as a tool that clarifies power relationships, conversation analysis of medical encounters can be applied to a focused critique of gender specific issues within medical institutions (Fisher and Todd 1983). A multitude of questions comes from critiquing clinical conversations in this manner. Are birthing women really given choices or are their clinical encounters structured in a way that prevents them from having the information to question the biomedical system in the first place? Are these women physically moved through hospitals and clinics at a pace and in an atmosphere that precludes their equal participation in even basic discussions with medical personnel (Hopkins 2000)? By highlighting what happens when patients are placed in the position of making decisions when they are in pain or when they do not have adequate information, the power hierarchies inherent in the medical system become apparent. Often, this leads to a class discussion and critique of the concept of “informed consent.”

## **The Cultural Construction of Risk and Stigmatized**

### **Populations**

In hospitals and clinics in many countries, as soon as clinicians and their patients begin discussing informed consents, the topic of risk comes up. Anthropologists argue that the concept of “risk” is a cultural construct (Douglas 1992). What is seen as risky in one society or culture may well not be seen as risky within another. The concept of risk includes what is locally accepted to be dangerous and it includes the idea that the possibility that one will personally be confronted with that danger can be mathematically determined (Skolbekken 1995).

The role of the anthropologist in analyzing risk is to focus on the process of cultural choice when it comes to what we are afraid of. Why are we afraid of home births and not the iatrogenic problems that come from giving birth in the hospital? How do the locally available medical technologies and the particular medico-legal system affect what patients and practitioners are afraid of (Cartwright and Thomas 2001)? Practitioners are often forced into practicing defensively to avoid malpractice lawsuits. Defensive medicine goes hand in hand with clinicians trying to exert more control over patients. Those who lose in this equation may well be those that are at a gender disadvantage.

Beyond being an exclusively “feminist” or “gay” issue, the continuum of human sexuality presents myriad problematic situations within the clinical setting that may affect a patient’s access to appropriate and sensitive medical treatment. A more comprehensive and perhaps less limiting view of the expression of one’s sexual identity and the range of

possible forms of sexual attraction would include understanding standard feminist critiques and men's responses to those as well as lesbian, gay, bisexual and transgender perspectives (LGBT). A recent issue of the *American Journal of Public Health* addressed "LGBT" issues (the first time in its 91 year history as the author of one of these articles points out) with the following caveat:

There are various gay male, lesbian, bisexual, and transgender populations: urban and rural, White and Black, poor and wealthy, and so forth. We refer to all of these as LGBT communities, but in doing so we risk glossing over important differences. White gay men in New York City's Chelsea neighborhood share little with transgender sex workers just a few blocks away in Greenwich Village; with gay men developing a gay liberation movement in Guadalajara, Mexico, with lesbians in Northhampton, Mass: or with bisexual married women on Long Island, NY. (Meyer 2001:854)

In my medical classes (to be transgender) is presented as more of a rare condition and not a human thing...this is the freak of nature, this is what happens when the chromosomes are messed up, and not an everyday issue. The way that she (Feinberg 2001) presented it as a continuum was the first time I had heard that and so it is kinda strange, but then if you think about it, it makes total sense. Everything about us biomedically, physically, is on a continuum and so why wouldn't that be also? But it was so appalling to me that I'd never heard of it I mean just on a daily basis, I would never had thought that it was a regular issue that people had to deal with on a day to day basis and that they were being refused

treatment, you know I'm still back in the dark ages where I'm still being appalled that lesbians and gays get treated badly, so I can't imagine what it would be like to have to go through life with this issue. (Class discussion, Shannon Case, Graduate Student, Occupational Therapy)

From an anthropological perspective, homophobia and heterosexism perpetuate old stereotypes and create new ones reflective of local political/economic/moral situations. The extant social ideas regarding gender identities play into the creation of stigmas in precise ways that can be studied and addressed within the purview of clinical medical anthropology training. Stigma, as Goffman (1963) described it, can be something one is born with or something one acquires. According to cultural norms and local contexts, stigmatizing conditions may be revealed or not to different individuals with different degrees of social distance and with various ramifications—everything from social shunning to secondary gains associated with the particular condition (Waxler, 1981). Issues of discrimination, subordination and relative privilege within a clinical setting are fundamental theoretical and descriptive issues to be addressed as one intellectually questions the enactment of biomedicine within clinical situations.

In the Clinical Medical Anthropology class, films are used to give specific examples of issues such as this. One particularly effective film, *You Don't Know Dick*, explores the lifeworlds of women who have sex changes and subsequently live their lives as men. How these individuals reveal their need to engage in hormonal and surgical treatments, who they talk to, the responses of family, friends and medical professionals, are all poignantly described in the interviews that comprise this documentary film. The issue of

engaging in this sort of medical treatment as well as the discrimination and social shunning that these individuals face is shocking to many of the students. Films engage students and give them the chance to apply anthropological concepts.

## **Genderizing Understandings of Clinicians**

Clinical worlds are peopled not just with patients but also with clinicians. While oft-ignored, the lifeworlds of clinicians leak over into their biomedical work. Not simply enforcers of medical regimen and protocols, clinicians bring with them all their own preconceived notions, stereotypes and ideas of gender identity. Cassell (1998) describes surgeons working within large hospitals from a gender perspective. She demonstrates how the way that one “does gender” can play a defining role in the enactment of patient care.

Cassell’s book not only tells about the individual experiences of women surgeons, but of the greater context, that of living as a surgeon in a woman’s body. Society has placed values on gender that inhibit the ability to act as a surgeon. Women (surgeons) are seen as too masculine or too feminine, both of which are unacceptable. (Sheri Murphy, Undergraduate Nursing Student, class memo 10/2/01)

Ethnographies such as Cassell’s (1998) bring clinical reality within the reach of students who may have little clinical experience themselves. As one student commented in her weekly class memo:

People, including surgeons, “do” gender, and they “are” female—they begin to embody knowledge the day they are born. This theory encompasses a gut feeling that we all have that we are acting naturally (unconsciously) and fluidly from day to day—that we have a unique identity (as a result of our personal interactions), but are, at the same time, a member of a symbolic and physically manifested group. This group is at times at odds with “others,” and at times struggles within itself to maintain/push at its borders, to question/support the place of the group within a larger social system. These contradictions exist, partly because the current socio-cultural climate (which superficially supports women’s ascension to high-level, powerful positions, while relegating the majority to traditionally submissive roles) allows, even encourages [these contradictions to exist] (Heather Schaper, Graduate Student, Medical Anthropology, class memo 10/23/01)

Beyond examples of women trying to break gender-role expectations by choosing to work in traditionally male-dominated occupations like surgery, other, basic issues about workday rhythms and timing can be called into question. Even within professions dominated by women such as midwifery, gender role expectations clash with job expectations. In their description of midwives working in the socialized medical system of the United Kingdom, Wrede, Benoit and Sandall discuss how midwives were forced to choose between being with their families or working extraordinarily long hours. New patterns of care contained an inherent assumption about the “genderless” job, which required flexibility and availability and ignored the needs of almost half the midwifery

workforce who had young children at home (2001:34). Through the use of such case studies, students are exposed to sufficient local details to begin to ask similar questions in a variety of cross-cultural clinical settings. The act of being able to envisage new “paradigms of professional practice” rests on expanding the imagination to encompass possible solutions to such things as the highly structured and sometimes inhumane learning strategies in medical schools and residency programs (Good 1995).

Bourdieu gives clinical medical anthropologists a way in which to conceptually describe and theorize about ways of learning and enacting specialized knowledge that goes beyond the codified, written representations that appear in medical textbooks. He challenges us to think about the unconscious and unquestioning embodied performances of clinicians in medical institutions (e.g. Cartwright 1998). Students can begin to envision new paradigms of professional practice that do not take for granted 12 or 24 hour shifts or months on end of work without vacations. It becomes apparent that male and female clinicians of all gender persuasions could provide services that would be healthier and perhaps even more efficacious for their clientele if they were not forced into extremely long hours of work and unremitting exhaustion. Whether or not future generations of practitioners replicate existing, rigid notions of the work day and the sexual division of labor in the home, depends, at least in part, on students being exposed to other possible paradigms of living and working in the 21st century. Things such as paternal leave for the birth of a child and flexible clinician work hours seem obvious starting points.

Both clinicians and patients engage in their lives via their gender identities and those that are in non-traditional unions have needs and experiences that have barely been touched by medical anthropologists. Ragoné and Twine (2000) have begun to question some of these experiences with respect to motherhood, but a vast universe of other gender issues and biomedical realms outside obstetrics await study.

Balance will not be achieved until the issue of gender is taken up as a serious area of concern. The issue must be approached in a way that is palatable to the entire spectrum of negotiated and embodied gender identities. (Diana Campanella, Graduate Student, Medical Anthropology, class 10/23/01)

The next section of the class focused on applying clinical medical anthropology concepts to particular diseases.

## **Diagnosis and Foreknowledge: Dilemmas inherent in trying to predict the future and vindicate the past**

There are clinical moments that are very difficult to convey to students who do not have experience working directly with patients. These moments, such as when a practitioner must convey the diagnosis of a very serious, perhaps incurable illness, are quintessentially important to the understanding of the workings of clinical settings. These moments are often lost when it comes to writing up research findings in journal articles and monographs. Some of the best descriptions come from fictional or semi-fictional writing such as the following. I include this extended quote from an assigned class reading as an elegant sample of writing that takes students out of their everyday worlds and into a mind-space where they can react emotionally. Many of them are

clinicians in training and they are given few chances to explore the affective side of working in and around clinics in their programs of study.

The first few seconds were like an ecstasy, a rapture, so pure I almost wasn't there. I'm writing this down because it's a moment our friends don't speak of, our writers don't write about. Characters in books, our husbands, neighbors, aunts, float in from the wings already knowing, already changed. It's a moment of such solitude, such nakedness, so utterly unlike any other, that we tend to look away from it politely as from an obscenity. If it is obscene it's because it leaves us shamelessly stripped of our learnt humanity, as animal, as instinctual as any monkey. Yet it's a moment that comes in the end to almost everyone.

Then I imploded. Some people probably explode at this point, bursting into tears, awash with anger and regret and fear and impotence. I can imagine, too, desperately want to drag time backwards just by a second or two and rerun the scene with different dialogue, no, before it's too late: "it looks like that flu that's going around...the wooziness, the lack of appetite...Take a few days off, I'll write you out a prescription...' Please say it again like that. Please. That did flash through my mind. But the seconds ticked on, carrying me with them. And I imploded. (Dessaix 1996:6-7)

"Listening in" to the situation of a patient being told he has HIV/AIDS is a powerful emotional and intellectual event. Like the character in Dessaix's (1996) book *Night Letters*, and indeed like the author himself, we witness conditions like AIDS and cancer

and other illnesses that imply fundamental shifts in how individuals think about the remaining days and hours of their lives. Writing on the boundary of fiction and non-fiction, the writer Robert Dessaix uses his illness and gender experiences to explore what such diagnoses mean. His writing involves students emotionally and allows them to challenge sterile clinical descriptions of topics such as “doctor-patient communication” and “stigmatization.”

In this section of the class we use the concepts and theoretical constructs from the first part of the semester (illness narratives, conversation analysis, stigma, risk, etc.) to explore particular configurations of issues that surround diagnoses such as AIDS, cancer, late onset neurogenetic diseases like amyotrophic lateral sclerosis (Lou Gehrig’s disease), and environmentally-induced illnesses (Balshem 1993). The students explore each disease from different levels—the individual, the social and the larger socio-economic context (*pace* Scheper-Hughes and Lock 1987, Kaufert 2000), using the analytical frameworks developed by the authors already discussed in class. From genetic testing (Rapp 1999), through diagnosis, treatment and beyond, the class explores different clinical scenarios. The creative intellectual work comes in taking the theories and applying them to different clinical settings and to different disease states; students work up individual written term papers in this manner.

## **Conclusions**

In this essay I have not tried to cover the entire literature of clinical medical anthropology that pertains to gender issues, but have instead focused on a progression of topics that

seems to me to take students through the intellectual and emotional steps necessary to begin to question and research gender relations in the clinical setting. Often, it is a most difficult task to see what is right before one's eyes, to challenge beloved notions of things like "the family doctor" and the power and hope of biomedicine. While in some cases these constructs need no challenging, there are also many times when they do. To provide students with "different hats" to put on with respect to the socially constructed nature of gender may well be a way to continue the process of making biomedicine an institution that can best serve both the patients who seek to be healed and the clinicians who spend their lives working to heal them.

## **Acknowledgements**

I would like to thank the students who participated in the Clinical Medical Anthropology Seminar, Fall 2001. Our discussions in that class resulted, in large part, in this article. It is students like these that make teaching a joy. Heather Schaper, Terry Livingston, Brian Mangum, Diana Campanella, Devon Denny, Shannon Case, Sheri Murphy, Rachel Wolfe, Rebecca Roberts.

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