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Introduction

INTERROGATING GENDERED PATHOLOGIES

Erin A. Frost and Michelle F. Eble

The goal of this collection is to point out, interrogate, and formulate tactics to intervene in unjust patterns of pathology. In doing this work, we assemble a transdisciplinary approach from/to technologies, rhetorics, philosophies, epistemologies, and biomedical data that surround and construct the medicalized body, and we seek to reattach them to bodies and to corporeal experience. In other words, this collection's purpose is to consider the lived effects of biomedicine's gendered norms on embodied experiences—on people's lives. This collection must necessarily rearticulate disciplinary contexts/territories/categories, utilizing a variety of inter/multi/transdisciplinary¹ approaches so the whole work taken together forms a transdisciplinary way of reimagining embodied data. This collection resists notions of embodiment as separate from or necessarily in opposition to biomedical knowledge. It interrogates gendered pathologies.

PART 1: WHY PATHOLOGIES?

Research that attempts to address health disparities and/or inequalities tends to focus on technology and biology despite the fact that pathology—the process by which causes and symptoms of diseases are determined—clearly has rhetorical, social, and cultural components that are just as significant. Even when health-disparities research addresses social determinants, it tends to focus on patient compliance, language barriers, environmental factors, geographic areas, or socioeconomic levels rather than on the relationship between gendered biomedical discourse and how bodies are defined and categorized.

We use the concept of pathology because it provides us with a theoretical lens through which to examine how bodies are marked, diagnosed, and categorized. Pathology has several meanings in biomedical

discourse. It can refer broadly to the study of disease or illness, or more specifically to the causes of a disease or examination of tissue, blood, or fluid samples toward diagnosing a disease while also being used in other contexts to refer to something abnormal or deviant, as in pathological fear or pathological liar. Outside biomedical discourse, scholars sometimes use pathology as a metaphor for indicating how groups of people are represented in discourse. For example, Nadine Hubbs (2014) talks about “pathologizing the working class through the queer” (157) in *Rednecks, Queers, and Country Music*. Hubbs’s treatment of country music works across class, gender, and sexuality (among other characteristics) to show that tolerance and acceptance of difference rests upon the middle class’s desire to separate itself from the working class, and vice versa. Thus, pathologizing—or stereotyping, categorizing, mocking, and pushing away—particular kinds of people serves as a way to reinforce class divisions.

We draw on these multiple meanings—both the literal and metaphorical—of pathology; in fact, this collection takes its exigence from the intersection of these two definitions. We are concerned not only with conditions, syndromes, disorders, and diseases that have been defined but also with how *pathologies* and *pathological* are terms used to define, identify, and categorize particular bodies in juxtaposition to the androcentric body. Female bodies in particular are disproportionately pathologized—which in this case means medicalized, labeled as nonnormative, and brought under surveillance and disciplined by the biomedical sphere. This should concern not just women but everyone: “Indeed, we are all more or less abnormal in some way or another, and thus we are all potential targets for psychiatric power” and medical power (Taylor 2015, 264). This relationship among gender, pathologies, and inequalities is deeply rooted in the patriarchal and hierarchical context of biomedicine and the types of knowledge (and bodies) privileged in those spaces. Gendered pathologies are perpetuated by divorcing women’s embodied experiences from technical and scientific information or knowledge generated about them by others. This sort of rhetorical move is not new and is predicated upon a (false) assumption that experiential data are not empirical. Feminists have long valued experiential data as a way to resist this separation—and these experiential data have long been dismissed within the realm of biomedicine when attached to or emerging from female bodies.²

Feminist technoscience scholars in particular provide a foundation for this collection of essays in at least two ways: first, they question how socially constructed notions about sex, gender, and sexuality “influence

the production of medical knowledge about sex and sexed bodies in ways that affect subsequent research . . . and lived experiences” (Fishman, Mamo, and Grzanka 2017, 397). Second, they call us to examine and resist knowledges that “produce and reflect inequalities through epistemological frames such as binary logics of normal/pathological” (400). Feminist technoscience scholars, as well as this collection, are concerned with how biomedical knowledge is produced, what that knowledge means for particular kinds of bodies, and challenging any inequalities that happen—and are reified—as a result.

Donna Haraway (1990) and Sandra Harding (2005), among other feminist technoscience scholars, question objectivity and neutrality within science, technology, and biomedical spheres, as these contexts are political, socially constructed, and gendered despite dominant narratives and claims to the contrary. Haraway’s cyborg imagery suggests “a way out of the maze of dualisms”—actor and agent, subject and object—“in which we have explained our bodies and our tools to ourselves” (181). For Haraway, embodied knowledge is essential to finding meaningful explanations for our bodies. The material body must be present for us to learn about and through it and to take “responsibility for difference in material-semiotic fields of meaning” (92). For Harding, the subjects or agents of knowledge are “embodied and visible, because the lives from which thought has started are always present and visible in the results of that thought” (63). Subjects of knowledge are not different from objects of knowledge in that “the same kind of social forces that shape objects of knowledge also shape knowers and their scientific projects” (64). In other words, classifications, categorizations, and pathologizations of bodies in modern biomedicine often depend on notions of knowledge incorrectly understood as universal, objective, and disembodied—failing to account for embodied knowledges so important in these contexts for specific bodies.

Intervening within the gendered nature of biomedicine and its knowledge, assumptions, and technologies requires an understanding of pathologies as “working machines” and how these machines have been used to separate the material body and its experiences from prevailing understandings and knowledges about the body. To explain, Judy Wajcman (2004) argues that “gender relations can be thought of as materialized in technology, and masculinity and femininity in turn acquire their meaning and character through their enrollment and embeddedness in working machines” (107). These machines—whether articulated as technology, biomedicine, or biomedicine-as-technology³—are “a socio-material product—a seamless web or network combining artefacts,

people, organizations, cultural meanings and knowledge” that operates within a set of assumed gender power relations (106). Wajcman’s theoretical approach, technofeminism, “shares the constructivist conception of technology as a sociotechnical network, and recognizes the need to integrate the material, discursive and social elements of technoscientific practice” (46). In other words, we must return experience—culture, embodied data, subjectivity—to the body.⁴

Biomedicine often tries to separate women’s unruly bodies and experiences, specifically, from the official information or data collected or assumed about them. Only considering the “standard” data about the body eliminates the context necessary in understanding how diverse bodies respond to disease and illness and, as a result, how they might be diagnosed and treated. According to N. Katherine Hayles (1999), “Information, like humanity, cannot exist apart from the embodiment that brings it into being as a material entity in the world; and embodiment is always instantiated, local, and specific” (54). While data about bodies allow us to have a broader view and generalize among groups and categories of bodies, they can also be limiting and exclusionary if embodied experiences aren’t also accounted for. For example, Alana Baker (2017) discusses the importance of considering the “numerous embodiments that are involved in the construction of the data bodies in medical technical communication that display differences” since focusing on centric epistemologies excludes other bodies. As one possible solution, she calls for clinical researchers to report findings that account for biological sex and gender, among other identity markers, in an effort to “create more inclusive, more accurate definitions of health and disease” (86–87). The ways biomedicine currently categorizes and defines certain diseases and illnesses based on specific data—or lack thereof—ultimately pathologize certain bodies already at risk or in groups disadvantaged in some way. We agree with Maureen Johnson et al. (2015) when they ask that scholars “approach embodiment through these complex relationships to emphasize the role of the physical body in all rhetorics, to complicate the ways bodies are understood to work and perform as rhetorical agents, and to intervene in the ways bodies both inscribe and are inscribed upon” (42). Rather than focusing on data and pathologies as separate from bodies or ways to categorize bodies, we want to reconcile data within the context of embodied experiences, as this gives us a diverse view of multiple bodies and how they are constructed. In response to decades of work on technoscience and health disparities, this collection interrogates, disrupts, and complicates the pathologies often marked on female bodies while also calling into

question the binary categories of gender often defaulted to and perpetuated as normal.

PART 2: BIOMEDICINE IS GENDERED

The flattening of gendered experience into two singular and supposedly dimorphic narratives happens commonly in language about reproduction and should be critiqued (Ritz 2017). Robert Martin (2018) refers to the common understanding that sperm race to penetrate an egg—an anthropomorphization of embedded gender roles—as “the macho sperm myth” and cautions that such “incorrect science” and “biased information” can have material consequences for fertility treatments. Robert Martin is drawing on Emily Martin’s (1991) “The Egg and the Sperm: How Science Has Constructed a Romance Based on Stereotypical Male-Female Roles,” which points out that female reproductive elements have a much more active role in the reproductive process than is normally represented; the uterus constricts to move the sperm along and “the egg traps the sperm and adheres to it so tightly that the sperm’s head is forced to lie flat against the surface of the zona” (493). Despite these biological realities, the active role of female reproductive agents still does not represent dominant understandings of reproductive biology. Obviously, cultural and social understandings of sex and gender influence scientific and biomedical explanations. Biomedicine is gendered. Science is not neutral. This is, in part, because medical researchers and practitioners are charged with responding to the needs of a wide diversity of bodies. In responding to so many needs, institutions tend to focus on the needs of a few, behaving as though one standard idealization of a body can be used as a referent for all people.

Unfortunately, this limitation means “female patients’ symptoms are less likely to be taken seriously by doctors, and women are more likely to be misdiagnosed, have their symptoms go unrecognized, or be told what they’re experiencing is psychosomatic” (Adler 2017, para. 6). In fact, this is true for nonbinary-, genderqueer-, trans-, and/or intersex-identified people as well as those who are queer, disabled, or identify as a racial/ethnic minority. While this collection takes gender as an organizing principle, for reasons we explain below, it also strives to point out the many inequalities (including intersectional inequalities) pathologies enact in biomedicine. (In particular, the chapters in this collection often refer to women’s health and experiences but may also describe the experiences of transmen and nonbinary patients.) No institution could ever be “neutral” in its treatment of human beings; however, institutions are often

not only unequal in such treatment but also inequitable. Biomedicine and public health as institutions also have historical patterns of responding to particular kinds of bodies in unjust and inequitable ways. These differences exist along lines of gender, race, sexual orientation, and ability—and they can only be remedied with a transdisciplinary, intersectional approach. In an example that evokes race as its organizing principle, Dr. Mary Bassett accepted Columbia University’s Frank A. Calderone Prize in Public Health in October 2016 with this directive: “We must explicitly and unapologetically name racism in our work to protect and promote health—this requires seeing the ideology of neutral public health science for what it is and what it does. We must deepen our analysis of racial oppression, which means remembering some uncomfortable truths about our shared history. And we must act with solidarity to heal a national pathology from which none of us—not you and not me—is immune” (*Huffington Post*, February 8, 2017). As Bassett points out, some bodies are well served by the existing institution of biomedicine and its attendant norms, priorities, and cultures. Some are not.

Women are categorically denied access to the same kinds of health-care men receive. This is true of everything from access to prescription medication to treatment of pain to the seriousness with which medical personnel assess women’s claims about their embodied experiences. “Nationwide, men wait an average of 49 minutes before receiving an analgesic for acute abdominal pain. Women wait an average of 65 minutes for the same thing” (Fassler 2015). Joe Fassler (2015) wrote about his wife’s treatment for ovarian torsion by an emergency room in which the hospital personnel simply didn’t believe she was in agony. “Pain without lesion” (Zhang 2017)—or symptoms without clearly observable causes—presents a problem for medical professionals, who then must accomplish their work based on their experiences *with* the patient rather than their observations *of* the patient. As Michel Foucault (1973) says in *The Birth of the Clinic*, lacking “a science in which the visible and the describable [are] caught up in a total adequation,” complete and accurate description—as in that of physician to physician, or, we might extrapolate, patient to physician—is impossible (116). In those situations in which “the [clinical] gaze is confronted by obscure masses, by impenetrable shapes, by the black stone of the body,” the physician becomes reliant not only upon what is describable (by the patient) but also by what is believable (by the physician) (117). What is believable by the physician is, of course, constrained by the physician’s beliefs about the patient—which, we know, are dependent upon the identity characteristics of both parties.

Historically, the subject of reliance upon (women's) experience has been taken up in feminist scholarship precisely because it is so often and so roundly discredited elsewhere. Evidence of this bias in healthcare is overwhelming. Depression in women is "misdiagnosed between 30 and 50% of the time" (Johnson 2013). Women are treated less aggressively by healthcare practitioners until they prove they are as deserving of care as male patients, a practice colloquially called "Yentl Syndrome." Baker (2017) shows that medical education materials privilege visualizations of male bodies as standard. Gender bias exists in diagnosis and suggested treatment options, especially when it comes to certain health conditions like heart disease, knee replacement, and critical care (Kent, Vital, and Varela 2012). Johnson's (2013) explanation of heart disease (the leading killer of women in the United States) diagnoses is instructive. She explains that men typically experience discrete blockages in their arteries, while women's arteries more often retain plaque in diffuse, even patterns; thus, a typical man may have a single, large blockage while a typical woman may experience a narrowing of the coronary artery. This narrowing is more difficult to see via cardiac catheterization—which is the standard test to diagnose heart disease, regardless of the patient's sex.⁵ An intracoronary ultrasound would be a more useful "gold standard" for women patients, and its widespread usage would reflect an equitable approach to healthcare. However, this test is not considered the gold standard because of the focus on a singular (male) pathology of the disease.

While diseases are often treated as if they affect only the "standard" body, the history of pathologizing women based on their bodily differences to men extends back centuries (Ehrenreich and English 2010; Tuana 1993) and resonates in modern analyses of biomedical discourse within contemporary scientific and medical establishments. In late 2016, the popular press began to report that a study on male birth control had been cancelled due to side effects. According to NPR ("Male Birth Control" 2016), researchers "gave shots to 320 men every eight weeks, in different countries around the world" and the trial was very effective—initial results said 96 percent—at preventing pregnancy. The most common side effects were acne and mood swings, and most participants said they would use the product if it were commercially available. Nevertheless, the study was cancelled. Many people critiqued the choice to cancel, and the concern of a number of feminist critics was that when women report the very same side effects, they are not taken seriously. Women in similar trials decades ago were not warned about side effects, were not told the drug was experimental in the first place, or (in the case

of incarcerated women) were not given a choice about participating. After women reported side effects similar to those reported in the recent male study, the drugs were still approved and distributed. In fact, subsequent studies of the side effects of female birth control then ceased, meaning women's complaints and experiences taking these drugs were ignored for decades until the first major study correlating hormonal contraception and depression came out—devastatingly late—in 2016 (Skovlund et al. 2016). It is worth noting that women—who are more typically responsible for birth control—are 70 percent more likely to experience depression than men (Johnson 2013). In addition, men are twenty-two times more likely than a woman to have a physician recommend a total knee replacement given the same symptoms (Borkhoff et al. 2008). A report by the Connors Center for Women's Health & Gender Biology (Brigham and Women's Hospital 2014) identifies and discusses four diseases (cardiovascular disease, lung cancer, depression, and Alzheimer's disease) for which sex differences and inequities exist in how men and women experience these illnesses and in the treatment for them. And these are just a few examples.

Further, evidence of gender- and race-based health disparities continues to exist despite numerous legislative attempts to eradicate them. The National Institutes of Health (NIH) Revitalization Act of 1993 requires the inclusion of women and minorities in clinical research (National Institutes, "NIH Policy," n.d.). The designation of the Center for Minority Health and Health Disparities as an NIH institute in 2010 evidences acknowledgment of these issues (National Institutes, "National Institute," n.d.). In 2000, the Healthy People program (originally established in 1979) transitioned from reducing health disparities to achieving health equity and eliminating health disparities by 2020, suggesting some progress (Healthy People 2020, "Disparities," n.d.). More recently, the Centers for Disease Control and Prevention Office of Public Health Scientific Services (2013) released the *CDC Health Disparities and Inequalities Report—United States, 2013*, which documents the factors that lead to health disparities and inequities in an effort to make healthcare more equitable across a variety of social groups. Partially in response to these failed legislative attempts to move toward equity, the field of health and medical rhetorics has produced numerous studies over the past fifteen years showing continuing disparities in health (Agne, Thompson, and Cusella 2000; Bennett 2009; Berg and Mol 1998; Britt 2001a, 2001b; Brueggemann et al. 2001; Dutta and Kreps 2013; Eggly et al. 2015; Kevles 1998; Lynch and Dubriwny 2005; Sankar et al. 2004; Zoller and Meloncon 2013).

Simply increasing attention to gender-based disparities is not enough. It is important to pay attention to other identity characteristics that put certain types of people at risk for less-than-adequate care (Sauer 2002; Scott 2003; Grabill and Simmons 1998; Kreps 2005). In addition, health-care professionals and scholars of health and medical rhetorics must complicate the notion of sex as a determining category, as well as the collapsing of sex and gender in many contexts. A recent article from *Pharmacy Practice* notes that “it has been recommended that sex and gender be examined as separate effects, especially when considering potential differences in diagnosis and treatment options between men and women” (Liu and Dipietro Mager 2016). Both sex and gender are independently complicated; for example, medical discourses do not often make apparent the experiences of either intersex or transgender bodies. Reliance upon a binary system—failure to recognize diverse types of bodies and how they experience illness and disease—has real consequences for people attempting to receive medical care. For example, as noted above, Johnson (2013) reports that heart disease presents differently in women than it does in men. While this information is important in better diagnosing women (who historically have been measured against male norms), it also risks not accounting for the fact that not all women (or men) present in the same way; some women might experience symptoms “like a man” or vice versa—to say nothing of those who do not identify according to either of our culture’s simplistic sexually dimorphic gender categories.

One of our responses to the gendered nature of biomedicine is this collection, which advocates for intersectional approaches to dealing with gendered pathologies and healthcare disparities while utilizing gender as a primary lens. We chose gender as our main approach because (1) it is an identity characteristic directly and overwhelmingly related to reduced quality of care and (2) it is the organizing category through which we (as cisgender white women) can most directly offer experience-based critiques of our own—and, as we can never remove the lens of our own bodies from research, this is important to acknowledge. Choosing gender as an organizing category for this collection called forth certain types of responses; while it did not prevent our contributors from discussing intersectional approaches, the chapters do constellate around particular types of experiences. In other words, this introduction and the chapters in this collection problematize particular pathologies. The essays in this collection contribute to the burgeoning field of health and medical rhetorics by rhetorically and theoretically intervening in what are often seen as objective and neutral decisions related to the body and scientific and medical data about it.

PART 3: ON THE IMPORTANCE OF A COLLECTIVE APPROACH

This collection, then, is a space for multiple disciplinary approaches to recovering the value of experiential data and putting it into conversation with a variety of other methods for gathering and making sense of data—some revered by biomedicine and some less so—to create a fuller picture of embodied experiences related to pathologies. The essays challenge notions of evidence-based medicine as the only data relevant to medical orthodoxy (Derkatch 2016) and engage the field of health and medical rhetorics in more actively reorienting ourselves toward recognition of the whole body—including attendant embodied experiences—in context. As a result, this collection examines how “this theoretical re-orientation is itself a disruption, which expands beyond one view of embodiment, and encourages listening to multiple voices” (Johnson et al. 2015, 42).

As contributors to this project, we resist the notion, however, of returning data to a single body. A single author—or a single disciplinary approach—attempting to do this work could easily contribute to narrow understandings of what this recovery work might look like. Instead, we have conceptualized this work as a transdisciplinary collection for this very reason: herein are represented a number of different perspectives on what it might look like to return health and medical data to embodied experience, to consider the effects of gendered and intersectional biomedical norms on lived realities, to subvert the power of institutions in ways that move us toward biomedical justice. We do not want to construct a single body, so we must employ a multiplicity of perspectives and voices. The authors in this collection operate from similar ideologies but from different (trans)disciplinary epistemologies. That is, we all operate from the belief that biomedicine as an institution treats some bodies unjustly based on identity characteristics, but we come to this central idea with different theoretical commitments, epistemologies, and approaches. Our ways of thinking about and responding to this shared belief are different.

We situate this collection within the field of health and medical rhetorics. Drawing on the work of both medical rhetoricians (Hefferson and Brown 2008; Keränen 2010; Koerber 2013; Scott 2003; Segal 2008) and technoscience scholars (e.g., Haraway 1990; Harding 2005; Hayles 1999; Wajcman 2004), this collection reunites technological and biological information with the lived, social, cultural, and gendered realities of the bodies said information belongs to—including valuing data that operate outside the schema of traditional dimorphic gender identifications. This collection responds to Lisa Meloncon and Erin Frost’s (2015) call

to consider how “feminist perspectives reveal insights into ideological perspectives of the other that are extremely important in a health-care industry that maintains persistent hierarchies and classes” and explore what a “feminist orientation can offer to the way we research in the rhetorics of health and medicine” (11). Part of the impetus for a collection like *Interrogating Gendered Pathologies* is that scholarship is extremely limited on rhetoric, gender, and intersectional theories as a lens through which to reunite technological and biological data with embodied data toward more complete and just approaches to health and medical rhetorics.

The field of rhetorics of health and medicine is a relatively newly established field; the books published to date have helped form a foundation. Still, much of this work focuses on in-depth studies of specific diseases or medical illnesses rather than taking thematic approaches that might reveal patterns across contexts of care. This collection follows in the vein of work like Barbara Hefferson and Stuart Brown’s *Rhetoric of Healthcare: Essays Toward a New Disciplinary Inquiry* (2008), Joan Leach and Deborah Dysart-Gale’s *Rhetorical Questions of Health and Medicine* (2010), and Meloncon and J. Blake Scott’s *Methodologies for the Rhetoric of Health and Medicine* (2018), which brings together chapters that offer approaches and analyses of a variety of health and medical topics. Since the early 2000s, other publications (see for example Page Smith, Bernice Hausman, and Miriam Labbok’s 2012 *Beyond Health, Beyond Choice: Breastfeeding Constraints and Realities*; Meloncon’s 2013 *Rhetorical Accessibility: At the Intersection of Technical Communication and Disability Studies*; Christa Teston’s 2017 *Bodies in Flux: Scientific Methods for Negotiating Medical Uncertainty*; and Elizabeth L. Angeli and Richard Johnson-Sheehan’s 2018 special issue of *Technical Communication Quarterly* aimed at forging ties between rhetorics of health and medicine, the medical humanities, and biomedicine) have addressed medical and health rhetoric topics and contributed to legitimizing and establishing this field, which makes books like *Interrogating Gendered Pathologies* possible. More recently, scholars in the field have produced monographs on particular medical topics—such as brain tumors, diabetes, HIV, breastfeeding, alternative medicine, hysteria, infertility, pregnancy, and cancer care (Arduser 2017; Bennett 2009; Britt 2001a; Derkatch 2016; Graham 2015; Jensen 2016; Kerānan 2010; Koerber 2013, 2018; Seigel 2014).

This collection, however, brings together scholars addressing health and medical topics along the axis of a particular critical perspective using a range of complementary and intersectional theoretical approaches. The work that follows builds on the promise of the field while capitalizing

on a unique and important concept—pathologies—toward investigating how a wide variety of theories and methodologies can help us interrogate the important issues we identify in health and medical rhetorics.

PART 4: CONTENTS OF THIS COLLECTION

This collection is organized into five sections that each focus on a particular concept or on a mode of communication. Those five sections are sensory experiences, patienthood and patient-provider communication, social construction of illness/biomedicalization of bodies, digital medical rhetorics, and textual examinations. The chapters in this collection are interconnected in myriad ways, and we could have chosen many approaches to constellating them. We chose this approach for several reasons: (1) by beginning with sensory experiences and moving to modes of communication, we enact our feminist argument in favor of framing experiential knowledge as foundational; (2) we believe this approach places chapters into manageable chunks that will be conceptually legible to students; and (3) by including different kinds of categories (e.g., concepts and media) as organizing principles, we draw attention to the messiness of arrangement work and create openings for readers to imagine other vectors of possibility. Although we have grouped the chapters according to the overarching categories mentioned above, each chapter contains elements that would allow it to move across those categories. We encourage readers to consider what different possibilities might emerge by paying attention to the transcategorical nature of many of these chapters and imagining the organization of this collection differently.

We also want to draw attention to what is not present in this collection. In soliciting chapters, we called for examinations of gendered approaches to pathologies, noting that female bodies, nonwhite bodies, queer bodies, and differently abled bodies are often marked as particularly risky and more frequently become subjects of damaging pathologies. We said, “This collection will focus especially on gender issues—in part because of a dearth of work in this area—but we also seek to recognize the intersectionality of health disparities across race, ethnicity, sexual orientation, and (dis)ability.” While some of the chapters in this collection engage intersectionality and take on important inclusionary and relationship-building work, the overall pattern of proposals we initially received in response to our call largely centered and/or made most apparent women’s experiences. This result is somewhat unsurprising, particularly given our choice to use gender (though, notably, not

sex) as an organizing principle. However, we would be remiss if we did not note the prevalence with which any engagement with the term *gender* is read as female oriented.⁶ Further, it is important we make apparent that this collection is representative of the proposals we received (and larger patterns in the field) in that it is almost exclusively women, queer, and nonbinary individuals who do the hard work of interrogating gendered pathologies.

We follow Julie Jung and Amanda Booher (2018) in their attention to “important exclusions” (6), as well as in their application of theoretical approaches aimed toward furthering responsible academic practices. This collection—its impetus, orientation, inclusions, and ultimate shape—and the feminist technoscience work it builds on owes much to indigenous and decolonial epistemologies (Haas 2012; Sandoval 2000; Smith 2012); in particular, the following chapters should be read within the context of thinking about the ways scholar-practitioners can make philosophies matter differently, the ways interdependence and intersectionality are “ontological fact[s] of human existence” (Jung and Booher 2018, 6), and the ways our theoretical commitments insist upon resisting “the subject/object dichotomy and the mind/body dichotomy as well” (Riös 2015, 65).

Section 1 (“Sensory Experiences”) highlights this collection’s promise to value experiential data—as many feminist traditions have—by privileging those data in the same way traditional medical knowledge is often privileged. In the first chapter, “Corporeal Idioms of Distress: A Rhetorical Meditation on Psychogenic Conditions,” Cathryn Molloy develops a theoretical lens, “corporeal idioms of distress,” in order to account for both the psychogenic and physiological symptoms that contribute to understanding and treating symptoms, disorders, and disease. She points out that clinical rhetorical listening and recognizing patient ethos might provide insight for those patients often marginalized in the medical encounter due to unknown etiologies or because their symptoms don’t seem to have an apparent cause. Maria Novotny and Elizabeth Horn-Walker’s “Art-i-facts: A Methodology for Circulating Infertility Counternarratives” offers their community-engaged methodology in order to disrupt the tendency in our pronatalist culture that links femininity with fertility and, as a result, pathologizes infertility. They see this public-pedagogy approach as a way to make “visible the gendered constructions of biomedicine” (44) and to circulate counternarratives in response to the dominant gendered experiences of women given an infertility diagnosis. In doing so, they help create a community of support, make apparent the experiences of

their participants, and help reduce the shame, silence, and stigma often associated with infertility.

In section 2 (“Patienthood and Patient-Provider Communication”), the authors describe, critique, and offer avenues of action related to the communication that occurs between physicians and female patients. Leslie R. Anglesey, in “‘We’re All Struggling to Be a Complete Person’: Listening to Rhetorical Constructions of Endometriosis,” uses her personal experiences as a patient with endometriosis in order to illustrate how women are not believed or taken seriously when communicating their pain to physicians, which can cause delays in diagnosis of serious conditions. Drawing on narrative medicine, Anglesey provides suggestions for how physicians might listen to how their patients make sense of their pain over time and work collaboratively as partners in these healthcare encounters. Drawing on field research, including observations and interviews with nursing students completing clinical simulations, Lillian Campbell’s “Simulating Gender: Student Learning in Clinical Nursing Simulations” discusses the gendered nature of nursing simulation training. Using a rhetorical material approach, Campbell concludes that the simulations and the debriefings after could benefit from discussions related to intersectionality in order to resist reifying stereotypical gendered interactions. Leandra H. Hernández and Marleah Dean, in “‘I Felt Very Discounted’: Negotiation of Caucasian and Hispanic/Latina Women’s Bodily Ownership and Expertise in Patient-Provider Interactions,” explore how physicians dismiss female patients’ concerns through the (re)construction of the historical, pathologized, neurotic female patient, as well as physicians’ outright rejection of patients’ experiential knowledge. They conclude that attention to the relationship between language and power in patient-provider interactions might make for more productive relationships in which patients feel heard.

The third section (“Social Construction of Illness/Biomedicalization of Bodies”) offers perspectives on sociocultural elements of pathologization practices. In “Orgasmic Inequalities and Pathologies of Pleasure,” Colleen Reilly examines the ways in which the female orgasm (or lack thereof) is pathologized by analyzing the debates in the medical literature pertaining to the vaginal orgasm. Reilly points out the inadequate information regarding female pleasure on popular websites (WebMD and the Mayo Clinic) that perpetuates the idea that the androcentric model of sex has contributed to orgasmic inequalities. The pathologizing of women who may not find pleasure in this way are told something is wrong with them. Reilly concludes by describing female sexual

dysfunction as the new hysteria. In “From the Margins to the Basement: The Intersections of Biomedical Patienthood,” Caitlin Leach argues for intersectional inquiry into how gender and health are constructed in US-based cardiovascular and sexual dysfunction research. Leach suggests that current medical discourse “problematically implies biomedicine alone can overcome the institutional structures of racism, sexism, cissexism, classism, and ableism as they intersect to impact women’s cardiovascular and sexual health” (138–139). Leach further argues that one common solution to practices of exclusion—inclusion—can actually compound injustice when actors do not pay attention to the effects of their practices as they exist within unjust systems. We must instead look to intersectional approaches to enact large-scale, institutional reform in order to resist inequitable effects of biomedicalization. Like Leach, Kerri K. Morris also raises concerns about exclusionary practices as a result of sociocultural understandings of illness in “Women and Bladder Cancer: Listening Rhetorically to Healthcare Disparities.” Drawing on her own experience of being—finally—diagnosed with bladder cancer, Morris examines the ways in which identification leads to misdiagnosis and/or missed diagnoses. By grounding her work in specific experience and calling attention to the ways her experience does not stand in for the experiences of all people or all women—“At the same time, I was going through perimenopause, *for me* a time of unpredictable menstrual cycles” (167)—Morris demonstrates the importance of personalizing medicine beyond socialized understandings of gendered disease: “It is a matter of listening in the gaps and acknowledging that women’s and men’s diagnoses diverge in ways that harm women. It is a way of listening rhetorically for nonidentification” (167).

The common characteristic of the collection’s fourth section is digital medical rhetorics. Miriam Mara’s chapter “Bras, Bros, and Colons: How Even the Mayo Clinic Gets It Wrong Gendering Cancer” examines how even an altruistic, prestigious organization like the Mayo Clinic can reinforce the pathologized gendering of illness. Mara examines the Mayo Clinic website to point out rhetorical patterns in which the organization implies (or even outright suggests) that women’s bodies are weak and that their reproductive organs will turn on them, thus justifying efforts to surveil and discipline female bodies to excess. Mara points to the ways this digital artifact reinforces problematic notions about women’s embodiment, and she questions those biases about women’s bodies. Lori Beth De Hertogh turns to community-generated digital artifacts in her examination of how *Black Women Do Breastfeed*, an online breastfeeding community, resists historical/biomedical

tendencies to code African American women as unwilling or unable to care for their children. “Interrogating Race-Based Health Disparities in the Online Community *Black Women Do Breastfeed*” engages race-based health disparities related to breastfeeding and offers recommendations for more inclusive research. More specifically, De Hertogh traces histories of African American women breastfeeding, while acknowledging her subject position as a “heterosexual, white, middle-class woman,” and engages in a deep “interrogation of the ways pathology operates as a form of meaning making that shapes women’s health experiences” (190). De Hertogh also cautions that even unofficial activist health texts can reify health disparities—as when documentation suggests formula feeding is somehow deficient—and that rhetoricians must be diligent about reframing these tendencies. In “Gendered Risk and Responsibility in the American Heart Association’s Go Red for Women Campaign,” Mary K. Assad likewise critiques rhetorical patterns that overgeneralize, recognizing the complexity when advocacy accomplishes a goal of greater awareness but also contributes to troubling cultural patterns that could counteract the positive effects of that awareness. Assad examines the web-based messages of the Go Red for Women campaign, critiquing its role in using heart disease as a site for reinforcing traditional roles. For example, Assad points out that Go Red for Women’s attention to self-care positions the campaign to advocate for more equal gender roles, but the campaign instead “reinforces them by urging a woman to perform self-care *so that* she can continue to occupy the caregiver role” (217). Assad complicates attention given to gender-based risk factors rather than sex-specific risk factors derived from a woman’s physiology.

The final section (“Textual Examinations”) offers critiques of literature about health and medicine. Jordan Liz offers a critical philosophical examination of two recent case studies about breast cancer. Liz’s “Pathologizing Black Female Bodies: The Construction of Difference in Contemporary Breast Cancer Research” critiques the pathologization of African American women in breast cancer research, articulating “a series of assumptions regarding race, gender and disease susceptibility operative in these studies” (224). By parsing the ways race and class are taken up in these examples of medical literature, Liz points out that concern over cancer rates in white women motivates the study of African American women, that these studies shift responsibility related to public health campaigns in worrisome ways, and that whiteness is falsely constructed as normal. While this chapter examines two case studies, those studies engage in rhetorical patterns that are familiar and

widespread. Beth L. Boser also focuses on rhetorical patterns in health literature in “*This Isn’t What I Expected: Overcoming Postpartum Depression: Individual and Social Gendered Pathology in Self-Help Discourse*,” which analyzes the rhetorics of postpartum disorder in relation to medical discourses. Boser is concerned with how gender and motherhood intersect with mental health and pathology and conducts a critical rhetorical analysis of the book *This Isn’t What I Expected: Overcoming Postpartum Depression* to point out the importance of revising such texts when their assumptions rely upon old-fashioned constructions of gender to the detriment of their readers. Boser astutely points out the importance of differential care and intersectional awareness in the self-help genre, as well as the necessity of resisting assumptions that equate “real” problems with biological problems. Boser ultimately advocates holistic and experience-based approaches as a way forward. The final chapter of this section—and the collection—builds on the importance of differential, experience-based, and material approaches to medical rhetoric. Sage Beaumont Perdue’s philosophical exploration “Making Bodies: Medical Rhetoric of Gendered and Sexed Materiality” argues for (and provides) a more thoughtful examination of medical rhetoric’s uptake of gender and sex. Perdue points out that biomedicine limits gendered possibilities while eliding the role of performativity and asks how medical rhetorics engender epistemological and ontological truths of materiality. This chapter “concerns itself with the ways medical rhetoric and fixed notions of bodily appearance reduce materiality as both *site* and *sight*, evading particular phenomenological experiences of the clinical encounter and nonnormative ways of being-in-the-world” (256). This chapter shifts the collection toward new lines of inquiry, centering transgender, nonbinary, and gender-nonconforming embodiment and questioning gendered and sexed norms in clinical and cultural encounters. Perdue ends with a plea “to not only honor stories of illness but also to honor stories and narratives of becoming and being gendered and sexed” (267).

In sum, these many diverse chapters offer a multiplicity of approaches to interrogating and intervening in the gendered pathologies that construct and limit our lives and health. By considering these perspectives in concert and by allowing them to exist in conversation and in tension with one another, we both model options and create openings for interventions in entrenched pathological patterns. We hope others might take up similar approaches with different orientations as guiding principles, and we hope this collection provides starting points for such work.

NOTES

1. Many of the chapters in this collection take multidisciplinary approaches, which we understand to mean they draw on and speak back to more than one discipline. Some also take inter- or transdisciplinary approaches; we have resisted labelling them individually because disciplinary boundaries and definitions are dependent upon individual (contributor and audience) perceptions. We leave this, then, as a jumping-off point for conversations about what constitutes inter/multi/transdisciplinarity. We see this collection as a whole as a transdisciplinary project, meaning that the sum of the parts demonstrates a way—beyond and across existing disciplines—of approaching rhetorics of health and medicine.
2. We purposely resisted adding citations to this sentence in order to challenge the notion that such common, mundane experiences for female and feminist scholars must be evidenced.
3. Francesca Bray (1997) argues that technologies include social and cultural systems.
4. Some scholars argue that data and the body have never been and never could be separated—that the nature-culture split is manufactured. We agree but also point to the political-scientific world in which we live, wherein agents of biomedicine and everyday culture behave as if that split is “real” (for more, see Barad 2007.)
5. These differences in disease presentation may explain why men and women tend to experience heart attack symptoms differently. Education surrounding heart attack symptoms is a parallel pathology. Education about heart attack symptoms has typically identified chest pain and pain in the left arm as warning signs. However, women more commonly experience jaw and neck pain, stomach pain, and fatigue.
6. Further, “women’s health” is often reductively read as “female reproductive health” (See, for example, Frost, Gonzales, Moeller, Patterson, and Shelton’s forthcoming *Technical Communication Quarterly* special issue on Unruly Bodies).

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