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During my second year of medical school, a few months before I was to start my clinical rotations, I spent an afternoon visiting the child and adolescent gender and sexuality clinic where I was conducting anthropological fieldwork. I followed the physician as she saw a patient, a transgender boy who was starting to take oral contraceptives to change his menstrual cycle. After we left the room, the physician suggested that I try writing a progress note about the encounter; she would review it, and it would be good practice for the next stage of my medical training. I froze, staring at the blank Epic electronic health record interface. As I jotted down in my fieldnotes later that evening—tucked between some quotations from Robert Desjarlais' *Shelter Blues* and a few key points from a late night renal review session about the BUN/Cr ratio—"I felt unprepared, acutely aware of my medical novice status."

Why did I struggle so much to write the progress note? Certainly, it was due in part to my lack of knowledge as a medical student. And the details I noticed in our encounter might not have fit neatly into a medical record; as another member of the clinical team put it, "You would have looked with totally different eyes!" But while these facts may explain why this task was difficult, they do not fully explain why I was so uncomfortable. What I felt was anxiety—a worry about my own efficacy, about the future of this transgender boy, and about an unfulfilled need for certainty in relation to practices of both medical diagnosis and anthropological critique. As critical trans and feminist scholars have documented, medical professionals have a complicated relationship to gender diversity, often playing an instrumental role in sustaining oppressive discourses of normative gender. In the hands of physicians and other healthcare workers, non-normative gender identities often become pathologies or problems to be managed.

I could not really imagine how to frame the experience of this patient as a problem. But I also could not imagine the medical record as conveying anything but a problem. In other words, fixing this boy's life in an electronic file represented the problematization of his experience, his gender identity and his desires, regardless of whether or to what extent it actually accomplished this. I was frozen by my sense that anything I wrote might implicate me in this practice of wielding knowledge as power.

As Seth Holmes and Maya Ponte (2011) argue, in learning to formulate clinical cases, medical students also form themselves as a certain kind of subject. Anthropological work on gender diversity, too, has been critiqued on the basis that it turns the lives of non-normatively gendered people into objects of study and commodities of professionalization for academics. Wanting to

avoid effacing the idiosyncratic richness of one family's experience, I reach for an anthropological counter-narrative; I am left with a vague anxiety about uncertainty and complexity. Does being an anthropologist commit me to being a failing medical student?

How do we make use of medical anthropology and knowledge of related disciplines in medicine? In my previous posts (part I and part II), I asked what social and humanistic disciplines promise in the arena of medical education. I argued that this promise is bound to a students' desires in the setting of education as a commodity, and complicated by a critical myopia that sees the possibility for transformation of medicine by anthropology, and not the other way around.

Perhaps my encounter in the gender clinic can illustrate the need to expand the concept of transformation; while it is certainly important to understand diverse experiences of gender in non-pathologizing terms, what this moment clarified for me was qualify my critical stance. This moment of participant observation framed clinical discourse in terms of a good enough language necessary for the everyday work of caring for gender expansive young people. Here, doing anthropology in the clinic promises also to challenge and reorganize theories by connecting them with ordinary practices. Though I am not sure how to do this in practice, I want to suggest that the creative energy of an anthropological intervention in medicine depends on leaving open the possibility that it is anthropology that will be transformed.

Works Cited:

Holmes, Seth M. and Maya Ponte. 2011. "En-case-ing the Patient: Disciplining Uncertainty in Medical Student Patient Presentations." *Culture, Medicine, and Psychiatry*. 35:163-186.