Counter-Clinical Spaces[1]

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Intermediary spaces between health social movements and biomedicine have proliferated since the 1970s and have typically been analyzed through the lenses of co-optation or hybridization. In this paper, we present data from two separate empirical projects (teaching and learning the pelvic exam in medical schools and feminist anti-violence counseling programs) in order to theorize what we call "counter-clinical spaces." Counter-clinical spaces are medicalized sites of knowledge production and practice that are produced through social movements' contestations with biomedicine. Other examples include sexual assault nurse examiner programs, LGBT health centers, and sexual health clinics. Counter-clinical spaces are 'counter' and 'clinical' in several ways. First, these spaces are distinctly clinical in that they intervene in the health of the body. Second, these spaces are counter-clinical in that they are organized in critique of dominant medical practices. Crucially, counter-clinical spaces engage the clinical encounter as a site of transformation: social movement actors target clinicians' deployment of medical power, especially in their interactions with marginalized persons. We thus attend to the scale upon which social movements make change in and against medicine, and we highlight how social movement logics can and do change practices even when they are unable to shift structures.

KEYWORDS: health social movements, biomedicine, feminism, clinic, scale, social change.

INTRODUCTION

Health social movements have increased dramatically since the 1970s, when activists began to challenge medical experts in new and collective ways, taking biomedical tools and

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knowledge into their own hands (Brown and Zavestoski 2004; Epstein 2008). With these social movements, the old boundaries between experts and the public broke down as "lay experts" (Epstein 1996) increasingly entered biomedical institutions and appropriated science for their own goals (Murphy 2012). As a result, biomedical institutions had to become more responsive to a changing public, even as science was increasingly regulated by the state and commercialized by private corporations (Frickel and Moore 2006). The result has been a proliferation of hybrid knowledges and practices that blend activist logics with those of biomedicine. While there has been a great deal of scholarly interest in these forms of hybridization, especially at the level of expertise, scholars have paid less attention to how hybridization has reshaped the clinic as an institutional space.

Why does the clinic matter? In both of our empirical research projects, we have wrestled with questions of *what gets produced* when movements meet biomedicine (Sweet 2021; Underman 2020). We have both found that new sites of care, new organizational structures, and transformed spaces of expertise may emerge when social movements intervene in biomedical knowledge and practices. Think, for example, of LGBT health centers, breast cancer advocacy programs in hospitals, and sex education programs. Such spaces are widespread and often emerge when a social movement advocating for health access or constituency-based services (Epstein 2008) meets a biomedical institution. Indeed, an analysis of "women's health centers" conducted in 2000 revealed that there are over 3,600 of these clinics operating in the United States, serving over 15 million women (Gharib and Manson 2000). Today, women can expect to encounter these sites, which grew out of women's health activism, when they access medical care. Likewise, a recent analysis of LGBT health centers in the U.S. reports that over 200 exist, serving hundreds of thousands of clients per year as part of a "health services in safe spaces" model (Martos, Wilson, and Meyer 2017). These types of interstitial spaces—shaped by social movements but part of large-scale institutions—are ubiquitous in contemporary life but under-theorized in existing literature.

These novel spaces are also sociologically significant: as Foucault has insisted, the clinic matters because it *organizes and materializes* the clinical gaze, both the "the field of objects to which observation [is] addressed" and the "perceptual codes…applied to patients' bodies" (1994:54). The clinic is powerful in contemporary life because "the whole of medical experience" is thought to reside there, and the clinic's very existence concentrates power for

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practitioners, validating their epistemologies (Foucault 1994:62). Indeed, while medical power is made up and extended by complex networks of expertise (Cambrosio et al. 2006; Eyal 2013), the clinic still codifies and organizes how patients experience "the medical gaze" in institutional contexts. As such, "clinics" need not be traditional "white coat" medical settings; rather, clinics are sites where patients *experience* medical authority, and where experts intervene in the health of the body. Thus, the production of new clinical spaces *through* social movements is a critical historical shift in "the clinic" as a site of medical power, forcing us to ask new questions about how hybrid forms of knowledge are materialized in organizations and institutions. Such hybrid spaces may also be found in courts or schools, which we discuss in the conclusion.

In this paper, then, we ask: How are these intermediary clinical spaces organized, materially and discursively? How do activist interventions change clinical practices in these spaces—or not? We present data from two empirical cases—gynecological teaching associate (GTA) programs and domestic violence counseling programs—in order to theorize the meso-level spaces that open up when social movement demands meet biomedicine. Our strategic juxtaposition of these cases shows how two distinct feminist mobilizations – both of which addressed discriminatory treatment in health-related settings – produced durable, quasi-clinical spaces where social movement claims intermingle with medical protocols. We call these *counter-clinical spaces* because they are: 1) clinical, such that they are located in hospitals or managed by medicalized experts; and 2) spaces of challenge, reorganized by activist critiques of clinical hierarchies. Counter-clinical spaces are created through activist pushback against biomedicine, which transforms the clinical encounter in important ways. In Michelle Murphy's words, activists "appropriate" health technologies and use them differently, as "counter-conduct," in order to challenge oppressive medical practices (2012). We draw from Murphy's (2012) work to show how feminists "counter" biomedicine on biomedical turf; but we focus on the production of intermediary institutional spaces, rather than on technological interventions.

Our cases both demonstrate that when social movements meet biomedicine, new institutional spaces are created that may bring together previously antagonistic actors. And yet, these counter-clinical spaces are limited in their ability to transform the structural basis of biomedicine. As our cases show, counter-clinical spaces demand attention to granular transformations, especially in the logics of interaction between "expert" and help-seeker. Analyzing counter-clinical spaces thus draws our attention to the *scale* of social change. While

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existing literature tends to explain such spaces as hybrid or otherwise "entangled," we zero in on the specific ways in which social movements have transformed expert interactions with patients and ideologies of care delivery.

Both of our cases focus on feminist projects in a historical context so that we can track antagonism and change over time between and within a social movement and biomedicine. Feminism is a particularly compelling case for exploring counter-clinical spaces because, since the 1960s, feminist activists have had an unusually polyvalent impact on biomedicine. From the rise of "women's health" in research and healthcare (Thomas and Zimmerman 2007) to the creation of sexual assault nurse examiner programs in hospitals (Morse 2019; Mulla 2014), feminists have made their way "into" biomedicine by reimagining what "the clinic" is and how it should operate. At the same time, feminists have contested biomedical power and authority "from without:" from the work of breast cancer advocacy groups (Klawiter 2008) to efforts to de-medicalize childbirth (Brubaker 2007; Brubaker and Dillaway 2009; Davis-Floyd 2004), activists have sought to keep women's experiences and bodies outside of biomedical control. In this sense, while feminist activism has transformed aspects of biomedicine—introducing new practices and changing logics of care—biomedicine remains a powerful, profitable, highly stratified institution, still "dangerous" for women.

As such, our analysis speaks to political questions at the core of social movements and medicalization. Why is it that activist attempts to make medicine more egalitarian often end up reproducing medical power? Do these hybrid projects retain the status quo and inoculate powerful actors from critique because they "look" inclusive? Our analysis suggests that because counter-clinical spaces are marginal to biomedical institutions, they may do little to challenge the logics and epistemologies of biomedicine—even when activists participate in creating new professional standards and forms of knowledge. This has to do with the enduring power of the clinic as a material space where medical authority is concretized and legitimated.

THEORIZING COUNTER-CLINICAL SPACES

Sociologists have developed two general accounts of what happens when a social movement meets medicine: co-optation and hybridization. In what follows, we outline these two perspectives and demonstrate how our concept of "counter-clinical spaces" works toward reconciling the strengths of each analytic tool.

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Medicalization and Co-optation

The medicalization literature addresses the interpenetration of biomedical knowledge and practice into everyday life. Where biomedicine defines and dictates reality, its targets of control both take up its tools and epistemologies *and* find ways to resist or subvert this power. In this literature, co-optation has been a popular analytic, in part because it attends to the massive economic, political, and cultural power that biomedicine wields in contemporary social life (Clarke et al. 2003; Conrad 1992; Goldner 2004). Co-optation focuses on the ways in which biomedical power swallows the aims and reforms of activists for its own ends. And indeed, health social movements have often engaged in what Maren Klawiter calls "consensus activism" (2008), which tends to leave biomedical power intact while executing small-scale, strategic transformations. For example, Elianne Riska argues that the women's health movement, which began as a way for women to claim ownership over their marginalized health issues, slowly became part of the disciplinary regime of medical enhancement (2003). Empowerment was diluted into apolitical versions of "self-help," as feminist interventions were co-opted into spa-like "pampering" services in hospitals (2007). Other scholars have shown that in such programs, women's bodies may end up getting used as sites for the construction of biomedical authority (Mamo and Fosket 2009; Martin 1987; Riska 2010). In general, medical attention appears to bring both wider recognition of "women's issues" *and* compromised feminist goals (Morgen 2002). This trade-off has been documented for issues such as breast cancer (Anglin 1997) and menstruation (Figert 2017), for which activism garners much-needed biomedical resources but also makes the problem vulnerable to co-optation by newly enlightened biomedical experts. In this way, co-optation focuses almost solely on how biomedicine subsumes health activism.

While these insights have been helpful for analyzing the power of biomedicine, the co-optation framework has largely ignored how social movements shape biomedical practice and knowledge in novel ways. There is substantial empirical evidence that new spaces of action and knowledge production have been forged through these dynamics. Adele Clarke and colleagues have highlighted the "new forms of agency, empowerment, confusion, [and] resistance" that have characterized the public's engagement with science since the 1970s (2003). Steven Epstein has called for a reorientation toward the study of lay and patient groups (2008), since the hybrid and boundary-crossing character of these groups has become central to medical practice over the past forty years. Scholars should pay attention to movement interpenetrations with science, he

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argues, asking where movement and institution begin and end (Epstein 2008). We draw insights from this call to action by examining the interstitial organizational spaces between social movements and biomedical institutions.

Health Social Movements and Hybridization

While taking medicalization and co-optation seriously, scholars have increasingly focused on lay experts and other hybrid forms of knowledge and action, which appear to be ever more present in contemporary life. For example, Joanna Kempner has shown that headache sufferers cultivate their own forms of expertise on and offline to self-advocate and manage the non-knowledge that surrounds their suffering (Kempner 2014; Kempner and Bailey 2019). Not only do lay-experts attempt to "author patienthood" in new ways, but they also change the way knowledge is produced, the way data are collected, the way rights are distributed – the way science is done (Epstein 1996; Landzelius 2006). Christoph Hansmann has shown how trans health activists shifted dominant ideologies of health by using "objective" population health data to make social justice claims for resource redistribution and personhood (2020). Hansmann refers to this as "counter-data action" and points out that it may engage a rational, detached tone *and* a tone of activist rage (2020:3). Kane Race (2009) uses the term "counterpublic health" in order to conceptualize collective forms of resistance carried out by queer people and others stigmatized by normative knowledges and practices in public health.

Likewise, in her work on the women's health movement, Michelle Murphy argues for a notion of feminist "counter-conduct," a term "that highlights modes of undoing, remaking, and antagonism that are immanent with and animated by hegemonic formations" (2012:183). Indeed, "counter-conduct" characterizes feminist spaces: activists seize biomedical tools – such as the Pap smear – to "do" clinical encounters in a more equitable and justice-oriented way, thereby producing new forms of health expertise. In this "counter-conduct," the relationship of steep authority between patient and clinician is put under attack and may be destabilized. We draw from these above notions of "counter" engagement to theorize how feminists intervene in the space of the clinic, reconfiguring the logics and practices of clinical encounters. However, we extend this literature by focusing on how "counter" forms of conduct become concretized in new organizational and institutional spaces.

Thus, literature on health social movements demonstrates that contributing to health knowledge is an intentional activist project. Marginalized social identities such as race, gender,

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and sexuality may themselves become sites of counter-hegemonic knowledge production when those categories are mobilized as part of movements (Decoteau 2017). These forms of counter-hegemonic knowledge may then become "subsumed" into mainstream science and biomedicine – if only partially (Decoteau and Daniel 2020). In this sense, health movements have become increasingly involved in the production of mainstream scientific knowledge, even when those movements retain a politics of identity and contestation (Brown 2007).

As such, medical sociologists and social movement scholars are increasingly attentive to multiplicity and interpenetration across social movements and biomedical institutions. These analyses acknowledge that biomedicine itself is constituted by multiple forms of knowledge, by diversity, and by fragmentation (Knorr Cetina 2007). As David Hess argues, under modern conditions, the distinction between lay and expert knowledge is "submerged" in a complex field (Hess 2004). Responses from expert domains often *integrate* epistemic challenges to science and medicine, rather than rejecting them (Decoteau and Daniel 2020; Hess 2004)—this pluralism is in fact characteristic of contemporary scientific and medical institutions (Goldner 2004). Science does not recede through such pluralism, but expands (Clarke et al. 2003; Hess 2004).

Thus, while the co-optation framework previously dominated analyses of health social movements, the literature on biomedicalization and health social movements has evolved to focus on blurred boundaries and hybrid activist strategies, on deconstructing binaries between experts and patients, between movements and medicine. To be sure, both styles of analysis point to important and enduring realities. The question becomes, then: how can we disentangle mechanisms of co-optation from those of hybridization?

Counter-Clinical Spaces

In this paper, we suggest that a more granular look at co-optation and hybridization dynamics between social movement and medicine is necessary. To do this, we turn to the meso-level, quasi-clinical spaces of action and knowledge that get produced through social movements' contestations with biomedicine. These new institutional sites may be feminist-founded medical clinics, patient advocacy centers in hospitals, or empowerment therapy programs in non-profit organizations. Peering into spaces of "counter-conduct" (Murphy 2012) exposes mechanisms of hybridity (feminist use of biomedical tools) *and* co-optation (feminist knowledge gets ensnared back into medicine as "patient self-advocacy"). To capture both the

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hybridity of these spaces *and* their rootedness in biomedical power, we refer to them as counter-clinical spaces. They are *clinical* while they also *counter* the hierarchies of the clinic.

Certainly, the clinic is no longer *the* social space for the enactment of medical power. Medical power is extended via complex networks of expertise that govern regulatory science and, in turn, clinical decision-making (Cambrosio et al. 2006; Eyal 2013; Timmermans and Berg 2010). And yet, the clinic remains an important "checkpoint" that organizes the work of medical professionals, institutionalizing how patients gain access to diagnoses and treatments. While the clinic is not *the* only site of medical power, it remains an important space in which experts gatekeep institutional legitimacy for patients' suffering. That said, not all "clinics" look alike, and many of them look especially different since the 1970s. It is our contention, then, that attention to the clinic can shed light on the scale at which activists intervene in biomedical knowledge and procedures – for example, by using medical tools alongside feminist discourses, or by deconstructing the authority embedded in the clinical encounter.

A wealth of sociological research reveals the clinical encounter to be an important micro-political site for the enactment of medical power (Foucault 1994; Heritage and Maynard 2006; Jutel 2009; Timmermans 2020; Vinson 2016). Clinicians—in particular physicians—control social space, time, and language (Anspach 1988), and the asymmetrical power relations between clinician and patient create inequalities in healthcare quality and access (Shim 2010). Annemarie Mol (2002) shows that the structure of the clinic changes the embodiment of disease itself. As LaTonya Trotter (2020) demonstrates, professional projects among healthcare providers delimit the boundaries of what is considered medical care in the clinician-patient interaction, and social problems are often misrecognized in the clinical encounter as beyond clinician jurisdiction. This produces further inequalities for already marginalized patients. Indeed, the entire project of the bio/medicalization hypothesis can be seen as, in part, patients' efforts to access care for fundamentally social problems through the powerful gaze of the clinician (Conrad 1992; Clarke et al 2003). This is evident in literature on the tension between social control and expansion of access that occurs through the micro-political act of diagnosis (Jutel 2009). The clinic, therefore, remains a foundational social space in which the structural power of biomedicine is enacted in uneven relations between clinician and patient.

Counter-clinical spaces are 'counter' and 'clinical' in several important ways. First, these spaces are clinical in that they intervene in the health of the body. They are about fostering health

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and well-being of marginalized individuals or groups. In this way, they carry out clinical work, differently conducted. Second, these spaces are *counter*-clinical in that they are organized in critique of dominant clinical practices. In this way, counter-clinical spaces target the micro-political practices of the provider-patient relationship. They are often intended to deconstruct the hierarchy between provider (e.g., a physician, especially a psychiatrist) and a patient. In doing so, counter-clinical spaces make claims *against* the structural arrangements of medicine, but do not specifically target or dismantle systemic mechanisms like racism and capitalism.

Crucially, counter-clinical engage the clinical encounter itself as a site of transformation: social movement actors target the deployment of medical power by clinicians in their actions with marginalized persons. Indeed, counter-clinical spaces focus on the clinical encounter as the specific location where problematic structural arrangements are embodied in social action. Social movement critiques are distilled down to the practices contained within the clinician-patient relationship. Thus, counter-clinical spaces *do* the clinical encounter *differently*. In articulating a concept of counter-clinical spaces, we thus attend to the scale upon which social movements make change in and against medicine, and we highlight how social movement logics can and do change *practices* even when they are unable to shift *structures*.

METHODS

We turn our attention now to two examples of counter-clinical spaces. In our analysis, we show both what is produced in counter-clinical spaces *and* how this concept helps explain the social action that occurs here. The data for this paper come from two different research projects that consider the historical origins and contemporary intersections of feminist activism and biomedicine: gynecological teaching associate programs and domestic violence counseling programs. In both cases, activists from feminist health and anti-violence movements contested biomedicine. These activists focused in particular on the clinical encounter as a site of biomedicine's oppressive power in action. As a result of feminist challenges, a new social space was formed, which we call a counter-clinical space. In neither case was the power of biomedicine or its actors radically transformed, though important shifts took place in and through these peripheral sites. Our cases detail different forms of feminist activism, and, indeed, in each of our cases, there are multiple forms of feminist action—which are sometimes contradictory. What is useful about "counter-clinical spaces," then, is that this concept draws attention to

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hybridity and multiplicity *within* as well as *between* spaces of social action, while retaining an emphasis on the durable power of institutions.

We have specifically chosen to focus on these historical cases, since during the 1970s and 1980s, feminist movements were deliberately antagonist toward mainstream medicine. Both empirical cases therefore follow feminist protest from the mainstream women's health movement or anti-violence movement of the 1970s into the present day, examining the effects of social movement antagonism on medicine (and vice versa). In fact, we chose these two cases because of their similarities *and* their differences. The case of teaching and learning the pelvic exam in medical education captures classic themes in the study of the women's health movement: antagonism toward biomedicine, reproductive (in)justice and medical exploitation, and the ways in which feminists seized the means of (re)production (Murphy 2012)—only to face backlash and political defanging. On the other hand, the anti-violence movement is typically analyzed as a case of criminal co-optation, or criminalization (Kim 2020; Richie 2012). However, theorizing the medicalization of anti-violence work reveals key similarities to women's health movements: a central aim of anti-violence activism was to challenge women's discriminatory treatment in health settings (i.e., therapy). Because of feminist success in this challenge, some of the most lasting products of the movement are quasi-medicalized sites of therapeutic intervention. As such, situating anti-violence activism alongside the women's health movement exposes critical overlaps between these movements, especially around their interventions in the clinical encounter. Our comparison of these cases also, however, reveals the broad reach of counter-clinical spaces, since they emerge across different types of mobilizations. In order to draw attention to the resonance between our cases, we use a parallel structure in each of our data sections below.

The juxtaposition of these two empirical cases is therefore strategic. Our cases are similar in their antagonistic approach to medicine while they differ in their specific goals and their targets of intervention: we leverage their differences to show how similarities emerge around the politics and compromises of counter-clinical spaces. Similar "clinics" are produced through diverse engagements with biomedicine. While the particulars of these cases are specific to feminist activism during the 1970s, the theoretical intervention we offer here may apply to many forms of health activism, a consideration we return to in the conclusion.

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Both of our empirical projects combine archival research with contemporary interviews of key participants in both fields. The first case is based on Underman's work (2011; 2015; 2020) on the development of a program for teaching and learning the pelvic exam in medical schools. Underman conducted fifty-six interviews with three groups of key stakeholders between the years of 2010 and 2015: GTAs and program coordinators, medical students, and medical faculty. Interviews with GTAs, program coordinators, and medical faculty covered both the historical development of these programs *and* their current use in medical education. In addition, Underman collected thousands of pages of documentary sources, including medical journal articles, newspaper and magazine articles, meeting minutes, and curricular materials such as teaching protocols and scripts. She analyzed her data using situational analysis (Clarke, Friese, and Washburn 2017), which combines traditional grounded theory techniques like open-coding and memo-writing with discursive analysis techniques like social arenas maps and positional maps.

The second case is based on Sweet's work (2021) on the feminist anti-violence movement. Between 2015 and 2017, Sweet conducted: 1) archival research at four archives that focus on the history of feminist activism in the United States[4]; 2) fifty-five interviews with domestic violence professionals around the United States, from national level policy leaders to local frontline workers.[5] Interviewees were recruited through a purposive sampling method in which participants were chosen for their deep knowledge of the field. All data were analyzed using layered processes of coding, memo-writing, and diagramming (Clarke 2005). Archival research reveals the extent to which activists contested psychiatry in the early movement, resisting medical models, while they also used medicalized counseling models to legitimate their work as the movement grew. Sweet further draws on interviews with contemporary domestic violence professionals to highlight the ongoing effects of these medicalizing shifts, as well as to describe what counter-clinical spaces look like today.

CASE 1: GYNECOLOGICAL TEACHING ASSOCIATE PROGRAMS

[4] Archives accessed: National Coalition Against Domestic Violence (Denver, CO), Harvard Schlesinger Library on the History of Women in America (Cambridge, MA), Illinois Coalition Against Domestic Violence Archives at DePaul University (Chicago, IL), and Smith College Violence Against Women Archives (Northampton, MA).

[5] Data for this project also include life story interviews with survivors of domestic violence, but these data are not included in the present analysis.

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Gynecological teaching associates are specially-trained laypeople hired by most medical schools in the United States to teach medical students the skills of the pelvic exam using the GTA's own body (Beckmann et al. 1988). These programs emerged during the 1970s and became institutionalized in medical schools in the 1980s due in part to feminist activism both inside and outside of biomedicine and due to efforts within medical education to improve clinical skills training (Underman 2011; 2015; 2020). As such, these programs are curious hybrids, blending logics and practices of care from feminist activism with biomedical logics. GTA programs are an example of a counter-clinical space, as a new organizational space that produces new kinds of practices and forms of embodiment where feminist health activism overlaps with biomedicine. Their existence has fundamentally reshaped how the pelvic exam is practiced—transforming the clinical encounter—and yet they have done so without shifting the larger stakes of biomedicine.

Pushing Back Against the Clinic: GTAs

Prior to the 1970s, medical students were taught a version of the pelvic exam that reflected the dominant culture of biomedicine: a physician (almost always a man) would deploy his expert knowledge on the passive body of the patient. The objects of medical students' education were coerced clinic patients, cadavers, rubber models, and sex workers (Kapsalis 1997). This prepared medical students to practice the exam such that the patient was entirely passive: the patient was flat on her back, there was a drape sheet over her knees so that neither patient nor physician can see the other's face, and, since the exam was assumed to be painful and embarrassing anyway, the patient was not informed of what was happening, nor was any care taken to make the exam physically more comfortable. Such practices equipped medical students to wield authority in biomedicine, in which impersonal skill, emotional detachment, and paternalism could secure economic and symbolic forms of power (Brosnan 2009; Fox 1979; Smith and Kleinman 1989).

Many feminists were deeply critical of the pelvic exam and, indeed, the subspecialty of obstetrics and gynecology (Bell 1979; Morgen 2002; Norsigian 1975; Ruzek and Becker 1999). This was an area for them that underscored the myriad ways in which biomedicine had wrested women's knowledge of their own bodies away from them. In response, heterogenous feminist projects emerged to challenge the economic, social, and cultural power of biomedicine. Some feminists began opening self-help clinics in order to provide alternative forms of reproductive

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healthcare, outside of the control of biomedicine (Kline 2010; Morgen 2002). Such social spaces often sought to democratize knowledge, wrestle health/care from the clutches of capitalism, and confront sexism, racism, and homophobia. These clinics began teaching women how to perform pelvic exams on themselves and their peers. In groups, women were encouraged to use specula to view their own cervixes, to examine and track the changes in their vaginal secretions, and, in some cases, perform their own Pap smears (Murphy 2012; Nelson 2011). In this way, feminist health activism emerged in the 1960s and 1970s as a loosely organized attack on biomedicine, seeking to undermine its stranglehold on reproductive healthcare.

New Organizational Spaces: GTAs

Feminist activism confronted biomedicine and, as a result, co-produced the GTA session as a counter-clinical space. Throughout the 1960s and 1970s, a growing number of medical faculty members became concerned with how medical students were being taught clinical skills (Underman 2020). The 'game' of capital-seeking in biomedicine was beginning to shift, as health social movements, managed care, and the pharmaceutical industry increasingly destabilized the medical profession. As a result, the orthodox assumption that mastery of scientific knowledge was enough to ensure continued professional dominance was shaken. A small group of medical educators became concerned with how best to judge a trainee's knowledge *and* performance of clinical skills. They believed that only through standardization of training and uniformity of practice could physicians maintain control over patients—and their economic resources. These reformers initiated curricular change based on educational psychology (Miller 1980). Their calls for change were, however, controversial to the wider profession, demonstrative of the remarkable durability of biomedicine. Debates appeared in medical journals over the worthiness of assessing *performance* as well as knowledge, with reformers occupying the heterodox position. Such a marginal group was amenable to the kind of projects that feminists were undertaking outside of biomedicine and used them in order to further their own interests. Given how many women were seeking care from self-help clinics and nurses instead of physicians, the pelvic exam was an important place for reformers to place their efforts. During the late 1970s and early 1980s, medical students and educators spoke at conversations at national conferences like the American Association of Medical Colleges (AAMC) about better ways to teach the pelvic exam. These educational spaces provided a meso-level space within which the tools and discourses of both biomedicine and feminist health activism could circulate.

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The first iteration of the GTA program occurred in 1976. As Susan Bell (1979) and Wendy Kline (2010) demonstrate, the Boston Women's Health Collective was one of the first feminist self-help clinics to work with medical educators on a new program for teaching and learning the pelvic exam. This counter-clinical space drew from the practices and knowledges of biomedicine *and* those of feminist self-help activism. The Pelvic Teaching Program (PTP) used a trained layperson from the women's clinic as a model for medical students at Harvard University to practice on. As this program developed, the layperson took a more active role in teaching. However, when the PTP published an article about their activities in a radical health journal, many feminists began to raise concerns about the likelihood of co-optation. The members of the PTP thus revised their curriculum to challenge "hierarchy, sexism, fragmentation of learning skills, profit, and division between provider and consumer" (Bell, 1979: 12). This new curriculum was intended to directly challenge the institutional power wielded by biomedicine. These changes were untenable to medical educators and the program disbanded.

However, feminist activism was not uniform in its relationship to biomedicine (Ruzek and Becker 1999). Whereas members of the PTP were cognizant of the risk of co-optation and chose to work outside of institutional spaces, other feminists elsewhere were more willing to work *within* institutions. This what Underman found occurred in Chicago. During the 1970s and 1980s, Chicago was home to diverse forms of feminist health activism (Kline 2010). One such group, the Emma Goldman Health Collective, was formed in 1974, but split apart a year later over debates about expanding the scope of services through collaboration with physicians and by reaching out to more poor women and women of color. The off-shoot became the Chicago Women's Health Center and incorporated feminist-oriented physicians among its staff. This was the organization that women medical students approached. They had learned at national conferences about new experiments in teaching and learning the pelvic exam, and they paid a member of the Center to teach them how to perform a sensitive and patient-friendly exam.

A member of the medical faculty learned of the project and became involved. He recruited more women from the Center and a local Planned Parenthood clinic to teach the pelvic exam. This produced a cohort who were politically motivated to reform teaching and learning the pelvic exam but were not positioned within the institution itself: "The [GTAs] are, in part, attracted to this ambiguous situation because they see it as a way of having positive influence on the training of doctors while not becoming incorporated within the medical education

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establishment which they may perceive as chauvinistic" (Beckmann, et al, 1988: 128). In this way, feminist activists intentionally sought a liminal social space to have "positive influence" without becoming "incorporated." As a result—or perhaps because of—this willingness to work with physicians and within institutions, the explicitly anti-racist and anti-capitalist practices of the Emma Goldman Health Collective or indeed the earlier model, the Pelvic Teaching Program, failed to be taken into this counter-clinical space.

As the program developed, the faculty member mentioned above invited non-physician PhD researchers from the university's office for medical education research to evaluate the program. The GTAs were taught to use a standardized communication checklist that these researchers had developed for teaching clinical skills. The faculty member and non-physician PhD researchers then published a number of academic articles, presented at conferences, and sought grant funding based on the GTA program. In this way, the movement to reform medical education was central to the formation of this counter-clinical space through reformers' efforts to secure scientific authority through the use of educational research. Their efforts helped institutionalize GTA programs in medical education.

Limited Transformations to Biomedical Power: GTAs

Today, over three-quarters of medical schools in the United States and Canada use GTA programs (Dugoff et al. 2016), as do other health professions training programs (Underman 2020). Most of those programs follow the model developed by feminist activists and reformers of medical education: GTAs usually teach alone or in pairs and use a curriculum that emphasizes respecting patient comfort and care. For example, GTAs teach students to avoid medical jargon (i.e., "palpate") *and* colloquialisms that could be overly sexualized (i.e., "stick my fingers in") in favor of 'neutral' language (i.e., "place my fingers"). GTAs also teach appropriate handling of the speculum, such as using lubrication whenever possible and never removing a speculum fully open. This model is considered a gold standard by national professional associations; indeed in side-by-side comparisons of feminist-written protocols and guidelines from the American College of Obstetricians and Gynecology (ACOG), many of these feminist-derived aspects like proper language use, demonstrations of respect and empathy, and patient-friendly handling of the speculum are presented as best practices (Underman 2020). Such patient-centered techniques align with broader trends in medical education to foster empathy and respect for patient autonomy. For example, many of the communication skills that GTAs teach medical students

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regarding proper language and nonverbal displays of empathy are tested on national-level licensing examinations and reflect the values of "patient-centered care."

And yet, despite their widespread usage, GTA programs remain at the margins of medical schools. GTAs are frequently employed as independent contractors and given no benefits or guaranteed work. Programs are often run out of simulation centers in the medical school by program coordinators who are also contracted workers, not employees. When medical schools face financial challenges, GTA programs may even be put up for closure. In this way, while GTA programs have become 'successful' at shifting how the pelvic exam in taught and, indeed, practiced, they remain lodged in precarious and unstable social spaces at the margins of the institution. GTAs themselves report being neither able or willing to become more integrated; many today espouse feminist politics and view their work as a form of activism or advocacy.

Thus, the GTA program as a counter-clinical space: a new organizational space that combines practices and knowledges from feminist activism and those of biomedicine. It has forged new social *things* as well; indeed, new types of experts and expertise are formed in this meso-level space that are neither wholly feminist nor wholly biomedical. The GTA is herself a hybrid expert whose authority rests on her ability to use her bodily knowledge in this way (Underman 2011; 2020). The early feminist activists of the Pelvic Teaching Program who challenged the economic and political power of the institution 'failed' at transformation, while activists such as those in Chicago were 'successful' at pushing back on the conduct of clinical work, without fundamentally changing the stakes of the game. In this way, our concept of the counter-clinical space best explains the multiplicity of feminist forms of protest and what types of change are tenable to the more powerful institution of biomedicine.

CASE 2: DOMESTIC VIOLENCE COUNSELING PROGRAMS

Domestic violence programs, too, are interwoven with knowledge and practices from both feminisms and medicine. Nevertheless, most scholarly work on the feminist anti-violence movement focuses on feminist collusions with the carceral state (see Kim 2020; Richie 2012). While analyses of criminalization are important and timely, they leave out the movement's deep engagement with psychiatry and psychology, which radically shapes the day-to-day life of domestic violence programs. Though feminist activists were the first to make domestic violence into a "social problem" worthy of resources from the state, the field of psychiatry had long used theories of masochism to explain "why women stay." The activists who developed domestic

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violence services in the 1970s and 1980s opposed the authoritative psychotherapist and his diagnostic project (Sweet and Giffort 2021). Even in their opposition, however, feminists drew from psychotherapeutic techniques and social work models when they built service programs. By refiguring the therapeutic relationship, feminists developed a new set of counseling tools, as well as a new space where women could find care (Sweet 2021). Domestic violence counseling programs, then, are *counter-clinical spaces*: meso-level sites where medical and feminist meanings, experts, and practices interact with and shape each other. Still, these spaces remain peripheral to biomedicine, sequestered in community organizations far from biomedical power, transforming medical approaches to violence only at the margins.

Pushing Back Against the Clinic: DV Counseling Programs

As feminists developed counseling models for abused women and lobbied for federal funds during the 1970s and 1980s, they faced pressure to collaborate with clinical professionals. This was a problem for many activists because their early organizing work *opposed* medicine and psychiatry: most of the first pamphlets, newsletters, flyers, and academic papers distributed amongst feminist organizers in the 1970s strongly critiqued psychiatric theories of masochism. Anti-violence activists testified against diagnostic categories at American Psychiatric Association hearings and protested at their conferences. However, even as feminists argued against psychiatric approaches, they drew on therapeutic expertise. In need of services to offer women who were seeking refuge, activists developed therapeutic programs in collaboration with feminist clinicians. In other words, “pushing back” against psychiatry did not look like pure resistance: rather, feminist challenges to psychiatric misogyny *materialized* as quasi-clinical spaces that combined feminist ideologies of care with medicalized therapeutic tools.

For example, in an Ann Arbor Wife Assault Task Force manual from 1976, activists are instructed to set up counseling services as the first line of defense when building grassroots anti-violence programs. Mindy Resnick, a social worker, conducted trainings in the area. She instructed volunteers, “to provide the victim with emotional support, to encourage her to talk about her experiences and to help her to identify and understand her feelings” (1976:6). Volunteers were asked to confront stereotypes about battered women during counseling sessions: “[Many believe] that women are by nature masochistic and thus expect and enjoy physical abuse. It is important to explore these beliefs and misconceptions with the victim to let her know that her counselor doesn’t believe these things are true” (10). Organizers believed that giving the

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power of counseling over to volunteers and survivors would *politicize* therapeutic techniques such as "listening" and "exploring feelings." Activists saw this rearrangement of the therapeutic encounter as core to their project of resisting psychiatry. Organizers were optimistic about the radical promise of bringing feminist-minded clinicians into the fold alongside survivors and activists in order to help execute this work. In this sense, teaching volunteers how to *deconstruct hierarchical therapeutic arrangements* was a central project for early activists. While feminist clinicians were invited in, counseling work was nevertheless supposed to be delivered by activists and survivors. This "peer" counseling model would come to define the distinctive approach of anti-rape and domestic violence agencies throughout the 1970s and 1980s.

Another set of discursive transformations in the 1980s affected how feminists "pushed back" against psychiatric authority. During these pivotal organizing years, national-level rhetoric around domestic violence shifted into the language of "epidemic." This shift was prompted by Surgeon General Everett Koop's 1985 national meetings on violence as a public health issue. According to feminist activist and doctor Anne Flitcraft, the meeting marked the first "articulated strategy to address violence as a public health problem" (1993:154). While the federal government's attention to domestic violence was lauded by feminist organizers, their own frameworks were sidelined during the meetings: rather than feminist language about patriarchy, medicalized language about the "epidemic" of family violence dominated. Domestic violence was likened to problems like smoking, priming domestic violence for the disease model (Sweet 2015).

Despite their longstanding critiques of medicalization, many anti-violence organizations seized on the language of epidemic. A 1980s Illinois Coalition Against Domestic Violence newsletter reads, "We must learn to inoculate ourselves against violence… Violence in our culture is a disease" (Illinois Coalition Against Domestic Violence 1981). The language of epidemic was useful because it granted activists legitimacy in their legislative efforts. Further, this discursive shift helped put responsibility on doctors to respond to domestic violence in hospitals: in 1992, the American Medical Association released their first statement on the responsibility of physicians to address domestic violence (American Medical Association 1992).

These shifts brought activists into increasing contact with medical experts: psychologists and clinical social workers were needed to testify in court to victims' distress; researchers were needed to develop psychological profiles of abused women; and doctors were asked to identify

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victims in healthcare settings. As Evan Stark points out, domestic violence programs were never "pure" feminist spaces: many incorporated mental health experts early on, despite their distaste for diagnosis (2007). By the 1980s, it was so common for domestic violence agencies to have incorporated clinical frameworks that the National Coalition Against Domestic Violence asked member relationships to account for their relationship to the mental health system in order to retain coalition membership (1989). By the 1980s, then, feminists were less focused on erecting boundaries between feminism and psychiatry, and more focused on developing spaces where they could conduct peer-to-peer, empowerment-based counseling in collaboration with like-minded clinicians. Developing such counseling spaces meant that feminist agencies began to hire advanced degree workers—mostly clinical therapists from social work programs. The passage of the Violence Against Women Act in 1994 amplified this professionalization, as agencies faced pressure to demonstrate professional efficacy in order to receive funds (Whittier 2016, 2018). Therefore, feminist pushback against psychiatry settled into a new form: counter-clinical spaces, which are counseling centers that used non-hierarchical, "survivor-centered" interventions, nevertheless characterized by medicalized discourses of epidemic and therapeutic intervention.

New Organizational Spaces: DV Counseling Programs

While domestic violence counseling programs in the 1970s sought to employ laypeople instead of therapeutic professionals, those programs became increasingly medicalized over the course of the 1980s (Sweet 2015, 2021). Early programs focused on equality in the therapeutic relationship and radical self-help practices. However, feminists developed increasingly professionalized therapeutic models in the 1980s and 1990s. Activists collaborated with clinicians to develop an assemblage of techniques from feminist activism (self-help and empowerment) and medicine (psychotherapeutic techniques of internal exploration). Feminists "reassembled" their programs into legitimate counseling models that drew from clinical paradigms focused on traumatic response. By the 1990s, feminists had created their own field—complete with federal legislation and funding—by making themselves into counseling experts (Sweet 2021; Sweet and Giffort 2021).

Domestic violence counseling programs became increasingly clinical. Anti-violence policy experts began using diagnostic checklists. Social actors on the margins of biomedicine—such as clinical social workers—played an increasingly central role in domestic violence organizations, transforming the symbolic stakes of such organizations. And the therapeutic

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encounter itself changed: outcome measures, individual psychological improvement, and quantitative measures of survivor self-efficacy became increasingly central to domestic violence work (Sweet 2014, 2015). As feminist activists interacted with biomedicine, a more professionalized, therapeutic style of feminism emerged, one that marginalized the radical, heterogeneous feminisms that had once played a major role in organizing efforts (Bumiller 2008; INCITE! Women of Color Against Violence 2006; Richie 2012; Whittier 2018).

Still, anti-violence leaders used the language of feminist empowerment throughout the 1990s and early 2000s. Archives reveal that policy experts used clinical PTSD measurement scales to educate medical professionals about domestic violence, but they also incorporated language about non-hierarchical counseling and empowerment. In domestic violence counseling spaces, it is not PTSD as a psychiatric category that reigns—rather, "trauma-informed" models reign, which seek to bridge the language of post-traumatic stress with feminist self-help. In meeting minutes about federal funding in the early 2000s, domestic violence leaders agreed that "trauma-informed" was *the* link necessary for working across feminism and biomedicine (Schechter 2003). This link is increasingly important in domestic violence agencies today. For example, Amanda, a policy leader, described her program as grounded in scientific knowledge about PTSD, while also characterized by "trustworthiness, choice, collaboration, empowerment and cultural competence" (Interview 12.15.15). For Amanda and other program directors like her, *this* is trauma-informed programming, which brings medicalized language and outcome measures into conversation with feminist principles. Amanda's program – like many others around the country – administers PTSD checklists to each client, but they do not "force" her into clinical therapy. "Trauma" is the new "bridging" language of these counter-clinical spaces.

Limited Transformations to Biomedical Power: DV Counseling Programs

Domestic violence counseling programs cannot be explained by a simple co-optation analysis, nor by an analysis that ignores the powerful role of biomedicalization. Anti-violence advocates infused therapy with feminist logics and they institutionalized counseling practices that broke down the hierarchical relationship between therapist and client. They created spaces where clinical social workers learned from activists and survivors. Still, these services would eventually come to be delivered primarily by clinically trained professionals oriented toward psychiatric trauma (Sweet 2014; 2015). Domestic violence counseling programs are an

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assemblage of distinct (even antagonistic) paradigms, the intermixing of which has produced new forms of therapeutic knowledge and practice.

Even though domestic violence workers are increasingly clinical, they are nevertheless limited in their ability to affect biomedicine as an institution. Domestic violence organizational leaders, for example, regularly complain that they cannot convince doctors to take seriously the gendered power issues inherent in domestic violence. Emma said, "Sorry, Mr. PhD," but women cannot be helped by diagnoses if the power dynamics of abusive relationships are not addressed (Interview 1.30.15). Indeed, there is a strong sense among domestic violence counselors that their work is not seen as legitimate by doctors. Kim, a statewide policy leader, explained that one of her biggest challenges is trying to convince medical experts that "therapizing is not going to fix you" (Interview 10.27.15). And as Alexis said in frustration, "How can I [even] talk to places that use a medical model?" (Interview 9.22.15). Using the language of PTSD was *supposed* to make domestic violence workers legitimate to health experts. Nevertheless, domestic violence counseling programs occupy a peripheral structural position in relation to biomedicine.

The concept of counter-clinical spaces helps explain these complexities, wherein feminist discourses proliferate while medicalization processes are also constantly encroaching, constantly threatening to overtake (or "co-opt") the work. Counter-clinical spaces are sites that, in this case, incorporate feminist aims without vanquishing the power of medicine to shape the rules of the game. While mainstream medical systems have not been transformed into feminist anti-violence spaces, something *has* changed: domestic violence counseling programs are credible quasi-clinical spaces that use legitimate counseling models – and the actors in those sites regularly espouse feminist ideas about their work (Sweet 2015). Feminist discourses of self-help, mutuality, and empowerment remain important and the clinicians executing this work are proficient in them. Feminists "got inside" biomedicine by politicizing its therapeutic tools, creating a new arena of social action in which those tools circulate, and popularizing non-hierarchical models of interaction between clinicians and clients. Still, these programs operate at the periphery of biomedicine and are largely unable to contest its core practices and hierarchies.

CONCLUSION: COUNTER-CLINICAL SPACES

Focusing on the clinic as a material product of relationships between movements and medicine, we have shown that micro-political changes at the level of the clinic are critical for understanding how movements challenge medicine. These challenges involve both co-optive and

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hybridizing mechanisms. We turn our attention now to generalizing several properties of counter-clinical spaces. First, counter-clinical spaces showcase the stability of biomedicine in relation to the challenges of health social movements. Counter-clinical spaces are intended to intervene at the meso-level of social action. Attention to counter-clinical spaces therefore allows for a scaled approach: it is possible in this way to follow tools, practices, and discourses through multiple levels of action, from everyday use by lay actors to institutional incorporation to macro-level legitimacy. Second, counter-clinical spaces are generative interstitial spaces that allow for incremental change to some aspects of biomedicine. Counter-clinical spaces may be populated by biomedical actors, as in the case of the pelvic exam—and therefore new practices are partially reincorporated into biomedicine. This allows social movements to make change within biomedicine by targeting the clinic and creating new norms within it—and yet these changes do not fundamentally challenge the larger structural forces such as capitalism, sexism, and racism that undergird biomedicine. For example, domestic violence counselors still feel invisible and non-credible to doctors, a dynamic that reflects a deeply gendered professional hierarchy in hospitals and other medicalized settings.

The framework of counter-clinical spaces can be applied to other meso-level spaces between health social movements and biomedicine. Such spaces are increasingly ubiquitous as biomedical institutions wrestle with social movement demands to expand access, address its history of abuse and coercion, and produce more socially just practices. For example, women's health centers are quasi-medicalized spaces, sometimes free-standing and sometimes attached to hospitals, wherein women can access reproductive care such as childbirth and abortion (Hasson 2012; Thomas and Zimmerman 2007). These services are provided in ways that align with feminist values (such as reciprocal sharing—i.e., "women helping women") but are bound up in the capital-seeking practices of biomedicine—making money and catering to white middle class patients. In some cases, even the very material and spatial arrangement of the clinic is remade to seem friendlier and more spa-like.

Another such example is the Sexual Assault Nurse Examiner (SANE) Program, which involves specially-trained nurses comforting victims of sexual assault while performing necessary examinations and gathering evidence (Morse 2019; Mulla 2014). Such programs exist as the result of feminist efforts and are located in a tenuous space between feminist programs and medico-legal fields (Morse 2019). In both of these counter-clinical spaces, feminist actors have

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pushed against biomedicine in such a way that knowledge and practices are transformed at the meso-level—the clinic—without radically shifting the stakes of biomedicine. In some ways, feminist work gets *relegated* to the segregated counter-clinical space, thereby absolving biomedicine of responsibility for the problems addressed there.

Yet another illustrative example is feminist efforts to institute doulas as a response to the overwhelming disparities in maternal and infant mortality among Black women (Bridges 2011; Davis 2019). A doula is a quasi-medical provider, trained in biomedical paradigms of pregnancy and childbirth, but doulas have feminist origins: doulas seek to empower pregnant people in the face of institutionalized barriers to care. Indeed, the counter-clinical spaces framework captures these highly contingent and dynamic movements; whereas some doulas embrace credentialing and professionalization in order to gain more widespread institutional access, others reject any form of biomedicalization (Davis 2019; Nash 2019). Regardless, the goal of the doula is to intervene in the clinical encounter—often by being physically present—in order to reorganize how medical care is provided to Black women. In this counter-clinical space, the elements of protest and cooperation hang together as a result of the conditions of their emergence (i.e., medical racism), and do so at the porous margins of the more powerful institution. The framework of counter-clinical spaces thus draws attention to the scale on which change occurs, theorizing both the institutionalized forces that delimit macro-scale transformation *and* the micro-political shifts in patient experience.

Furthermore, we offer insights from our counter-clinical spaces framework to scholars studying other forms of social movements and science—and indeed, those studying institutional change more broadly. Hybrid institutional spaces also exist at the margins of institutions like the state, legal systems, and education. These spaces are intended to intervene in some way in how institutional power is enacted in the daily lives of people. Think, for example, of drug courts or diversion programs for shoplifting, drug, or sex work charges. Activists here attempt to reorganize how criminal-legal power is applied to particular groups by reworking a social space in which that power is deployed. Likewise, consider the role of sustainability offices (Augustine and King 2019) or offices of Diversity, Equity, and Inclusion (DEI) (Ahmed 2012) within universities to enact some forms of change in daily practice while insulating the larger institution from social movement critique. Accounting for spaces of "counter-conduct" (Murphy, 2012) at the meso-level of powerful institutions and organizations allows for understanding when and

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how social movements reshape dominant institutional knowledge and practices without fundamentally dismantling institutions themselves.

Our analysis urges consideration of meso-level spaces to understand the complex work that social movements do in relation to powerful institutions—the many ways, for example, in which professional practices can be shaped by countervailing forces. Our goal is not to argue that biomedicine cannot change, or that social movements are bound to be only intermediary, but rather than new "counter" spaces may emerge in surprising places as sites of practice that hold a great deal of potential to intervene differently in people's lives. Perhaps it is in further "seizing" counter-clinical spaces that more radical possibilities lie.

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