

Simulating Gender

Student Learning in Clinical Nursing Simulations

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“I love her earrings!” a female nursing student exclaims when she first encounters Josie. “Oh, she’s wearing a bra, just noticed that!” comments a male student. Josie, or Joe, is a robotic patient manikin a group of nursing students are meeting for the first time. In addition to earrings and a bra, the white male manikin is wearing a grey wig, and its penis has been replaced with a plastic vagina. This will enable students to practice catheter insertion on their elderly female patient once the simulation begins.

Nursing education has a rich history of incorporating simulated care into student training. Historically, students practiced procedures on models of body parts or worked with volunteers who could provide real-time feedback. However, since manufacturer Laerdal’s introduction of the first affordable patient simulator in 2000, SimMan, simulations have included life-sized robotic manikins that can respond to treatment (Rosen 2008, 162). As the title SimMan suggests, physical interactions with simulators have the potential to impact students’ understanding of the role of gender in their care of patients. At the same time, the technical skills acquired from physical care in simulations are only one dimension of student learning. Simulations also prompt conversations about the power relationships in clinical settings and promote a view of nurses as patient advocates. At times, conversations explicitly address gender, as students and instructors discuss how to appropriately lift an older female patient’s gown or correct a self-assured physician’s error. Overall, nursing’s feminized nature, as well as its integration into the masculinized world of medicine, makes nursing simulations a site for frequent and often conflicting opportunities for gendered learning.

This chapter uses a material rhetorical lens to build on previous feminist research on patient simulation by studying simulators not just as static objects but also as apparatuses in action (Johnson 2005; Sundén 2010). To account for “gender-and-scientists-in-the-making,” to expand on Karen Barad’s (2007) concept, I argue that research on simulation must capture both the technical learning that occurs at the physical interface between student and machine and the interpersonal lessons that emerge in conversations with the simulated patient. Thus, I draw on field research with third-year nursing students that included observations of over thirty clinical simulations and the activities that surrounded them. I also include excerpts from interviews with five focal students (four female and one male). This range of data offers access to the multitude of ways nursing students are taught to orient to and perform gender in simulations.

Studying gendered lessons in simulations necessitates a heuristic for understanding what we hope students learn about interacting with patients on a gender spectrum. Ultimately, I see this as an opportunity for rhetorical scholars and nursing instructors to collaborate, as I discuss in the conclusion. For my purposes, however, I draw on the work in this volume (informed by both rhetoric of health medicine scholarship and feminist theory) to offer three premises for gendered interactions. First, research shows men’s experiences continue to be normalized in medical care and practice. Kerri Morris’s analysis in this collection of how bladder cancer is often considered a men’s disease and misdiagnosed as UTIs in women provides a compelling example of this normalization. Thus, students should understand how and why their patient care will differ in response to gender. Second, research indicates that even within a single gender, care cannot be generalized because gender interacts with other identity factors including sexuality, class, race, age, and disability (see De Hertogh and Liz in this collection). Thus, students should take an intersectional approach to gendered care that accounts for the influence of different demographic backgrounds and identities. And finally, nurses must understand every patient interaction is different and act responsively to emerging patient needs rather than approaching care statically. Leandra Hernández and Marleah Kruzel’s discussion in this collection of how individual experiential knowledge is often discounted during the patient-physician exchange highlights the importance of responsive care. I see such care as deeply rhetorical—immersed in a specific context, tied to a unique individual, and emerging in response to a pressing exigence.

Using these three premises, I discuss a number of overlapping and at times contradictory gendered lessons that emerged for students during their physical and verbal interactions with the patient simulator. First, I argue that the simulator and the simulation coordinator both establish “typical” gender features and expectations for student care. These typifications emphasize how care is different for men and women, but they can also support stereotyping and reliance on shared experience. Perhaps because of the risks of stereotyping, intersectional identities are rarely portrayed when establishing typical gender features, with the exception of age. Thus, students had limited opportunities to address specific strategies for intersectional gendered care.

Second, I demonstrate how the simulator and instructor disrupted student expectations, necessitating that the future nurses learn to act responsively. I use the word *disruption* to describe actions that disturbed, redirected, or overturned the existing simulation scenario. The simulator’s disruptions came in the form of its imperfect representations of both a human body and a gendered body, while the instructor’s disruptions were often strategically introduced. In both cases, disruptions provided opportunities for students to reflect on how they would modify their care for different kinds of bodies, supporting an awareness of variation and flexibility with interventions. In the conclusion, I elaborate on why these physical and verbal disruptions are so critical to the gendered lessons in clinical simulations. I also discuss the potential for integrating diffractive strategies into debrief conversations to help students think through the challenges of intersectional care.

Gender and Simulation

Nursing as a field has long been feminized. As Rachel Prentice (2013) explains, “The gendered distinctions that make technical work the physician’s province and leave caring work to nurses remain. The work of caring often becomes coded as ‘soft’ or as ‘woman’s work’” (226). In contrast, patient simulators have been critiqued for promoting a dehumanized view of the patient that aligns with the “technical work” of physicians (Johnson 2005; Sundén 2010). Thus, research on nursing simulations can consider how gendered learning occurs at the intersection of feminized and masculinized domains. In this section, I briefly overview scholarship on gender and simulation from the fields of nursing and gender studies to set the groundwork for my own investigation.

Nursing scholarship on gendered learning in clinical simulations has focused primarily on differences in how male and female students respond to simulation technology (Grady et al. 2008; Mould, White, and Gallagher 2011). These studies found that male students were more likely to report higher levels of comfort and confidence in high-fidelity environments. Research argues that outside simulation contexts, male nurses must find ways to negotiate often feminized modes of care. For example, Murry Fisher (2009) draws on interviews with twenty-one male nurses to describe how they perform bodywork (“the labour performed on others’ bodies . . . , emotional labour, and the effects of work on one’s own body” [2669]) that is gendered as female. Fisher finds that male nurses leverage a range of strategies including providing detailed descriptions of upcoming procedures, receiving patient consent before interacting, and avoiding unnecessary bodily exposure or touching. He concludes that “gender implications of bodywork should be included in nursing curricula” (2676). Clinical simulations provide an ideal context to study this embodied gender learning.

Conversely, gender studies scholars have considered how medical simulators perpetuate problematic conceptions of gender for healthcare providers. Notably, this research is confined to considering how manikins represent male and female genders, since companies have not yet created manikins with identities outside of this binary. Jenny Sundén (2010) researched Noelle, a simulation manikin made by Gaumard designed to provide students with hands-on practice in supporting labor and delivery. Sundén argues that adding details like hair and breasts but not the fluids, odors, or sounds that accompany birthing represents a “selective bodily awareness” that supports problematic gender conceptions in the medical imagination (107). However, Sundén’s analysis is based only on physical simulators and manuals, interviews with designers, and promotional materials, not on simulator use in practice. In contrast, Ericka Johnson (2005) draws on ethnographic research on an anesthesia simulator to argue that the simulator’s removable plastic pelvis emphasizes reproductive organs as the defining gender feature (156). According to Johnson, these one-sex models position female bodies as less developed versions of male bodies, contributing to the normalization of male medical care. Meanwhile, Johnson (2007) reflects on the difficulty during data collection of reconciling practitioners’ general attitudes towards gender (“politically correct, gender sensitive, and pedagogically concerned with integrating female students into their practices” [150]) with their disinterest in gender during simulations. Thus, there is still a need for more attention to how interactions with patient simulators teach students both to orient to

differences in gender in their care and to embody gendered professional roles.

Field Context

I took a “rhetorical field methods” approach to this project, which immersed me in many activities surrounding clinical simulations (Endres et al. 2016). Over the course of a year, I followed a group of eighty third-year baccalaureate nursing students through their three different clinical simulations at a mid-sized private university in the Northwest. The simulations took place in two high-tech simulation suites, which each included a patient manikin—Joe/Josie in the adult suite and Hal in the obstetric/pediatric suite—as well as most supplies needed for care (gloves, oxygen, catheters, telephone to reach other providers, etc.). The simulation coordinator, the students’ clinical instructor, and I sat in the simulation control room, which is positioned between the two suites with a large one-sided window looking into each. The simulation coordinator, Maura, operates a computer that controls all the simulator’s vital signs and a microphone that connects to its speaker box.



Figure 4.1. Air force medical personnel practice patient care on a male manikin similar to the one used by nursing students in this study.

After an orientation to the simulation room, three groups of two to four students are immersed in a narrative set up by Maura. Each group takes a turn caring for the patient for approximately twenty minutes while the patient’s condition worsens. During their turn, students practice conversations with one another and with the patient, engage in critical thinking to prioritize problems, and decide on interventions. They also have physical interactions with the simulation environment and the simulator—applying sanitizer, putting

on latex gloves, checking a wound, and so forth. While one group provides care, the other two groups sit in a nearby classroom watching a live stream. After each group's turn, the students, clinical instructor, and simulation coordinator reconvene in the classroom for a debrief. This is a formal instructor-facilitated conversation in which students reflect on their experience and receive feedback from their peers and instructors.

Of the simulations I observed, the first involved an elderly female patient, Eliana Ruiz, who was diabetic and experiencing complications after a leg operation. The second was with a young male patient, Jason Lee, who was recovering after a leg surgery caused by a car accident. And the third was caring for a male infant, Eric Joslin, with a respiratory infection. Despite the age and gender differences between Eliana and Jason, the same white male robotic manikin was used for both simulations. My analysis below focuses primarily on these first two simulations, as they offer contrasting case studies of how students were taught to orient towards gender through both physical and verbal patient interactions. Despite the fact that both Eliana and Jason were ethnically marked by their last names and the pictures that accompanied their patient profiles, I found students largely ignored race in interactions. In the conclusion, I consider how diffractive debriefs could be leveraged to support more intersectional learning in simulated contexts.

A Material Rhetorical Framework

As I turned to a rich data set that included interviews with focal students and observations of over thirty clinical simulations and their surrounding activities, I wanted to analyze patient simulators not as static objects but as active rhetorical agents. Thus, I drew on research in material rhetorics, which considers the persuasive capacities of nonhuman objects and spaces. Barad's (2007) concept of intra-action, specifically, can account for the rhetorical force of the simulator while also addressing power relationships between individuals.

By engaging in a material rhetorical analysis of simulators, my aim is to move beyond a critique of the simulated body on the grounds that it does not accurately represent a human body. As other authors have emphasized, representational accuracy is not the goal for simulation design; fidelity of physiological experience is paramount (Johnson 2010). Both Prentice (2013) and Johnson (2010) turn to Bruno Latour's actor-network theory (ANT), which posits that human and nonhuman "actants" share agency and thus provides a framework for understanding rhetorical action at the interface between bodies and machines. However, feminist scholars have expressed concern that posthuman research like Latour's has the potential to obscure unequal power relations—like gender, race, and class—between human actants (Booher and Jung 2018).

In fact, Barad (2007) argues that overlooking human power relations is a trend in posthuman science studies research: "While [science studies] scholars insist on the importance of tracking 'science-in-the-making' . . . they fail to attend to 'gender-in-the-making'—the production of gender and other social variables as constituted through technoscientific practices" (87). Thus, Barad's theory of "agential realism" synthesizes posthuman work with feminist poststructuralism, like Judith Butler's theory of gender

performativity (57). Key to this framework is the notion of “intra-action,” which emphasizes how objects and bodies come together to create apparatuses and ultimately phenomena that “matter” in particular moments. In order to demonstrate how intra-action can reorient posthuman scholarship towards power disparities, Barad uses the story of a key discovery in the field of quantum physics—a demonstration of space quantization that depended upon the smoking of a cheap cigar in the lab. She asserts that the cigar is a “‘nodal point,’ as it were—of the working of other apparatuses, including class, nationalism, economics, and gender” (167). Barad recognizes that attributing causal agency to the cigar is misguided but demonstrates how ignoring the experiment’s entanglements in gendered and class-based material practices would create a limited account of “science-in-the-making.”

In this way, Barad’s agential realism offers a posthuman approach for studying scientific practice with attention to gendered, class-based, and race-based materializations. Thus, recent work in feminist medical rhetoric, like Christa Teston’s (2016) research on genetic biomarkers in cancer care, turns to Barad as a theoretical stronghold. This chapter demonstrates how Barad’s theories can be mobilized to better understand classroom practices and student learning as well, or “gender-and-scientists-in-the-making.” By calling attention to how particular classroom apparatuses like patient simulators teach students to embody gendered roles, this research can offer insights not just into nursing practice but also into nursing training and curriculum.

Gendered Lessons in Simulations

Across all aspects of the simulation, students were exposed to lessons about how to perform gender as nurses and how to orient to their patient’s gender during care. As one example, their clinical instructor reminded them to “get to the point” in a phone call with the physician, describing nurses’ tendency to be storytellers as a female trait. However, given my interest in the simulator’s rhetorical role, the following analysis focuses specifically on gendered lessons that emerged in physical and verbal intra-actions between students and the patient simulator. Ultimately, I demonstrate how these intra-actions at times created opportunities for students to practice modifying their care to meet men’s and women’s differential needs and at other moments disrupted students’ expectations, teaching them to be responsive providers.

Physical Intra-actions with the Simulator

On the preparation sheet students received prior to their simulation, there was a photo of their elderly patient, Eliana, shown wearing a thick grey sweater, a crimson scarf, and a black hat. Her dress was conservative, cuing students into the fact that modesty should be prioritized. Indeed, part of what students learned in their physical intra-actions with Eliana was how to best maneuver her gown to uncover only the body parts they needed to access—heart, leg wound, or genitals. During one group’s simulation, a male student attempted to lift up Eliana’s gown to listen to her heart, but another student suggested he reach the stethoscope

through the neck-hole of her gown instead. During their debrief, the simulation coordinator encouraged students to check in about a patient's comfort level with nurses of a different gender, remarking, "Don't make a big deal of yourself as a man, but with any patient ask if it's okay."

Practicing lifting a medical gown modestly teaches students to be thoughtful about modifying their care for patients of different genders, as well as individuals whose cultural backgrounds might impact their expectations about privacy. Johnson (2010) argues that simulators do not provide the same feedback as patient actors, who often comment on things like eye contact, tone of conversations, or the temperature of the medical instruments. However, intra-actions with Eliana did provide students with an array of opportunities to consider how their touch could foster comfort or embarrassment. In addition, students were also given hands-on practice with a gender-specific procedure: female catheter insertion. While they had practiced this on a pelvic simulator during skills lab, students had to be more attentive to patient experience during the simulation. For example, my focal student Michelle reflected on her experience of the instructor responding to her touch through the manikin's speaker box, saying, "I forgot to warn the patient that I was going to touch her genitals and she was obviously just like, 'Oh, oh my gosh . . . ' so I was just like, 'Whoa, okay, this is real like I need to actually warn her.'"

Nursing students are constantly intra-acting with every inch of the patient's body as they inspect, palpate, listen to, and ultimately feel how the bodies of their patients resist or yield to their aims. Aspects of Eliana's robotic body provided students with cues to practice intra-acting differentially with a female body. Her bra was a cue for students to consider how to modestly maneuver her gown, and the removable genitals enabled students to practice a gender-specific procedure. However, physical intra-actions with the simulator patient also disrupted students' expectations for a female human body—which was not quite human and not quite female. In our conversation following her first simulation with Eliana, my focal student Kira reflected, "The first thing I noticed was that my patient was a very big woman." Later, she elaborated, "I don't know how to describe, but she was HUGE. She must have been like seven feet tall. And she's got these man-hands and so I was like struggling to lift up one of her legs . . . I see people as these bendable moveable objects and so when it's just dead weight but it's stiff dead weight it's even worse." According to Kira, Eliana's simulator body represented an imperfect human body, in part because of its stiffness/dead weight. Along similar lines, Ryan, a male focal student who was responsible for performing a catheter insertion during his group's simulation, reflected on the ways the imperfect simulator body disrupted his care: "It doesn't move like a person . . . like putting a catheter in a female, you would have them bend their own legs and spread their legs rather than you adjusting them and you have to be a lot more rough with the manikin."

For both Kira and Ryan, the simulator's lack of fidelity as a human body became apparent in their intra-actions with the machine. As they lifted it, repositioned it, and attempted to orient to it so they could provide care, the machine acted back, resisting these movements. This resistance called attention to its inhumanness, but it also provided students with opportunities to reflect on the differences between their intra-actions with the simulator and

with a “regular patient.” Ultimately then, the machine fostered meta-awareness for students about how their practice must be responsive to each individual patient’s body rather than suggesting certain technical approaches are universal.



Figure 4.2. Nursing instructors often use wigs to transform a male manikin into a female for the simulation.

However, Eliana’s simulator body is not just imperfectly human, it is also not the appropriate size or shape for a female. Gender matters for these nursing students in part because the size of the male patient body significantly impacts their ability to maneuver the patient during care. Thus, Kira described Eliana first euphemistically as “a very big woman” but then later emphasized the unbelievable scale of her size: “HUGE . . . like seven feet tall.” Kira also observed how Eliana’s hands were incongruent with her gender, referring to them explicitly as “man-hands.” Though it was offered only as an aside, this comment was important because it was the only instance in which Kira’s feedback about the simulator body was an aesthetic critique, not addressing how Eliana’s body felt in intra-action. In this way, it resembled a disturbing moment Ben Singer (2013) describes when a group of nursing students laughed after arranging a simulated body so that the top half was male and the bottom half was female. Singer argues, “The laughter of these students, if neither purposeful nor malicious, reveals that trans-specific embodiment is unthinkable, hence invisible, in clinical settings” (250). Along similar lines, Kira’s comment articulates intolerance for the incongruity between a female patient and male hands and in doing so undermines the wide range of possibilities for bodily variation. This comment, rather than helping Kira be reflective about how her simulated patient differed from future patients and fostering

responsive care, set clear boundaries between categories of bodies and in doing so planted the seeds for derision or, like Singer's example, even mockery.

Overall, then, examining several instances of physical intra-action with Eliana during simulations demonstrates how the patient simulator can directly support physical lessons for students about how to differentially provide care—from the procedure for inserting a female catheter to the proper direction for lifting a dressing gown. Meanwhile, the manikin also frequently disrupts these lessons through its inability to perfectly replicate intra-actions with a human body. The physical distance between intra-acting with a simulator and with a real human body provides students with opportunities to reflect on how they will modify and revise their care for different kinds of bodies, supporting an awareness of variation. Student critiques of the simulator become problematic, however, when they emerge in an attempt to define what constitutes normal. On the other hand, patient feedback, delivered through the instructor's microphone, has a crucial role to play in student learning as well. Eliana gasps when she is touched without warning, groans when a catheter bag pulls on her urethra, and expresses embarrassment when she is left uncovered. Thus, to fully understand how students are learning to orient to gender in their care, it is important to consider the patient's voice as key to the intra-action of machine and student as well.

Verbal Intra-actions with the Simulator

In contrast to Eliana, twenty-year-old male patient Jason presented students with the chance to consider how they would need to adjust their care for a young male. From requesting a hamburger two hours after surgery to asking whether he would have “cool” scars from his operation, simulation coordinator Maura, whose microphone was connected to Jason's voicebox, ensured conversations with Jason would reflect a typical positioning. One of the primary ways Maura represented this perspective was by having Jason ask a male nurse questions about the catheter. For example, during focal-student Ryan's shift, Jason called Ryan over, saying,

Jason: It's kind of embarrassing. How long do I have to have that tube in my penis . . .

Ryan: So you're on day one right now. So you'll have it until tomorrow.

Jason: Okay yeah it's—I didn't want to ask the other nurses . . .

Ryan: I totally understand . . .

Later on, when Ryan informs Jason that he is going to clean the catheter, Jason responds, “I'm glad it's you.” Overall, Ryan discussed these exchanges positively during our interview: “He was like, ‘Oh I'm glad that it's you because I don't want that other nurse to look at me’ and then, it made sense. Before now I never understood why it would be an issue that I was a male but now I understand when a male's more comfortable with me, that fell into line, which was cool.” Thus, for Ryan the exchange with Jason represented a rare instance in which he felt his gendered perspective was uniquely useful. He describes clarity from the

exchange about how his gender will sometimes be an asset. Of course, not every male patient feels comfortable with another man talking about or examining his genitals. Ryan will ultimately need to learn to “listen metonymically” to both male and female patients, a key tactic for rhetorical listening that “assumes that a text or person does not share substance with all other members of its/his/her cultural group but, rather, is associated with them” (Ratcliffe 2005, 99). This tactic explicitly addresses the kind of overgeneralization Ryan makes in assuming all male patients will react to his gender in the same way.

At the same time, while Jason’s attitude towards male caregivers helped Ryan feel valued in his simulation, identification also comes with risks of “erasure and alienation,” as discussed by Kerri Morris (this collection). Indeed, one of my female focal students, Liz, described feeling distanced from the patient: “Allen had to take out the patient’s foley [catheter] . . . the patient was definitely more comfortable with a male figure just because he was male so didn’t want us to impose as much.” If one assumes patient connection is created through shared experiences, when nurses cannot easily identify with patient experience—because of age, gender, race, class, or disability—this can create a barrier to relationship building. This need for identification is why current feminist scholarship is calling for new ways of imagining how connections might be built between individuals to account for and value their different experiences (Hesford 2011; Ratcliffe 2005). For authors coming from a materialist perspective, objects and environments (nonhuman actants) have a role to play in promoting these ethical relationships to others and the world (Bennett 2010).

Ultimately, many students struggled to connect with Jason during his simulation, not only because of differences in gender but also because there were many technical tasks to accomplish. One strategy Maura used to counter students’ task-focused care was to make Jason cry. Actual liquid could flow from the simulator’s eyes, which often surprised students. As one student explained during debrief, “With anyone else crying you’d see eyes welling up, puffy, but it was like, ‘Oh okay, he’s crying!’” Even though Jason’s tears were not perfectly human, they disrupted student actions and redirected care. For example, in the following exchange, a nursing student is taking Jason’s pulses when he suddenly begins to cry.

Kylie: What’s going on? Talk to me.

Jason: I think it’s all just starting to hit me. What happened.

Kylie: [Grabs a tissue and dabs the tears] Yeah? Are you in any pain right now?

Jason: Yeah I’m hurting a little bit, but mostly I’m just starting to worry about everything.

Kylie: What are you worried about?

Jason: Well you may have heard that when I had the [car] accident I was drinking and I’ve never even been in trouble. I just haven’t been in trouble before and never ever had a problem and I don’t know how mad my dad’s going to be.

Kylie: Do you want me to call your dad and we can talk to him? We can have

him come in . . .

Jason: [Exhales] I'm just not ready to face [my parents] so no, thank you but not yet.

Kylie: Of course, is there anyone else you want to talk to?

Jason: I don't know, I just—I don't know if I can go back to school, I just don't know a whole lot of stuff. It's just all hitting me what happened and I just can't [inaudible].

Kylie: I know. It's okay we're just going to get you well and then you can focus on it once you feel better, okay? Is there something I can do for you right now, though?

Jason: [Exhales] No, just uh—you're right I just have to focus on getting better.

Kylie: That's okay, do you want to talk about it?

Jason: Well go ahead and do whatever you gotta do and I'll—I'm okay, thanks for listening. I'll be all right.

At the beginning of this conversation, Kylie tries to intervene to “fix” the crying. As a reversed version of the many instances Cathryn Molloy (this collection) describes of providers attributing women's pain to psychological origins, Kylie begins by assuming the crying male patient is suffering from physical pain. Once she discovers the pain is emotional, she makes several offers to contact Jason's parents or others for support. Ultimately, though, Kylie realizes Jason is just looking to talk about his feelings, so her last offer is simply to listen. The exchange between Kylie and Jason is notable because the solution is to set aside instincts for identification or intervention and listen to the patient's experience from their point of view, a mode that closely resembles “standing under,” another tactic for rhetorical listening (Ratcliffe 2005).

Ratcliffe (2005) emphasizes that “standing under” necessitates a shift from listening *for* a speaker's intent or our own interests to listening *with*. In this instance, and undoubtedly many clinical contexts, the provider's automatic response is to listen *for* the problem so they can identify an intervention. However, Maura's disruption necessitates that Kylie listen *with* and let the patient's experiential “discourses wash over, through, and around” (28). A materialist lens also calls attention to the rhetorical role the simulator plays in fostering this exchange. The crying was a catalyst for Kylie's responsive intra-action. The imperfect tears worked in tandem with the coordinator's words to disrupt Kylie's agenda and foster a different kind of listening.

Broadly, then, like the physical intra-actions with Eliana, verbal intra-actions with Jason also provided two kinds of gendered lessons. Some lessons focused on teaching students to orient to “typical” characteristics of a young male patient, emphasizing, for example, the likelihood that a male patient would want to ask a male nurse questions about his catheter. While these intra-actions helped a male student understand how his gender might be an asset, they ran the risk of suggesting all male patients will react similarly. In addition, these exchanges tie empathy for patient experience to assumptions of sameness. In contrast, the

simulation coordinator also strategically introduced conversational disruptions to redirect students away from their plans for care and to emphasize patient interaction. Learning to dwell in the uncertainty of such moments helped students navigate between their premeditated, often static plans for a patient and the persons' emergent needs, ultimately gaining the rhetorical skills to be a responsive caregiver.

Disruption and Defractive Debriefing

Fisher's (2009) study emphasized that "the gender performances of male nurses were not fixed dualities . . . but were fluid and tailored to individuals, located in a specific space and in a historical moment" (2672). Ultimately, the simulator and instructor's capacity for disruption become a significant resource in fostering this fluid and responsive orientation to and performance of gender in simulation settings. My analysis throughout this chapter demonstrates that both the simulator and the instructor serve as sources for disrupting students' orientations to gender in their care. The simulator body, in being not perfectly human and not perfectly gendered, disrupts physical intra-actions, while instructors speaking as the patient provide verbal sources of redirection. In both cases, students must act as responsive caregivers, not assuming that what works for one patient will work in all instances.

Thinking back to the three premises for student learning about gender I introduce at the beginning of this chapter, however, it is clear that premise two, taking an intersectional approach to gendered care, is receiving the least attention in simulations. The simulator and the instructors worked together to establish "typical" physical and verbal features that provided students with opportunities to think through how they might differentiate care by gender. At the same time, there were rarely opportunities to address how these practices might be modified for patients from different races, gender identities, cultural backgrounds, and so forth.

In order to establish typical gender features, instructors had to rely on stereotypes and generalizations that would have been more noticeably problematic if modified to suggest, for example, that Black women or homosexual men act in certain ways. This, in part, demonstrates the way gendered stereotypes continue to be normalized in workplace contexts (Frost 2016; White, Rumsey, and Amidon 2016). In addition, the simulation coordinator and clinical instructors may have limited knowledge of the experiences of individuals from different backgrounds. In a rare instance when a student who was familiar with Chinese culture tried to strike up a conversation with Jason about his favorite Chinese New Year food, Maura was at a loss for a response. Finally, recognizing the active role of the physical simulator in gendered learning, physical modifications that might call attention to intersectional differences are more complex than adding a wig or a brassiere. Even when the image of their patient on their preparation sheet indicated a nonwhite cultural background, the manikin students were caring for was still white. As Sundén (2010) discusses in her analysis of birthing simulator Noelle, which is also "routinely portrayed and sold as white," the simulator's whiteness enables students and instructors to efface race in their care (110).

With those limitations in mind, the debriefs that follow clinical simulations offer a rich space for “mak[ing] white strange,” as Sundén (2010, 110) describes it, as well as making straight, able-bodied, middle-class, and other normalized identities strange. In order to do so, instructors could shift the conversation away from only reflecting on the simulation interactions to imagining how interactions and care might change for patients from different backgrounds. For example, following Ryan’s catheter exchange with Jason, instructors could ask the group to think about how this interaction would change if Jason came from a cultural background that vilified homosexuality, and then how it might change if Jason identified as a trans man but had not had bottom surgery. Rather than putting the onus on a single simulated patient (and thus a single coordinator) to represent a particular identity, debrief conversations could open a space for students and instructors to draw on their own experiences and previous clinical interactions to offer possibilities for responsive care. These questions would be in line with the current debrief model, which already tends towards discussing a number of possible approaches rather than a single right answer. It would also shift the conversations from a mode of reflection, which Barad (2007) argues is often self-referential and oriented towards sameness, towards diffraction, which is attuned to differences and the material “effects they have on the world” (72).

Barad (2007) describes the methodology of diffraction as “reading insights through one another in attending to and responding to the details and specificities of relations of difference and how they matter” (71). In this way, diffraction also resonates with Ratcliffe’s (2005) call for listening metonymically and being attuned to individuals’ material experiences of difference while at the same time not attempting to generalize them. Diffractive debriefing conversations would offer students and instructors opportunities to multiply the strategies for intersectional gendered care while avoiding the challenge of having to represent a single “typical” example of these identities. Working in tandem with both instructor and simulator disruptions during the simulations, diffractive debriefings have the potential to help students think expansively about how they both perform and orient to gender in their care without offering easy answers.

Of course, the effectiveness of diffractive debriefing relies on the ability of instructors to facilitate challenging conversations about the influences of student and patient identity. My analysis throughout this chapter builds on existing calls for more pedagogical collaboration between rhetoricians of health and medicine and health instructors (Campbell 2018). Nurses have developed a number of evaluative tools for simulations that are often attentive to considerations of gender and identity. For example, one checklist for evaluating health communication in an obstetric simulation includes items such as “Touched patient appropriately” and “Avoided stereotyping behaviors (re: teen mom, unwed mother, ethnicity, sexual orientation, gender, or economic diversities, etc.)” (Campbell et al. 2013, e547). Meanwhile, rhetoricians of health and medicine can bring to the table alternative ways of understanding how simulations might foster ethical communication strategies, like this chapter’s attentiveness to the role of the physical simulator and the simulation space in gendered learning. These perspectives have the potential to disrupt typical ways of thinking about gendered communication in the nursing field and thus can generate flexible and innovative strategies for simulation pedagogy.

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