I’m Touching You Now

It’s a Monday night, and five young medical students huddle in the far corner of an exam room while I pull on latex gloves. “Come closer,” I say, and I step next to Julie, the woman lying on her back on the exam table. The students shuffle toward us, like a single entity with multiple arms and legs and peering eyes. For some of them, this will be the first time they’ve ever touched a live woman’s naked body. For all of them, it will be the first time they perform a breast exam or palpate a uterus or slide a speculum into a vagina as they attempt to see the shining ring of the cervix tucked inside.

I am turned toward Julie, looking at her eyes, but I raise my voice so all the students can hear me. “I’m going to do a breast exam now, Julie,” I say. “Can you raise your right arm above your head?”

She says sure and raises her arm, resting it on the exam table.

“We need to slide your gown over your arm so I can examine your breast—do you want help?”

Julie says no thanks and does it herself. Then she lies back, and her summery blond curls spread across the pillow, the tan skin of her shoulder and soft white of her breast glowing in the fluorescent lights.

“Each time you touch a patient,” I tell the students, “you need to let her know beforehand. No surprises. It’s her body, and she’s granting you the privilege to be in her physical space.”

I turn to Julie. “I’m going to touch you now, is that okay?” When she says yes, I place my hands on either side of her right breast and begin pressing my fingers in tiny circles, moving clockwise around the tissue. I explain how she can do this part at home

for herself, once a month, and describe the quadrants of her breast as I make my way closer to the areola. I tell her about the size and texture of the nodules I am checking for—what cancer would feel like. “Hard, like an eraser nub,” I say. I squeeze her nipple to check for fluid, spend extra time on the upper outer quadrant of her breast, press the divot in her armpit, and then I ask if I can examine her other breast. She says yes, and I reach across her body.

The students have gathered around the table and are now leaning in to watch me repeat each motion on Julie’s left side. Next, I ask her to sit up and drop her gown from her shoulders so I can look at her breasts while she’s seated upright, and the students move to give us space. “I’m looking for any unevenness in skin texture, any differences from right to left,” I say, and I ask her to lean forward. I watch as her breasts swing to and fro and side-to-side. “I’m looking for dimpling, any catching as the tissue moves.”

I’ve said these lines to Julie dozens of times. She knows what’s coming next—the stirrups, the internal exam, and the real excitement, the speculum. She and I and a team of women meet on Monday nights in the basement of a cancer treatment center with medical students to teach them how to give gynecological exams. Our task, the role of the “patient” at least, has at times in the past been performed by prostitutes and by anesthetized housewives. Even mannequins have been used as “patients.” We’re called Gynecological Teaching Assistants. None of us are doctors or nurses, but we’ve all been trained in how to give and demonstrate a thorough gynecological exam. Our director is an attending physician, and she bounces from room to room, unable to spend much time with any one group of students. It’s Julie and I and the other GTAs who do the real work of teaching these kids how to treat a woman on the exam table. We are alive, awake, and

very aware that they will learn from us tonight the privilege and responsibility of providing good medical care to women.

After I've completed Julie's breast and pelvic exam, supervised two medical student examinations of her, and then been examined three times myself, I clean up and dress in my street clothes. I will ride my bicycle the two miles home, sore from the multiple internal exams and speculum insertions. My car, an old Toyota with more than 200,000 miles on the odometer, sits at home for use only when I absolutely need it. I cobble together money from tips I make as a waitress during the day, and then, once a week, I work for a long evening at $30.00 an hour as a GTA. I add this to the child support my ex pays every month and try to make wise choices about buying food and paying the electric bill and the mortgage.

It was a shock when my husband left. I'd been a full-time mom for five years, taking care of our two young boys and working odd jobs only if they were compatible with staying at home with the kids. Being alone and poor is a struggle, a different kind of struggle than being married and poor was. Ours was a difficult marriage, full of threats and various kinds of abuse, but staying with him was what I'd thought was the only option when I left home on the back of his motorcycle at sixteen. When I realized I was pregnant a few years later, I didn't want an abortion—I wanted to be a mom, a good one. Though we were poor college students at the time, he and I agreed we didn't want our child in daycare, so I stayed home with the baby and later with his little brother, thinking all the while I was doing my part, my best, to be a good mother and a good enough wife.

Poverty and single motherhood have given me a strange kind of liberation. If I hadn't been so poor after the divorce, I'd never have considered being a gynecological

teaching assistant. It is hard work, and it feels odd to let strangers learn how to perform exams by using my body as a tool. If I were still married to my ex, I would never have known about doing this kind of work. I see a doctor for yearly gynecological exams, but most doctors don't know about GTAs, and the kind of women doing this work – progressive, passionate, independent – are not the kind of women my ex-husband wanted me to befriend.

I had friends when I was married, but they were usually also married, raising kids at home, like I was. When we got together, we had our children in tow—our lives were about our kids. My ex had few friends of his own, and he monitored my friendships, preferring me to be with women who had families or at home or with him. When we were in public, he suspected me of flirting. He threatened me frequently, as in, every week—if I ever had sex with someone else, he'd kill me, he said. No questions asked. We didn't go out on dates. We did little together as a couple, and I did nothing by myself. While he was working or at school, I was with the kids, my only adult companionship married women he had approved.

Now, as a single woman, I have all kinds of friends, male and female. And once a week, I lie in a hospital gown on an exam table in front of a group of young medical students, and I teach them how to respect a woman's body. This isn't sex, but in my ex's eyes, somehow, it would be.

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Julie and I switch Mondays—sometimes she takes the first turn as the "patient," which means I am the "doctor." I model once for the students exactly how to give a complete exam, and then I watch and evaluate as they perform, and then Julie and I

switch roles. If one of us is bleeding, the other sometimes agrees to take on an extra student. More often, though, we just keep it even, no matter if there is blood or bloating or discomfort. These medical students might have to examine a rape victim someday, or a woman presenting with STD symptoms while she's on her period. It's important, to Julie and me and the other GTAs, that the students learn to approach the female body with respect and compassion at the peak of health as well as during illness or the aftermath of violence, which is when a woman would be at her most vulnerable and would need all of the empathy these young doctors-to-be can give.

Going first as the "doctor" is easier. Because I'm performing a role the medical students associate with authority – a position they are hoping to someday step into themselves – they look to me with respect. They see me as the teacher, and they understand that I'm evaluating them. What is more difficult is to be the "patient" first. I'm on my back, the first to be exposed and poked and prodded in front of a room full of young, gangly onlookers. It helps that I know and trust Julie, a thirty-something mother of three. When she is the doctor, she establishes the tone of professionalism and respect the students will follow when they perform their subsequent practice exams. When I am the patient, the students have trouble recognizing that I am also their teacher, that from my supine position, I am also evaluating their technique and bedside manner.

When I ride my bike home after work tonight, a new guy I'm dating is waiting on my porch. Darren is thick and handsome, a former college rugby player. We've been seeing each other for a few weeks. He knows I've just come back from working at the hospital and teases me. "Sore tonight?" he says. I laugh. I enjoy his company, sitting with him on the swing on my front porch. The evening is warm and we exchange stories about

our day. What I don't know yet is that he has herpes, and that I've been exposed to it the handful of times we've had unprotected sex. Nor do I know yet that his wife still lives with him. I think they are divorced already, or at least separated. A mutual friend will hint to me a few weeks after this night that I'm in deeper than I realize, that this guy isn't quite who I think he is. But for tonight, I enjoy the easy freedom with Darren. I joke with him about the pimply medical student with curly brown hair, the one who looked like he would faint when he touched the inside of my leg and said, "I'm touching you now."

"Yes," I'd said, "you are." And we'd both laughed, the medical student and I, and now Darren and I are laughing, too. My ex would never have laughed. He'd have choked me or called me a whore. He'd have tried to make me feel ashamed for being willing to let men see my most private body parts.

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When a doctor examines a woman, it's a moment of acute vulnerability. And it lasts until she is sitting up and fully clothed. It lasts until she gathers herself and leaves, stepping back into the "normal" world and her place within it.

I've been divorced for over a year now, and for many more years after this night, I'll stumble through men, learning as I go how to say no and how to say yes. Ben – the tall, thin lover who lives in a tree house and studies physics in his free time – will spend lazy afternoons exploring my body and letting me explore his, helping me discover that my nipples are hard-wired and that, yes, it is possible to have hands-free orgasms. Tony – the dark-headed young athlete with 70% hearing loss – will teach me to sink into my body and leave spoken language behind as we extend our sessions late into the nights after my sons have fallen asleep in the next room. With each lover, I'll understand

something more about my body, about my lover's body, about what I like and what I don't.

On the next Monday evening in the exam room and for many Mondays to follow, I'll work with Julie to teach waves of students how to approach a woman when she is on her back, ready for a gynecological exam. When she is the patient, Julie's waxed pubis will rise high above the table, her tan legs and painted toenails spread before me and the newest gathering of bright, young medical students.

"I'm touching you now," I'll teach the students to say to Julie.

And when it's my turn on the table, I'll get to practice saying, "Yes, it's okay to touch me there." Or "No, I can undress myself." Or "No, that hurts."

When the students tell me, "I'm touching you now," I'll look them in the eye, and to each of them, I'll get to say, "Yes, you are."