EVERYONE IS UNIQUE BUT NOT SPECIAL

On trans health care and negotiating care towards less violent health infrastructures.*

The Undercover Nurse: Let's talk about healthcare and trans*ness. I'm a nurse, and I'm pretty sure that we (the royal we) don't get it right all the time when providing healthcare for trans* people. I know there are some things which we can change pretty quickly, and others which will take longer and that are harder to change. It's really good for me that we can have a conversation about these things. So, have you been in hospital recently?

Loren Britton: Yeah, not so long ago.

TUN: And how was that?

LB: It was a strange experience. I'm a migrant and the care that I received in Germany was significantly better than the care that I've received in the US, where I'm from.

TUN: Often names, identity characteristics and pronouns aren't asked when people first come into hospital. Imagine you broke your arm. When you come into the hospital we just say "are

That's a practice that we can change, but I don't know how quickly, because it's about prioritization. I guess the obvious question that I have for you, is: how does it feel when you're not asked for your pronouns? Especially in a healthcare context, as when you're accessing healthcare you're most likely feeling vulnerable. How is it not to be asked your name, not to be asked your pronoun?

LB: So firstly, my experience with healthcare is marked by the fact that I am a migrant. When I was living in the US, I did not have health insurance, and coming to Germany changed that for me. There was the regular anxiety that I had of going to the doctor, where my first thought would be 'shit, how much is that going to cost?'. Every time I would go, I'd be like 'I'm not sure I can afford this'. So, there was always a financial barrier to accessing care. Further, I think that in terms of names and pronouns and trans* awareness and doctors, it's few and far between. Very few doctors have trans* awareness, although this is changing. In Germany I have had some pretty good, and then some very bad experiences with doctors, who have misgendered me, called me by my dead name because that's what's listed on my health insurance card, or generally mistreated me because of the intersection of being someone who didn't have health insurance before. I often feel like I should already know something that I don't know. Answering your question, it feels very invalidating and nerve-wracking to go to a space where I'm not sure if I'm doing it right in the first place. My name not being asked, and my pronouns not being respected - this situation of power feels like it's set up to make me feel unsure if I'm doing the right thing or if I'm actually safe there. So directly to your question, it feels very invalidating and nerve wracking to go to a space where I'm not sure if I am doing it right in the first place because of my previous experience. For me the whole apparatus, my name not being asked, and my pronouns not being respected - the situation of power feels like it is set up to make me feel unsure if I'm doing the right thing or if I'm actually safe there.

TUN: I think that's a common experience for lots of people in healthcare, which compounds when other things going on: extra layers of vulnerability, complexity and billing systems. You've mentioned before that when you engage with healthcare, it becomes all about being trans*. Could you say a little bit more about that?

LB: For example, I went to a dentist a few years ago to get my teeth cleaned, which is truly not a trans* experience. At the time I had recently started HRT, so my voice was cracking a lot. I was having a conversation with a dentist about my teeth, and my voice cracked while we were speaking. She then asked me what my pronoun was. That was interesting, because it was this kind of clocking that happened because of my voice shift. When I then responded that I use gender neutral pronouns, she didn't know what that was. So suddenly the conversation about my teeth turned into an educational moment. It felt frustrating because it was so not the reason for which I was there, but this on-the-fly education happens all the time - and sometimes I refuse to engage with it, too. It's a banal example, but it points out this paradigm of 'on whom the burden of proof and the work of education falls' - in my experience, it's on me as a trans* person seeking care, rather than on the infrastructure that could do more to care for different kinds of vulnerable people.

TUN: When would be the right moment for you to ask for pronouns?

LB: I think the infrastructure is the thing that needs to change. I do go and have gone to trans* aware doctors before, and they might have an additional box for the name that you use, next to where you share your health-insurance name on an online form when you're making an appointment. I think that when you're filling out forms in general, it's often unnecessary to ask for gender identity. The researcher Katta Spiel wrote this really great paper about their interactions with gendered online fillable forms called Why are they all obsessed with Gender?" – (Non)binary Navigations through Technological Infrastructures, where they note all the places where gender is required to be filled in. They pose questions like "why do you need to know my gender for buying a book online?".

TUN: Infrastructurally for me, as a nurse who teaches other nurses, I'm trying to think through how we/I teach this to new (and old!) nurses. The classic example that I use is admission to hospital via ED. Most hospitals in the Global North have rules around single-sex accomodation, which means that people will be offered a bed along a binary gender division: men with men, women with women (in Germany, an average room has 2 beds, but in the UK 4-6 beds in one room is common). The question comes up: how should the trans* person be accommodated? The easy answer is obviously to ask them and to put them in that bay.... but, it's trickier than that. The nurse (we/me) have to consider everything else happening in that situation. More often than not, one of the other patients in the bay may have a mental disability and may (or may not) be unkind to the trans* patient. As a nurse, I want to protect the trans* person from that. In particular, older women can get scared of men overnight, so male nurses often take chaperones into women's bays at night. If the trans* person appears quite masc then this could draw attention from others in the bay, which I just don't want the trans* person to deal with while they're feeling crap in hospital. So, what often happens is that trans* people get a bed in a single room. But how do we navigate these infrastructural barriers disenfranchising trans* people's healthcare, while also making sure that the ward runs well? I don't want trans* people feeling like they get shoved in a side room, but I also don't want them to have to deal with all the other rubbish that could come their way.

LB: There's lots of things to think about there. One thing is the mandate to pass within binary gender, plus there is so much to say about the intersection of medicalization and transgender experience. I'm someone who has decided to medically transition, but I want to hold the door wide open for the many ways of being trans* or gender non-conforming that do not include medical transition as part of someone's experience. This also relates to questions about how to care for trans* people who also have disabilities. Another part of this is about how much a dominant culture values passing as a gender or as able bodied, and how much effort someone wants to or is able to put into that performance as well as the personal and cultural decisions that come with notions of 'passing'. And of course, issues of safety come up at every moment. I think the situation that you're describing is a hard one. What's hard about how you described it is that in this scenario, there are vulnerable people situated differently: a trans* person who is a patient and a nurse who represents a structure, these are both vulnerable positions. I wish to think of ways of negotiating difficult situations that don't pit our vulnerabilities against each other, but instead protect or create

mean that nurses are taught these scenarios from an early stage of training - and, trans* people in the hospital would be surrounded by support from friends and lovers so that they could make decisions in the least stressful way.

TUN: There are so many vulnerabilities, and you're completely right: it's about working together with everybody's vulnerabilities… survival of the most collaborative! But yes, there's lots of ways to do gender, lots of ways that can be expressed, as well as the matter of trying to find ways to work with trans* people that don't disenfranchise them, while also considering other people.

LB: Another thing to mention is that many trans* people are multiply marginalized and may also have multiple traumatic experiences. My suggestion would be to ask the people what they would prefer, and then to move ahead with the trans* person's preference. More often than not, trans* people have not been asked about so much, and our agency needs to be respected.

TUN: Another thing to mention is that many trans* people are multiply marginalized and may also have multiple traumatic experiences. My suggestion would be to ask the people what they would prefer, and then to move ahead with the trans* person's preference. More often than not, trans* people have not been asked about so much, and our agency needs to be respected. I guess what we often teach is to challenge the behavior, not the person. So if troubles arise, if people aren't getting along in a bay, you challenge their behaviors. I would want to ask the trans* person what they want, and then other people in the bay what they want. But then, people in the bay might say "No, we don't want them in here". And then you challenge that behavior and say, "that's inappropriate". We have a yellow and red card system, so if they're being really rude they get a yellow card, and if they do it again, they get a red card. Then we'd start the process of transferring their care elsewhere.

LB: It's interesting what you just said about these cards. Maybe there are parallels between hospitals and prisons as systems. Systems that are purported to be "caring" for us, but as we know in the case of prisons undoubtedly, they're all mechanisms of control.

TUN: I think you're right. As nurses, we enforce these infrastructural powers. I have no choice, because I have between 4 and 12 people to look after. My job is to enact care through infrastructural power. We need to be reflective of that.

LB: How do you teach nurses about this? How is it that you train nurses to be able to hold the complexity of the situation, when someone's in a vulnerable state and they're racist or anti-trans* or anti-Muslim or whatever it is that they are? How do you teach people to be able to push back against these things, because in a way you're teaching how to navigate colonial infrastructural power and enact anti-racism on-the-go, with multiple vulnerabilities around. How do you do that?

TUN: You teach them that everyone's unique but no one's special, be they white, Black, trans*, whatever. Sometimes you have to say no to people. No matter if they've got every

consider. Nevertheless, you challenge the behavior of the person - they are unique, but they're not special (because you have another 11 people to look after). It sounds terrible because I'm talking about enacting infrastructural power and about being a bit strict, and it's a really fine line; there's no right answer, it's so situational and dynamic. I just teach them that they're allowed to say no to people. I say, "I give you permission to say no to people" – then again if someone's in pain or dying, of course you do your absolute best not to say no. I do worry, though, that I say this because I'm fortunate to get the space and time to reflect on this. If I teach the nurses this, and they then go into practice and are working under super stressful conditions every day, then they won't have time to think about these things, and they might come on too strong with the infrastructural power.

LB: So as a nurse, you're enacting institutional or structural care, but at the same time... (trails off). What if we follow Maria Puig de la Bellacasa, when she says that care cannot be determined in advance? She talks about how care for some is not care for others, and I think that the kinds of care that she's talking about and the kinds of care that you're talking about are quite different. Does medical care come from a different reality? What do standards of care mean to you, and how is it that you practice the flexibility of care?

TUN: Good question. Two things that come to mind. First, I think I completely agree with Maria Puig de la Bellacasa's argument: we produce care. These productions play with power relations between materiality, and that is how we produce care. However, because of the way that nursing has become professionalized, the other part of our job is to be gatekeepers and resource managers. This is also a sustainability issue, because we're acutely aware of the resources available, you know. But we also know what is restricted, and we try to navigate a path between this and resource management. We ask: what can we actually do for this person, and what is possible for this person? Sure, other futures are possible, and we aim for all possible futures. But some of those futures might restrict possibilities, and what then?

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Loren Britton & The Undercover Nurse

LB is an interdisciplinary artist and researcher tuning with practices of Critical Pedagogy, TransFeministTechnoScience and Disability Justice. Playing with the queer potential of undoing norms they practice joyful accountability to matters of anti-racism, collaboration, Black Feminisms, instability, TransFeminisms and transformation. With Isabel Paehr as MELT, they queer knowledges from computation and chemistry to shift metaphors of melting in times of climate change (Meltionary). Britton is an Associate Lecturer in Queer Feminist Technoscience & Digital Design at i-DAT at the University of Plymouth, UK; and an artistic researcher on the interdisciplinary project Re: Coding Algorithmic Culture within the Gender/Diversity in Informatics Systems Research Group at the University of Kassel, DE.

TUN has been a hospital based nurse for 15 years.