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How Chinese Women Cope with Physical and Psychological Traumas in Gynecological Examinations: A Situational Analysis of Patients' Communicative Accommodations

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Based on 792 posts and 14 in-depth interviews, this study employs situational analysis to examine Chinese women's communicative accommodation strategies and the complex situations that motivate their adoption of specific strategies. It finds that strategies such as interpersonal control and discourse management have empowered them to negotiate with medical authorities on the one hand and challenge the sexual and moral connotations of gynecological symptoms on the other hand. However, coping with disadvantageous material, relational, and spatiotemporal situations necessitates not only the enhancement of patient-provider communication but also the advocacy for institutional intervention and sociocultural transformation. The approach of situational analysis goes beyond the focus of intergroup relationships by original communication accommodation theory to highlight broader sociocultural and structural barriers to women's health.

Keywords: gynecological examination, communicative accommodation, situational analysis, patient-provider communication, women's health

Gynecological examination (GE) is the most effective way to detect sexually transmitted infections and reproductive system diseases (Williams & Williams, 2013). State-sponsored health promotion efforts have made many Chinese women aware of the necessity of routine GEs (Liu & Zou, 2023). Nevertheless, according to a nationwide survey in China, among female respondents who had gynecological complaints in the preceding year, only 57.8% sought medical treatment (HealthInsight, 2022).

The high rate of GE avoidance can be partially explained by the sense of discomfort, shame, vulnerability, fear, or humiliation (Galasiński & Ziółkowska, 2007) caused by the dismissal, gaslighting, and invalidation that women encounter during patient-provider communication (Thompson, Babu, & Makos, 2023). As a solution, communication accommodation theory (CAT) suggests individuals attune their

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communication behaviors with interaction partners to maintain desired social identities and achieve communicative goals (Zhang & Giles, 2018). However, due to the patient-provider knowledge and power asymmetries within health-care settings, previous research has focused predominantly on improving providers' communicative behaviors to enhance patient trust and satisfaction (e.g., Kabir & Chan, 2022; Sparks, O'Hair, & Wright, 2012). As a result, patient perspectives, particularly those from socially disadvantaged groups, are not adequately reflected in relevant studies.

Rather than meekly submitting to medical harms and traumas, patients could employ various communicative accommodation strategies to negotiate, make sense of, and navigate complicated situations within GEs (Yoon, Park, & Park, 2021). By revisiting the initial focus of CAT on mutual accommodations between communicators (Farzadnia & Giles, 2015), this study seeks to unpack Chinese women's accommodative practices in GEs as well as their implications for health empowerment.

A situational perspective is essential for a comprehensive understanding of Chinese women's GE experiences. This is because women's accommodation practices during GEs are sometimes driven not just by the fear of diagnosis but also by the anguish caused by providers' gender-biased discourses (Galasiński & Ziółkowska, 2007). Moreover, gynecological patients encounter a wide variety of uncertain examination settings, which are entwined with their own demographics, sexual experiences, psychological vulnerability, and previous GE experiences (Tugut & Golbasi, 2014). These human and nonhuman elements combine to constitute different situations requiring dynamic communicative accommodations (Towle, 2022) in exchange for tolerable GE experiences, which have been largely ignored by previous research. As Clarke (2022a) pointed out, social phenomena are taken up, resisted, and modified within situations. Therefore, it is critical to be conscious of nonhuman, discursive, cultural, and socio-structural situations, as well as their intersections, when examining gynecological patients' agency for communicative accommodations.

The subsequent section begins with an investigation of Chinese women's GE experiences and their sociocultural and institutional roots. It then follows a review of CAT in the context of GE. A situational analysis of the online self-disclosures of and in-depth interviews with Chinese female netizens not only presents how gynecological patients' communicative accommodation strategies could ease their stress but also showcases how these strategies actively respond to various situations of GEs. Finally, the theoretical implications of situational accommodation practices are discussed in relation to Chinese women's health empowerment.

Literature Review

Understanding Chinese Women's GE Experiences

Public hospitals are the mainstay of China's health-care system. As of 2022, compared with China's 0.69 billion female population, there were only 373,000 obstetricians and gynecologists (OB/GYNs), of whom approximately 15% were male. It means one OB/GYN should serve around 1,850 women on average. Geographically, OB/GYNs are inequitably distributed. Rural women in the western region have less access to OB/GYN services (National Health Commission, 2022).

Chinese women's GE experiences are inextricably linked to the country's sociocultural and institutional milieus. Confucian culture instills a sense of body modesty, a taboo against premarital sex, and avoidance of open discussion of sexual health issues (Liu & Zou, 2023). Given the negative connotations of gynecological symptoms in relation to sexuality, Chinese women often lack the support of their partners in undertaking GEs (Holroyd, Twinn, & Adab, 2004). In many cases, Chinese women accept GEs only when gynecological problems cause health crises, especially threatening their marriage and fertility (Jia et al., 2013).

Institutionally, the absence of public education on reproductive health contributes to the prevalence of misconceptions about GEs (Chang, Woo, Yau, Gorzalka, & Brotto, 2013). The high rate of GE avoidance in China is also because it is not covered by the country's basic medical insurance. Rural women, who are generally less health conscious and financially independent, are more unlikely to accept GEs (Cao & Wang, 2021) compared with young urban women with higher income and educational attainment (Jia et al., 2013). Informed by the neoliberal ethos of self-empowerment and self-care (Liu & Zou, 2023), the latter are more inclined to view GEs as effective health management practices.

However, GEs have been demonstrated as being an undesirable necessity for not only Chinese women but also the worldwide female population (Galasiński & Ziółkowska, 2007; Towle, 2022; Tugut & Golbasi, 2014), which can be explained from three perspectives: Material, symbolic, and discursive (Hintz, Betts, & Buzzanell, 2023). Gynecological examination is materially undesirable, primarily due to the bodily discomfort and terrible sensations it induces. The insertion of a speculum may cause stress and pain and could even trigger flashbacks among victims of sexual abuse (Ackerson, 2011). Embodied sensations, such as embarrassment over undressing, worry about personal hygiene, and fear of pain, make GE an undesirable experience (Huber, Pukall, Boyer, Reissing, & Chamberlain, 2009). Moreover, women may experience unprofessional and inappropriate treatment during GEs, including forced physical intrusions, pain infliction, rudeness, and excessive examinations (Ackerson, 2011).

Symbolically, GE is imbued with negative connotations in relation to sexuality and morality. Gynecological symptoms are often perceived as abnormal and indicative of sexual misconduct (Kapsalis, 1997), leading to the perception that gynecological patients fail to manage their sexual desires (Sandelowski, 2000). Some women feel deeply offended when providers make derogatory comments about their bodies, using terms like "gross," "sick," or "unclean" (Hernández & Dean, 2020). These inconsiderate comments, instructions, and attributions could frustrate their self-integrity and agency (Cook, 2011) and necessitate patients' communicative accommodations.

The Potential of Patients' Communicative Accommodations

Communication accommodation theory initially addresses how individuals adjust their verbal and nonverbal communicative behaviors to negotiate with their interlocutors in a way that is compatible with their personal and group identities (Dragojevic, Gasiorek, & Giles, 2016). It views patient-provider interactions as interpersonal communication occurring at an intergroup level (Baker, Gallois, Driedger, & Santesso, 2011; Watson, Jones, & Hewett, 2016). Specifically, the hierarchical and role-bound health-care system prioritizes providers' professional identities, which further shapes their languages, values, and

treatment strategies (Farzadnia & Giles, 2015). In contrast, patients have long been defined as passive targets of treatments and (hoped-for) compliant followers of instructions (Hunter, 2010). As an antidote to provider-centered communication, CAT proposes ways in which providers accommodate patients to achieve satisfactory medical outcomes (Watson et al., 2016).

Five accommodation strategies have been identified in previous CAT studies. Cretchley, Gallois, Chenery, and Smith (2010) discovered that providers may improve the interpretability of talks by using clearer vocabulary and even adjusting their language and behaviors to cater to patients' preferences, which is called approximation. Alternatively, they may maintain interpersonal control by asserting their authoritative professional identities (Cretchley et al., 2010). Farzadnia and Giles (2015) later proposed strategies of emotional expression and discourse management, respectively, indicating providers' efforts to calm patients' negative sensations and promote dialogues, enhance patient engagement, and respect patients' self-reservation.

While these strategies demonstrate the potential for optimizing patient-provider interactions, providers with higher status and a stronger professional identity may be less inclined to accommodate patients (Baker & Watson, 2015). High work intensity and occupational burnout also reduce the possibility of providers' communicative accommodations. Patient-centeredness is difficult to achieve in the Chinese context due to the high doctor-to-population ratio, inadequate public health policies, and medical education that neglects the cultivation of doctors' communication skills (Jiang & Hong, 2021). On the other hand, patient empowerment studies have shown that patients are knowledgeable and defend their threatened identities to control their own bodies, conditions, and treatments (Aujoulat, Marcolongo, Bonadiman, & Deccache, 2008), indicating the potential of patients to accommodate providers during medical treatments.

Toward a Situational Understanding of CAT

Patient-provider communication could never be reduced to a static process that occurs against a fixed backdrop (Frers, 2009). Individuals' accommodation practices are strongly influenced by the sociohistorical contexts of interactions, their interpersonal and intergroup histories, and their idiosyncratic preferences (Zhang & Giles, 2018). In the case of GEs, communication is a fluid, embodied experience shaped by material contexts, emotions, and women's concerns about gender and sexuality norms (Thompson et al., 2023). However, we propose to examine patients' situational rather than contextual accommodation practices and their potential to facilitate better GE experiences.

This is because context denotes "what surrounds something but is not part of it," whereas situation captures "the relationality of the parts in a particular temporal and spatial ecology" (Clarke, 2022a, pp. 17–18). Accordingly, a defining characteristic of situational analysis is the articulation of how social phenomena are "co-constituted" through the relationships of entities at "all levels of organizational complexity" (Clarke, 2022b, p. 60). In other words, situational accommodation analysis may concentrate on the effects of material (e.g., nonhuman factors), relational (e.g., implicated actors), and spatiotemporal complexities on patient-provider communication in GEs (Clarke, 2022b; Frers, 2009).

The vaginal speculum, for example, a key nonhuman actor that allows doctors to inspect the cervix from outside women's bodies, not only creates fear and discomfort in women but sparks debate due to its sexualized connotations. The design and application of the speculum are based on a White, abled, childbearing-age female body template (Kohler et al., 2021). Thus, it may cause discomfort or pain when it is used to examine obese, multiparous, virginal, and elderly female bodies (Towle, 2022). Under patriarchal biomedical rules, women who cry during speculum insertion may be labeled as emotionally disturbed, overly anxious, or uncooperative (Williams & Williams, 2013). Patients may even encounter humiliating remarks when they are judged "promiscuous" with the assistance of a speculum (Sandelowski, 2000). Overall, the use of vaginal speculum engenders various physiological, emotional, and discursive situations that impact patients' accommodation strategies.

A frequently overlooked relational situation in GEs is the patient-provider tension regarding which side has more legitimacy in defining symptoms, on which medical and lay perceptions often diverge. For example, providers may unnecessarily adopt GEs to detect symptoms as a prerequisite for prescribing hormonal contraception (Gabzdyl, Engstrom, & McFarlin, 2015). However, when some women reported vaginal pain during GEs, they did not get medical diagnoses and were only informed that the pain was psychologically produced (Huber et al., 2009) because providers possibly invalidated their gynecological symptoms as normal physiological phenomena or as psychological reactions caused by malingering, exaggeration, or overreaction (Bontempo, 2022). In these circumstances, women's self-control agency was neglected.

Moreover, family members and sexual partners, as implicated actors, are frequently absent from the examination process. Female adolescents may seek gynecological care without parental accompaniment in an effort to keep their conditions under their own control (Bair, Hutson, & Burnette, 2014). Many women experienced GEs without their partners' support to avoid their awareness of such private inspections (Holroyd et al., 2004). These situations of isolation may aggravate women's fear of negative medical outcomes and thus necessitate more friendly patient-provider interactions.

Gynecological patients are highly sensitive to spatiotemporal situations. They anticipate that GEs could take place in a closed environment without the presence of outsiders and away from a group of medical interns (Vaughn, Rickborn, & Davis, 2015). Providers in countries such as China are often time-pressed during visits even though patients expect sufficient time for consultations (He & Qian, 2016). These spatiotemporal situations undoubtedly exacerbate patient-provider tensions that hinder mutual trust (Frers, 2009).

Overall, a situational analysis of women's communicative accommodation strategies in GEs will shed light on how they cope with physical and psychological traumas brought about by unfavorable professional discourses, medical routines, power relations, social norms, and access to medical resources (Zhang & Giles, 2018). It further allows us to identify the social structures, collectives, institutions, and historical or present-day realities surrounding GEs (Towle, 2022) by addressing the following research questions:

RQ1: What are the specific communicative accommodation strategies employed by Chinese women during GEs?

RQ2: How do material-discursive, relational, and spatiotemporal situations shape Chinese women's communicative accommodation practices during GEs?

Methods

Data were primarily collected from two major social media platforms. Due to the taboo nature of sexual health issues, Chinese women turn to online communities for more open and anonymous expressions about their GE experiences. A niche online community based on Douban, one of China's largest interest-oriented social media platforms, enables female members to ease fears of upcoming GEs and heal traumas caused by GEs by offering peer support. For the sake of privacy protection, the name of this online community has been abbreviated as ETGE in this article. In addition, to address other women's concerns about GEs, female netizens also post narratives about their unique GE experiences on Zhihu, China's largest Q&A community.

The online data collection was conducted in September 2022. We retrieved 1,837 posts under 275 threads from the ETGE community, which were released from July 2021 to September 2022. Additionally, 415 posts that responded to a question about personal GE experiences were retrieved from Zhihu. Samples were considered invalid and consequently removed if authors solely expressed their negative feelings about GEs or narrated their traumas experienced during GEs but did not mention how they interacted with providers. Finally, 792 posts were retained for data analysis. Although nicknames were used by these authors, they were each assigned a code name to avoid having their nicknames used to confirm their identity.

Clarke's (2022a) situational mapping approach, which aims to provide a full picture of GE situations by "turning up the volume" (p. 10) of quiet, mute, and silenced discourses and actors rather than focusing on the dominant medical discourse, was employed for data analysis. Primarily, the first author carefully read through each post. Female netizens' accommodation practices during GEs and their specific situations, including human actors (e.g., male providers), nonhuman actants (e.g., vaginal speculum), implicated actors (e.g., male partners), collectives (e.g., lesbian women), sociocultural components (e.g., sexual norms), and spatiotemporal elements (e.g., examination rooms), were identified as initial codes. Then, the two authors met to discuss the characteristics of these initial codes and agreed to categorize these accommodation practices according to three common broader situations in which these practices were conducted: Material-discursive, relational, and spatiotemporal situations.

Under each broader situation, female netizens' specific accommodation practices were further coded according to Farzadnia and Giles' (2015) five communication accommodation strategies, and their operational definitions in the context of GE were formulated and refined through ongoing discussion. The data were checked back and forth to ensure that the five accommodation strategies could describe all the accommodation practices mentioned in the sample posts. Two postgraduate students verified the reliability

of the accommodation strategies by coding 100 randomly selected posts. Table 1 shows that Cohen's kappa for each individual category was not less than 0.88, indicating that the reliability was acceptable.

Accommodation assumes someone is motivated and able to use strategies (Dragojevic et al., 2016). To gain a more contextualized understanding of Chinese women's motivations and agency for communicative accommodation in GEs, particularly those unaccustomed to sharing their personal experiences online, we conducted in-depth interviews. Interviewees were recruited through social media contacts and were neither members of ETGE nor had they ever participated in relevant discussions on Zhihu. Purposive sampling was conducted to make interviewees as diverse as possible in terms of age, marriage, place of residence, and prior GE experiences.

All interviews were conducted between November and December 2022 through online voice calls. Before the interviews, all respondents verbally consented to their participation in and the recording of the interview. After completion, they received 30 Chinese yuan (around US$5) as a token of appreciation. The recruitment ended when theoretical saturation was reached (i.e., no fresh accommodation strategy emerged in the latest interviews). Ultimately, 14 women who had undergone GEs were interviewed, with durations ranging from 35 to 92 minutes. Pseudonyms are used in the text to protect their privacy (see Appendix A for interviewees' demographic information).

Situational analysis was also conducted to examine their accommodation strategies under specific material, relational, and spatiotemporal situations. However, because of the detailed accounts of GE experiences by our informants, we were able to gain vivid insights into their motivations undergirding their specific accommodation strategies. As a young woman who experienced health dismissal, the first author was able to better understand the informants' GE experiences as well as the hidden meanings and nuanced sociocultural implications underlying their narratives. The second author, as a mature man, engaged in fewer subjective feelings in data analysis. The two authors collaborated with awareness to ensure a gender-sensitive and emotionally detached data analysis process.

Findings

Table 1 shows that rather than merely complying with medical authorities by enhancing approximation and interpretability, Chinese women negotiate asymmetrical power relations by adopting discourse management and interpersonal control. In some circumstances, they even radically respond to physical and psychological traumas through emotional expression, demonstrating their agency in counteracting the systematic trivialization of women's suffering. Below, we present the specific accommodation strategies that Chinese women adopt to cope with the material-discursive, relational, and spatiotemporal complexities of GEs.

Table 1. Summary of Patients' Accommodation Strategies.

Situations	Strategies	Operational Definitions	Specific Performances (Prevalence)
Material-discursive	• Approximation	• Modifying cognition and behavior to comply with providers (κ = 0.96)	• Wearing easy-to-take-off lower clothing (134) • Adjusting the body to the examination table (117) • Maintaining proper posture (35) • Making self-referential relaxation (137) • Swallowing the discomfort consciously (106)
	• Interpretability	• Expressing properly to negotiate with providers carefully (κ = 0.91)	• Voicing personal demands (61) • Adopting euphemisms for self-disclosure (24) • Wearing a ring or make-up to conceal premarital sex (6)
	• Discourse management	• Discursive resistance to stigmas about GE (κ = 0.92)	• Redefining GE as an ordinary examination (44) • Eliminating sexual connotations of GE (34) • Normalizing gynecological symptoms (17)
Relational	• Interpersonal control	• Control over patient-provider interactions (κ = 0.92)	• Selecting gynecologists in terms of demographics (89) • Recording providers' misconducts as evidence (11) • Finding excuses to halt offensive examinations (7) • Using nonverbal cues to keep distance from male providers (29)
	• Discourse management	• Discursive solution to patient-provider conflicts (κ = 0.90)	• Counteracting nonmedical gaslighting (28) • Complaining to the hospital (68)
	• Emotional expression	• Venting negative emotions verbally (κ = 0.88)	• Rebutting or using offensive language (34)
Spatial-temporal	• Interpersonal control	• Keeping implicit or explicit control over one's privacy (κ = 1.00)	• Closing the door and drawing the curtain by themselves (44) • Requiring irrelevant individuals to leave (45) • Wearing short skirts to promptly react to sudden break-ins (8)
	• Discourse management	• Normalizing providers' impatience (κ = 1.00)	• Redefining the role of health-care providers (23)

Note. Prevalence indicates the frequency that each specific performance was mentioned in all sample posts and in-depth interviews.

Coping With Material-Discursive Situations

Our informants described their embarrassment and stress when removing their lower clothing before receiving GEs. Many of them reported anxiety, panic, and intensive pain when speculums were used during their GEs, especially when providers were reluctant to explain their proper use or select the appropriate size. Transvaginal scans, Pap tests, and human papillomavirus tests involve using probes, swabs, scrapers, and small brushes in contact with women's genital areas. In some cases, informants who were not sexually active found the use of a swab acceptable since providers only took samples from the vaginal orifice. However, the use of a swab could be quite violent, such as "stabbing straight through" (T64-P3, personal communication) for sexually active women. One informant commented, "Do sexually active women have to bear painful GEs? Providers fail to consider that some women do not enjoy sexual encounters" (T45-P8, personal communication).

Moreover, while vaginal sampling may cause bleeding if cervical tissue is removed or there is inflammation (Williams & Williams, 2013), some informants found it difficult to distinguish between normal bleeding and bleeding under providers' rough treatment. Uncomfortable feelings induced by bleeding may amplify the accommodation gap between patients and providers, increasing patients' distrust in providers' expertise and resulting in resistance to GEs. For example, one informant said, "I was devastated to discover that I was bleeding after returning home from the examination. The memory of this incident lingered for a long time. Even after my discomfort subsided, I remained resistant to undergoing GEs" (Chenjing, personal communication). According to a few interviewees, providers' behaviors during GEs were more likely to be perceived as dismissive and unprofessional compared with other medical examinations due to some OB/GYNs' moral judgments and the physiological sensitivity of female sexual organs.

Approximations, as nonverbal communication strategies that comply with providers both cognitively and behaviorally, were used first by informants to deal with these material situations. Some informants thought that providers may consider a patient's ability to undress promptly an indicator of compliance, so they made nonverbal approximations by wearing pants or skirts that were easy to take off. Adjusting their bodies to the examination table and maintaining suitable postures were also necessary efforts. During the examination procedure, informants overcame their fear and reluctance by making self-referential relaxations.

A key motivation for their adoption of approximation was the prioritization of physical well-being, which could justify the harsh treatment they received. One informant stated, "No matter how uncomfortable the GE is, I tolerate it for the sake of my health" (Chunan, personal communication). Swallowing discomfort consciously was an attempt to avoid dissatisfaction from providers, which was not indicative of passive victimhood but rather a form of self-protection in the face of medical authority. For example, one informant recalled that after she cried out, the provider criticized her more vehemently. Consequently, "I then realized I needed to hold back and not offend her, or else she would make me conduct more tests" (Xiaoguo, personal communication).

In contrast to approximation, some informants consciously enhanced the *interpretability* of verbal communication. This included reminding providers of their discomfort immediately and requesting gentler

operations as well as the use of smaller specula. To avoid potential hymen injuries from invasive screenings and, meanwhile, maintain their self-identity, lesbian informants who had not engaged in penetrative sex or informants who were virgins with masturbation experiences adopted euphemisms such as "physical contact but no penetration" (T88-P11, personal communication) to describe their sexual lives. Interpretability could also be enhanced through carefully conceived nonverbal self-disclosures. Worrying about rough treatment by providers who had prejudices against adolescents with gynecological diseases, one informant mentioned that she wore a ring to fabricate her married status (T227-P3, personal communication), and another informant applied heavy makeup to demonstrate a mature appearance (P43, personal communication).

As noted by Ussher (1996), the materiality of women's undesirable bodily experiences in GEs is always mediated by the problematic discursive construction of gynecological symptoms and examinations. As an example, providers' humiliating discourses may cause psychological traumas in patients, as demonstrated in statements such as, "We are not unclean women, and the provider's attitude really hurts" (T14-P7, personal communication), "I have had my fill of awful GEs" (T37-P1, personal communication), and "It is so unfair that sometimes I would like to go insane and ruin everything" (T14-P1, personal communication).

Informants used discourse management to counteract the stigma that GEs are mostly for "promiscuous" women with "unclean" bodies (Sandelowski, 2000). They redefined GE as an "ordinary" health examination and an integral part of self-protection and self-responsibility; as one informant noted, "Sexual organs should not be specially treated by relating them to women's innocence or sense of shame" (T102-P1, personal communication). Moreover, Chinese health-care providers have long employed the discriminatory term "cervical erosion," which implies pathology and sexual uncleanness, to refer to cervical ectropion, a benign condition that takes place when the columnar epithelium of the cervical canal turns outward and is exposed to the vaginal environment (Xiao, 2019). For example, one informant was questioned by her provider: "How does your cervix look like that of an old lady?" This made her feel that her cervical ectropion was shameful and cureless (P160, personal communication).

Several informants who reported being overtreated due to cervical ectropion advocated clarifying this definition to combat providers' misdiagnoses and derogatory remarks. This helped them reestablish positive self-consciousness. One of them posited, "We are not that terrible, and cervical ectropion is just an outdated scary term used by unscrupulous gynecologists to make money" (T42-P1, personal communication). By interrogating the commercial interests behind the problematic designation of "cervical erosion," informants attempted to reclaim their control over the right to define their own gynecological status.

Coping With Relational Situations

The uncertain nature of patient/provider, mother(-in-law)/daughter(-in-law), and heterosexual relationships paints a mixed picture of women's struggle for health justice in both the public and private spheres. First and foremost, health-care providers adopt divergent, maintenance, and convergent stances (Dragojevic et al., 2016) verbally and nonverbally during GEs, which seriously influence patient-provider

relationships. The divergent stance is manifested through unpleasant facial expressions, harsh examinations, reprimands for "noncompliant" patients, and prejudiced comments on patients' symptoms.

One informant, who experienced a sudden vaginal insertion without being informed in advance, dodged and shrieked in response to the sharp discomfort. Rather than soothing her, the providers reprimanded her by asking, "You have already been sexually active, so what's the fuss about the examination?" (T125-P1, personal communication). Furthermore, some providers expressed hostility verbally or nonverbally toward patients' symptoms, relationship status, and gender identities. For example, one provider commented that a female netizen's genitals were too smelly and disgusting (P2, personal communication). Another provider behaved harshly and impatiently after a 19-year-old girl reported condom breakage during premarital sex (P37, personal communication).

To manage the above patient-provider tensions, a few informants tended to preempt the opportunity for *interpersonal control* before GEs by selecting gynecologists based on demographics. They generally preferred female providers with higher education levels. Some believed that female gynecologists could demonstrate in-group compassion, whereas others claimed that female gynecologists may be more aggressive, especially when they considered that their patients were receiving what they "deserve" due to their sexual "misconducts" (T8-P1, personal communication). Despite a few comments arguing that younger providers are more likely to be empathetic toward patients' pain relief needs, many informants were still prepared to receive a diagnosis from a senior provider with extensive expertise. *Interpersonal control* was also shown by activating the audio or video recording function on their smartphones before entering the clinical room to witness potentially unpleasant GE experiences. During the GE process, informants also conceived various excuses, such as forgetting to void urine for pelvic examinations, so that they could halt the examination and leave the room if they felt offended.

Rather than internalizing providers' critiques of their sexual experiences, some informants treated such nonmedical discourses as gaslighting and sought to counteract them with non-moralizing and self-empowering discourses. These counter-discourses included "Providers should not lay a guilt trip on women who make their personal choice of sexual life" (T195-P1, personal communication), "Providers should stop disrespecting those brave women who allow strangers to touch their private parts" (T213-P3, personal communication), and "Undertaking GE with courage means cherishing oneself" (T125-P1, personal communication). While complaining is also a form of *discourse management* that allows women to vent negative emotions, some informants tended to avoid direct conflict with the gynecologist by complaining to the hospital after their GEs to save face. This strategy reflects informants' optimism that the current health-care system could change to meet their physical and psychological demands.

In some cases, however, informants resorted directly to *emotional expression* by rebutting or even using offensive language to vent their grievances, anger, condemnation, and sadness, thereby defending their self-respect and self-identity. One example is shouting back at the provider's impatience to overpower the other side (T5-P4, personal communication). Moreover, when a lesbian informant recounted that a female provider ridiculed her sexual orientation with an offensive question—"Don't you think it would be more appropriate to have sex with men?"—other female netizens suggested that the informant could mock the provider with "You may never have orgasms with men" or reply with "None of your business, idiot" (T56-

P4, T56-P7, personal communication). Considering the patient-provider power asymmetry, aggressive emotional expression is more driven by individuals' "separative attack" motivation (Orbe, 1998, p. 15), which goes against the structural inequities within the health-care system.

It should be noted that ideal communicative accommodations should be based on the mutual effort making of providers and patients. Providers' gentle operations and empathetic language could demonstrate their convergent position. One informant felt greatly relieved when the female provider referred to gynecological conditions as "our women's conditions" (T56-P3, personal communication), which highlights the gender identity shared by both female providers and patients and thus transforms intergroup interactions into in-group communication. Following providers' convergent stance, patients were encouraged to adopt verbal and nonverbal *approximation* strategies, thereby increasing the mutual benefit for both parties.

Special attention should be paid to informants' subtle attitudes toward male providers. Some informants attempted to justify their cooperative stance by eliminating the sexual connotations of physical contact with male providers, which implies that they adopted both *approximation* and *discourse management* to deal with the embarrassing situation. As one informant argued, "You are not a woman, but a patient to the provider; mutual cooperation saves both parties' time" (Andy, personal communication). Meanwhile, they preferred using nonverbal communication for *interpersonal control*. For example, one informant stared straight at the male provider until he looked away before she undressed (Xiaoguo, personal communication). Silence became an indicator of male providers' professional ethics. One informant stated that verbal communication with female providers was normative, whereas loquacious male providers incurred an embarrassing and weird atmosphere (Zero, personal communication).

Patient-provider interactions are also deeply embedded in broader social relationships. As in some other Asian countries, such as India and Pakistan (Ali et al., 2010; Singh, 2007), gynecological symptoms are often labeled as "the results of sexual misconduct' in China. For example, one informant never discussed gynecological issues with her mother, who forbade her from engaging in romantic relationships in the name of health protection (Yingzi, personal communication). When complaining about her postpartum urinary incontinence to her mother-in-law, another informant was told, "There is no need to seek medical treatment because every woman leaks urine after delivery." This resulted in her delayed treatment after the failure of self-medication (Xingxing, personal communication).

Lacking informational and emotional support from their families, some informants worried about the adverse results of GEs and adopted more passive accommodation strategies in response to medical treatments and discourses. One informant noted, "Neither my mother nor my boyfriend was informed of my gynecological condition. I was very nervous when I arrived at the clinic. My heart pounded when the provider inquired about my condition, which I had little courage to disclose" (P309, personal communication).

Male partners vary in their attitudes toward GEs. An informant's boyfriend concluded after seeking information that "cervical erosion" was a misleading term, allowing her to recover from depression and regain a positive self-concept (P141, personal communication). Another informant, however, shouted at her ex-boyfriend, who refused to accompany her to conduct her GE: "How could I have gynecological problems if I haven't had sex with you?" (Chunan, personal communication). In another case, after a rough transvaginal

ultrasound, an informant's boyfriend joked, "What about my [penis] size in comparison with the probe?" making her feel ridiculed and frustrated (P36, personal communication). Within a conservative culture, exposing private parts to strangers in GEs has been internalized as a source of shame. This also explains why informants were more likely to adopt the strategy of *interpersonal control* to interact with male gynecologists.

Coping With Spatiotemporal Situations

Patients often expect medical examinations to be conducted in gender-specific private spaces. A typical GE room in Chinese hospitals is usually divided into two parts by a curtain in the middle: One for consultation and the other for inspection. Due to the loose privacy protection policy, nurses, interns, other patients, and curious visitors are not strictly prohibited from entering the consultation room, over which even providers themselves may lose control. As a form of interpersonal control, informants closed the door and drew the curtain themselves to address their privacy concerns. A few rights-conscious informants also asked the interns directly to leave the room. In addition, feeling that communicative accommodation could not completely solve this problem, informants viewed wearing short skirts as a safer choice because they could promptly react to sudden break-ins by covering their private parts.

Because hierarchical diagnoses and treatments have not yet been implemented in China's medical system, providers are too exhausted by intensive medical schedules to accommodate patients properly. In a tense temporal situation, patients' slightly delayed reactions are easily blamed for prolonging the examination process. For example, when an informant experienced uncontrollable and excruciating shivering during rectal ultrasounds, her provider commented, "Even eight-year-old girls could get through this examination" and "Don't take this examination if you are unable to comply" (Xiaoshi, personal communication). The informant gritted her teeth to stop shivering but eventually failed and burst out crying. This showcases how the temporal barrier undermines patients' self-efficacy in controlling the situation, preventing them from adopting any accommodation strategy.

Due to the intractable mismatch between the short supply of spatiotemporal resources and the pressing patient demands for tolerable medical experiences, some informants embraced a neoliberal ethos of self-responsibility, claiming that "the best solution is to earn more money and go to a costly private clinic where providers only serve a few patients each day" (T8-P8, personal communication). However, most informants had to accept the reality that "healthcare providers are not service providers, and you just pay to be cured rather than to be served" (T8-P18, personal communication), which means that patients' proactive communicative accommodations have been recognized as a realistic choice without obtaining sufficient medical resources through institutional intervention.

Discussion and Conclusion

Adopting a situational analysis approach, this study addresses how Chinese GE patients employ multiple communicative accommodation strategies to cope with interwoven material, relational, and spatiotemporal situations. Unlike previous studies examining women's communicative disenfranchisement in medical encounters (Thompson et al., 2023), we outline five communicative accommodation strategies that demonstrate Chinese women's agency in challenging asymmetrical patient-provider power relations,

preventing physical and psychological traumas, defending self-identity, and promoting positive social change. By amplifying the overlooked "voices" within the health-care system (Towle, 2022), this study advocates for mutual and egalitarian patient-provider communication in gynecological practices that cater to women's feelings, demands, identities, and autonomy.

In terms of different communication orientations, Chinese women's accommodation strategies could be further categorized into compliant, negotiated, and assertive accommodations. Recognizing GE as an indispensable means to diagnose gynecological conditions, they primarily employ cognitive and behavioral approximations to tolerate or minimize discomfort during GEs, thereby fulfilling providers' preference for passive, compliant, and accepting patients (Kapsalis, 1997). Nevertheless, approximation also means patients' acquiescence to the patient-provider power asymmetry and could possibly normalize potential traumas in GEs (Hernández & Dean, 2020).

Interpretability and interpersonal control can be seen as Chinese women's cautious negotiations with the professional authority to protect themselves from physical and psychological traumas. They may have recognized the denigration of female sexuality and the trivialization of women's suffering within the health-care system (Thompson et al., 2023). However, realizing that they could not shake these structural obstacles through individual effort making, Chinese women may strategically seek out appropriate providers, secretly retain evidence of possible power abuse, appeal to the administration of the hospital, disclose sexual life with reservations, and use nonverbal cues to reduce embarrassments, discriminations, and insults while avoiding direct conflicts with and saving face from providers.

In contrast, discourse management and emotional expression demonstrate some Chinese middle-class women's determination to defend their self-identity by combating misogyny, moral judgment, and nonprofessionalism within the health-care system (Zou & Wallis, 2022). Their assertive strategies include avoiding moralizing their sexual lives, separating sexual connotations from exposing private parts in GEs, and rejecting the stigmatization of gynecological symptoms. More than this, they may radically vent anger toward offensive, nonprofessional discourses. Through "restorative narratives" (Fitzgerald, Paravati, Green, Moore, & Qian, 2020, p. 356) in virtual communities, female netizens can obtain resilience (Hintz et al., 2023) by reclaiming group identity and sharing counter-discourses to be used in future patient-provider interactions. Optimistically, these strategies are transformative insofar as they challenge the taken-for-granted sexual and gender norms behind women's ordeals and provide impetus for potential patient activism (Cole, 2021).

Chinese women's accommodation strategies vary greatly under specific GE situations. By reappraising the "minor" patient discourses within the traditional provider-centered health-care model (Clarke, 2022a), situational analysis provides an alternative approach to understanding the full complexity of patient-provider communication as well as the motivations underlying patients' accommodation strategies in GEs. First, the introduction of material or nonhuman actants complicates patient-provider communication during GEs. Providers' harsh operations using vaginal specula of unsuitable size and their dismissal of patients' responses jointly drive patients to adopt accommodation strategies that comply with or cautiously negotiate with the authority of providers (Williams & Williams, 2013).

Second, providers' accommodation orientations, being either convergence, divergence, or maintenance, create different relational patterns, which consequently incur patients' various accommodation strategies (Farzadnia & Giles, 2015). Despite the significance of the patient-provider relationship, women who contract gynecological diseases but lack support from their families or partners are particularly vulnerable in negotiating entangled sexual and medical discourses because they themselves may have internalized conventional gender norms and attributed gynecological symptoms to their own "unclean" sexual lives (Cao & Wang, 2021). On the contrary, women who are emotionally supported by significant others and informed with sufficient scientific knowledge may have higher self-efficacy in challenging medical nonprofessionalism and the problematic health-care system by virtue of discourse management and emotional expression.

The disadvantageous spatial and temporal situations of GEs reflect the structural injustice in the redistribution of medical resources to women, who are the main bearers of human reproduction and who are far more likely to contract reproductive diseases (Borras, 2020). An insecure GE space, uncertain examination processes, and isolated social support intertwine to increase women's fear and shame, driving them to be either extremely compliant with or emotionally radical toward providers. Moreover, due to the high ratio of providers to patients, the former are usually pressed for time during gynecological consultations and examinations (Jiang & Hong, 2021). Women may enhance their approximation or interpretability to accommodate impatient providers to avoid being criticized as "ignorant" or "incompliant" patients. Sometimes, providers' urging may incur patients' radical emotional expressions despite the fact that providers should not be demonized because they are also victims of the problematic health-care system.

Applying situational analysis to the study of GEs offers a theoretical contribution to the CAT literature by extending its traditional focus on enhancing social relationships to fostering sociostructural changes. The three accommodative orientations outlined in the prototypical CAT, namely divergence, maintenance, and convergence (Dragojevic et al., 2016), imply that communicative accommodation strategies are only used to deal with interpersonal or intergroup relationships. However, informed by Fraser's (2007, 2009) tripartite intertwined components of justice as redistribution, recognition, and representation, we argue that in the context of GEs, what women need to cope with through communicative accommodation is far more than the representative injustice reflected in the undesirable discourses of providers. They should also challenge the structural injustice in the redistribution of medical resources that neglects women's fundamental demands for appropriate medical instruments, private GE space, and sufficient consultation time (Borras, 2020). Moreover, recognition injustice, in which unjust representation and redistribution are rooted, should also be addressed due to the problematic gender culture, which imposes moral connotations on gynecological symptoms and examinations.

The situational perspective of CAT also has practical implications for women's health promotion. Health campaigners should not only promote patient-provider accommodations but also emphasize the transformation of disadvantageous situations that restrain their accommodations. First, medical institutions may inform patients in advance about what necessary information they should provide frankly for gynecologists to select suitable medical instruments and adopt proper procedures. Second, health-care providers should use gender-sensitive and non-moralizing language during examinations and refrain from judging a patient's private conduct. Although this study focuses on patients' accommodation strategies, we

advocate mutual accommodations between patients and providers, which means providers should also be conscious of the influence of situations on patient-provider interactions. Third, there is a need to desexualize GEs through public education campaigns, with particular attention paid to clarifying misconceptions about GEs across generations and genders. Finally, institutional interventions are necessary for the amelioration of examination conditions to ensure patients' privacy protection and gynecologists' reasonable daily workloads. This is particularly challenging for China's public hospitals, which are undergoing commercialization due to insufficient government financial subsidies. While public hospitals have established channels for patients to file complaints, the performance evaluation of doctors is based more on patient volume than patient satisfaction (He & Qian, 2016).

This study has a few limitations. Western women's health movements advocate the production of embodied knowledge and self-care activities that promote women's health (Cole, 2021). This trend is echoed by Chinese urban middle-class women's collective narratives of GE experiences in virtual communities. By bringing together self-disclosure, knowledge sharing, and counter-discourse production, informational and emotional supports in online communities empower Chinese women with collective wisdom to challenge medical nonprofessionalism (Liu & Zou, 2023). Nonetheless, online expression thrives only among a small group of well-educated, technologically savvy young women. In acknowledging the efforts of female netizens and interviewees who were willing to discuss their GE experiences on social media or with researchers, it is important to note that their experiences may not necessarily reflect the communicative accommodation practices of those who prefer not to discuss GEs under any circumstances. Methods such as participatory observation could be adopted in future research to examine the accommodative strategies of those voiceless women.

Because this study does not sufficiently cover the voices of rural and underclass women as well as trans people, the structural and sociocultural barriers they confront in GEs should be the focus of future studies. Moreover, the voices of gynecologists should also be heard to overcome possible biases in female netizens' online narratives. Some radical expressions may not be encouraged because these accommodation practices may result in a vicious circle of patient-provider communication and because providers are also the victims of redistribution injustices. Therefore, mere advocacy for mutual patient-provider accommodations without calling for institutional intervention and sociocultural transformation may be fruitless.

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Appendix A

Table A1. Demographics of Interviewees.

Pseudonym	Age	Monthly Income (Chinese Yuan)	Education (Degree After High School)	Residence	Sexual Orientation	Marital Status
Chenchen	29	4,001–6,000	Bachelor's	Lower-tier city	Heterosexual	Married
Wenwen	26	6,001–8,000	Associate	Lower-tier city	Heterosexual	Married
Xiaoshi	26	2,001–4,000	Bachelor's	First-tier city	Heterosexual	Married
Xingxing	25	4,001–6,000	Bachelor's	Rural area	Heterosexual	Married
Yitian	25	6,001–8,000	Bachelor's	Lower-tier city	Heterosexual	Unmarried
Zero	29	6,001–8,000	Bachelor's	First-tier city	Heterosexual	Unmarried
Yingzi	22	4,001–6,000	Bachelor's	Lower-tier city	Heterosexual	Unmarried
Ziyue	22	2,001–4,000	Bachelor's	Lower-tier city	Heterosexual	Unmarried
Chenjing	25	6,001–8,000	Master's	First-tier city	Heterosexual	Married
Chunan	28	Above 10,000	Bachelor's	Lower-tier city	Heterosexual	Married
Huahua	45	2,001–4,000	Associate	Lower-tier city	Heterosexual	Married
Xiaoguo	22	2,001–4,000	Bachelor's	First-tier city	Heterosexual	Unmarried
Xiaoli	28	8,001–10,000	Master's	First-tier city	Heterosexual	Married
Andy	34	6,001–8,000	Master's	First-tier city	Heterosexual	Married