Gender and Health

AN INTERNATIONAL PERSPECTIVE

CAROLYN F. SARGENT

CAROLINE B. BRETTELL

GENDER AND HEALTH

An International Perspective

Edited by

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Contents

PART I The Language of Science and Medicine

PART II Gender, Health, and the Life Cycle

PART III Technology, Gender, and Health

PART IV Gender, Medical Ethics, and Personhood

PART V Gender, Healing, and the Social Production of Health

PART VI Gender and Health Policy

Introduction: Gender, Medicine, and Health

◧ Carolyn Sargent
Caroline Brettell

A growing anthropological literature addresses the articulation of gender roles and ideology with health status, the organization of health care, and health policy. This book presents an interdisciplinary focus on these issues viewed in cross-cultural perspective. We envision that the book will be relevant to advanced undergraduates, graduate students in the fields of women's studies, anthropology, and the health sciences, and to clinicians and others interested in public health policy.

Most of the contributors to the book are anthropologists engaged in cross-cultural research. Others include a literary theorist, a physician, and an ethicist, all of whom are primarily concerned with medical discourse, medical research, and the delivery of health care within North America. The premise of all these authors is that women and men seeking medical care should be conceptualized as gendered persons functioning in particular socioeconomic contexts. In addition, all the authors share the assumption that analysis of the production of health, as well as the provision of health care, must consider gender, ethnicity, and class as relevant factors (Lewin and Olesen 1985; Ginsburg and Rapp 1991). Those chapters drawing on cross-cultural research also shed light on multicultural issues pertaining to gender and health in the United States.

Following emergent lines of inquiry in medical anthropology, the chapters trace the linkages between gender roles, ideology, and 1) the language of science and medicine; 2) the cultural construction and medicalization of the life cycle; 3) the impact of new reproductive technologies on concepts of childbearing and parenting; 4) ethical dilemmas arising in the provision of medical care; 5) the social production of health; and 6) health policy.

THE LANGUAGE OF SCIENCE AND MEDICINE

Within anthropological thought, it is commonly accepted that language constructs and shapes our perceptions of reality. The language we speak influences the way that we react to the world and behave in it. It mediates our values and carries our ideological concerns. It is with this realization that a number of scholars engaged in a feminist reexamination of science have pointed to the gendered rhetoric and masculine metaphors that are characteristic of the language of science (Haraway 1981; Jacobus, Keller, and Shuttleworth 1990; Keller 1985; Merchant 1980). "Scientific enterprise, since at least the 16th century, has repeatedly been described and discussed in the language of sexuality and gender; science and medicine have been associated with sexual metaphors clearly designating nature as a woman to be unveiled, unclothed, and penetrated by masculine science" (Fee 1991:44–45). In these scientific texts, women, as body and emotion, are not only equated with nature, they are also defined as inferior to male as culture, mind, and reason. Hence, women's bodies are justifiably subject to masculine or scientific control (Berman 1989; Jacobus et. al 1990; Jordanova 1980; Russett 1989; Tuana 1989).

The major contribution of this feminist rethinking of the scientific enterprise in general, and of medical research in particular, has been to increase our awareness of the extent to which seemingly value-free descriptions of physiological processes are layered with cultural meaning. As Ruth Bleier has so aptly argued, scientists "do not recognize or acknowledge the degree to which their scientific writing itself participates in producing the reality they wish to present nor would scientists acknowledge the multiplicity of meanings of their texts" (1991:160). In Bleier's view, literary criticism has been brought to bear on scientific writing precisely to debunk the "myth of neutrality" of the scientific text.

It is within this perspective that both Emily Martin and Helena Michie frame their contributions to the analysis of the epistemology and language of biomedicine as it pertains to issues of gender. In her book *The Woman in the Body: A Cultural Analysis of Reproduction* (1987), Martin suggests that images of women's bodies in medical textbooks employ metaphors drawn from the language of capitalism and emphasize production, control, and hierarchy. Female reproductive processes are discussed in terms of efficiency and organizational function; menopause becomes a deficiency disorder rather than a life cycle phase (Kaufert and Lock 1992).

In her essay in this volume Martin focuses on language that represents menstruation as failed production. This negative and bemoanful rhetoric has no parallel in the descriptions of male spermatogenesis, a process that is described, Martin suggests, with intense enthusiasm. Martin illustrates her argument about the gendered discourse of conception with a detailed discussion of the textbook imagery of the egg and the sperm, the former a sleeping beauty patiently awaiting the arrival of her charming prince/hero who must endure a perilous journey to achieve his mission. The power of rhetoric is apparent in the fact that, even when new research has demonstrated a more aggressive role for the egg and a more mutually interactive process of conception, scientific writing adheres to the notion of the sperm as the active penetrator, albeit performing these actions more weakly than originally thought.

The new research on conception continues to employ the kind of masculine military metaphors—"kamikaze-sperm" or "vanguard" sperm that "seek and destroy"—that Berman (1989:227) has identified in other arenas of medical discourse—the "battle" or "war" against cancer or AIDS; the "magic bullet," for drugs; and the "mobilization of the troops" referring to white blood cell activity. At the close of her essay, Martin offers a more egalitarian set of metaphors drawing on cybernetic models, but cautions that these, too, may be influenced by their own set of cultural biases. In short, Martin's essay forces us to consider the powerful links between the metaphors we use to describe the body "scientifically" and the gender dynamics of our society. If such links exist they should be made explicit in medical education.

In the area of reproduction, masculinized metaphors of domination and success are not restricted to representations of conception. They are equally prevalent in the medical discourse of childbirth. Treichler (1990) draws on a passage from Margaret Atwood's *Surfacing* to engage this issue. Using a language that deliberately evokes the power and control with which natural processes are coopted by the culture of science, Atwood describes technicians, mechanics, butchers, and clumsy and sniggering students who practice on your body, and take the baby out "with a fork like a pickle out of a pickle jar." "Most medical discourse," Treichler comments, "focuses on the act of the fetus alone, and further represents it as an act in which the physician's presence is crucial. Indeed, in some obstetrics and gynecology textbooks the woman is erased altogether" (1990:122). The medical view of childbirth is of a "potentially diseased condition that routinely requires arts of medicine to overcome the processes of nature" (Treichler 1990:119).

In her contribution to this volume, Michie also explores the way in which "natural" childbirth has been appropriated by institutional medicine. However, her provocative perspective asks us to question whether the movement to regain control of childbirth should operate within the rhetorical idiom of "the natural." Focusing on the Cesarean as a mechanism by which birth is separated from the female body, Michie, like Martin, notes the ways in which language denies woman agency in reproduction. Language such as this implies that the cesarean mother, in some sense, is not a mother at all. Vaginal birth equals success; cesarean birth equals failure. The natural way and the cultural way are opposed and, in constructing this opposition, we set limits on what it means to be female.

Michie is drawing attention to women's own use of language and how, through it, they "buy in" to a particular conception of the world. In an article focusing on nineteenth-century medical discourse on mental illness in the United States, Theriot (1993) argues that women, as physicians and as patients, were "active participants in the process of medicalizing woman" (1993:2). Women patients' illness narratives indicate that in many cases they "came to physicians asking to be committed or to be given medication for behavior the patients themselves described as insane or nervous, including lack of interest in husband and family, violent feelings toward their children, and continual sadness or suicidal urges in spite of being well taken care of by husband or family" (Theriot 1993:17). It was not at all unusual for mothers to bring in daughters who were not conforming to behavioral norms. Whether as patient or family member, women commonly linked their symptoms of mental illness to physical problems with their reproductive organs.

The twentieth century counterpart to Theriot's analysis is to be found in the language with which patients speak of their health and ill-health and the differences that can be noted according to gender, class, ethnicity, and cultural context. For example, in a study of white middle-class, middle-aged men and women in the United States, Saltonstall (1993) demonstrates that men speak of themselves as having power over their bodies, while women generally do not use the language of ownership in talking about their bodies. Rather, they view their bodies as having a momentum of their own (1993:9). Concepts of self, which are shaped by gender ideology and embedded in the language people use to represent their state of well-being or ill-health, differ between men and women and must be considered in the process of treatment. Similarly, the decisions that men and women make "about what actions to take to be healthy [are] colored by ideas about appropriate masculine and feminine behavior" (1993:12).

Rapp's (1988) study of amniocentesis patients demonstrates class and ethnic differences that are pertinent to the discourse of genetic counseling. While middle-class and scientifically educated pregnant women respond to a question about why they are talking to the genetic counselor with a quick "we're planning to have amniocentesis," an Hispanic patient might claim it is because of "the fault of my age." Medical language, Rapp argues, must be "adjusted to the language and assumptions of the pregnant patient" (1988:146), something that is easier said than done when the communication involves translation. For example, there is no word in Haitian Creole for mongolism or Down's Syndrome.

Rapp concludes that "the language of biomedicine limits communication by locking counselors into a discourse in which technical language dominates, despite a sincere desire on their part to reach out to patients. Counselors are caught between the need to sound authoritative and the desire to glide on the patient's wavelength" (Rapp 1988:151).

The research on the reporting and experience of illness or disease by Rapp, Saltonstall, and others (see, for example, Celentano, Linet, and Stewart 1990; Macintyre 1993) illustrates that the perception of one's own body is culturally constituted. This perception is to some extent shaped by language, particularly by the fact of whether or not there is a vocabulary with which to talk about symptoms and disease.

This is perhaps most apparent in the literature dealing with the Premenstrual Syndrome. By talking about it, many women have been able to codify a set of symptoms. And yet, Zita (1989) has noted that the observation language used to describe PMS has the same negative effect as that used to describe menstruation and menopause. Very quickly the subjective meanings voiced by women are replaced by a language of objectivity. "All too quickly women's cyclicity is turned into adversity and reconstrued within the labeling process of 'symptom,' 'syndrome' and 'disease.' This linguistic tour de force is preconditioned by hidden research assumptions which presume the negativity of premenstrual changes, leave unclear the baseline against which deviation is measured, and expand the list of symptoms so that the syndrome seems to become a fact about women or women's nature" (Zita 1989:197). Clearly, much of the research on the epistemology and language of biomedicine is directed to drawing our attention to the bias of nature inherent in the understanding of women's bodies. To medicalize is to "biologize."

Similarly, Warshaw (1993) argues that subjective information is devalued in medical discourse, while objective information is considered to be that observed by the clinician. She shows that in domestic abuse cases, physicians focus on physical trauma, subordinating the meaning of the woman's symptoms. The ways in which medicine is taught and practiced validate and institutionalize socially sanctioned hierarchies of domination and control that constrain the possibility of effective communication regarding domestic abuse (1993:75). Her research suggests that the language of medicine structures interactions so that battered women are unable to voice their concerns. One emergency room chart illustrates how a woman's experience is translated by medical staff: the nurse's note remarks "Hit by a fist to Rt eye . . ." while the physician writes "blunt trauma face." The trauma, rather than the woman, becomes the focus of the medical record, thus obscuring the cause and meaning of the woman's symptoms (Warshaw 1993:75). Thus gender-based trauma, a serious public health problem facing women, and one that has only recently been acknowledged by the medical community, is biologized and reduced to isolated body symptoms manageable within the context of medicine.

GENDER, HEALTH, AND THE LIFE CYCLE

Gloria Steinem (1978) once asked what would happen if men could menstruate. "Men would brag about how long and how much. Boys would mark the onset of menses . . . with religious ritual and stag parties. Congress would fund a National Institute of Dysmenorrhea to help stamp out monthly discomforts. Sanitary supplies would be federally funded and free . . . Military men, right-wing politicians, and religious fundamentalists would cite menstruation as proof that only men could serve in the Army, . . . occupy political office, . . . be priests and ministers, . . . or rabbis." In this provocative thought exercise, Steinem draws attention to the way in which women's biological processes throughout the life cycle are constructed within a cultural context.

Following in Steinem's footsteps, numerous other feminists have repeatedly pointed to the social and cultural factors that shape the way in which women experience their bodies and the normal changes that are part of the life cycle (Flint 1982; Martin 1988; Sargent 1992). As Margaret Lock (1993:xx) has recently phrased it with respect to menopause, the "endocrinological changes associated with female midlife are universal facts on which culture weaves its tapestry." If culture shapes the experience of reproductive processes such as menstruation and menopause, so too does the medical profession. "Biomedical researchers," writes Carol Tavris (1992:133), "have taken a set of bodily changes that are normal to women over the menstrual cycle, packaged them into a 'Premenstrual Syndrome,' and sold them back to women as a disorder, a problem that needs treatment and attention."

Increasingly, women's reproductive processes have become pathologized and subject to the management and control of a medical community that can "create a market for its services by redefining certain events, behaviors, and problems as diseases" (Lock 1993:257). This is precisely what has happened to PMS, a phenomenon that did not exist as a medically defined category prior to the 1930s but that has become the focus of research, diagnosis, and therapy in recent years (Bell 1987). Although the recognition of PMS as "real" is gratifying to some women whose monthly discomfort had for years been tossed aside as "all in the head," more recently feminists have warned of the implications of the medicalization of PMS, which has occurred not only through the use of biomedical language to define symptoms, as noted above, but also through its categorization as a debilitating disease.

Both Martin (1987) and Johnson (1987) have noted the association between PMS and women's productivity. According to Martin, the emphasis on PMS grew with women's participation in the labor force—when this is seen as a threat to the social order, menstruation becomes a liability. Muller (1990) argues that PMS has been used as a mechanism of social control that excludes women from participation in sports, education, and public office. Most recently, the National Organization of Women has suggested that the creation of PMS as a depressive disorder in the new diagnostic manual of mental illness put out by the American Psychiatric Association can only lead to further discrimination against women in jobs, custody hearings, and insurance. "So far," NOW argues, "the psychiatric association hasn't paid equal attention to the effects of testosterone on male behavior and mental health" (Chase 1993:B1).

Others have noted the lucrative market for PMS cures in the form of books, tapes, seminars, drugs, and support groups established throughout the United States to help women deal with their debilitating disease. Finally, some researchers have simply chosen to highlight the serious flaws in the very definition of the syndrome with its vague, numerous, and frequently contradictory set of symptoms (Fausto-Sterling 1985).

If PMS is extensively medicalized in North American culture, so, too, is menopause. Physicians will tell a woman "that the continuation of sexual activity is normal, but that to lose the desire for sex is an expression of a disease state, the menopause, which is to be managed by hormone therapy. Just as obstetricians and pediatricians would define how women should feel and behave when becoming mothers, gynecologists and psychiatrists tell women what it is to be menopausal" (Kaufert and Lock 1992:203).

Several authors have observed that menopause, like PMS, is big business, whether it is surgically induced by means of a hysterectomy (Corea 1985) or treated through a regime of estrogen therapy. During 1990 over 200 articles dealt with hormone replacement and, in the same year, estrogen sales in the United States were estimated at $460 million (Lock 1993:xxxi). Tavris (1992:158) predicts that, despite the attempts of some writers to reconceptualize menopause as "post-menstrual freedom" or "post-menopausal zest," the aging baby-boom generation is simply too large to leave menopause undiagnosed and untreated. According to Lock (1993:345), research that shows no difficulties for the majority of women going through menopause is uninteresting to most physicians. This parallels the observation made by biologists such as Anne Fausto-Sterling (1985) and Ruth Bleier (1988) about sex-differences research—that those studies showing little or no difference between males and females in such phenomena as mental abilities or aggressivity are virtually ignored—buried in the back pages of the newspaper rather than featured on the front page.

In her contribution to this volume, Dona Davis explores the literature on premenstrual and menopausal syndromes within a cross-cultural framework. This framework allows her to challenge a number of commonly held assumptions: that biomedical constructions of premenstrual and menopausal syndromes are universal; that they are based on female reproductive and hormonal biology; and that they are manifest in negative elaborations of biological, psychosomatic, psychological, and psychosocial symptomatologies.

As Davis points out, in a range of cultures around the world menstruation and menopause are experienced differently and are by no means automatically defined as a source of stigma, depression, or emotional stress. While menstrual blood is frequently viewed as a source of pollution (Buckley and Gottlieb 1988; Delaney, Lupton, and Toth 1988), in some cultures it is associated with the creative spirituality of women (Buckley 1988; Gottlieb 1988; Powers 1980). In many cultures, menopause is not even emphasized biologically or socially. Maya women, for example, do not view it as a life crisis characterized by specific psychological or physiological problems. Nor do they expect hot flashes or make salient other kinds of aging complaints, such as osteoporosis, that are a common focus of attention in the Western industrialized world (Beyene 1989).

Lock (1993:32) observes that the Japanese have no single and unequivocal word that describes the hot flash, the core symptom that defines menopause in the West. Furthermore, although Japanese physicians read the same medical literature about menopause that is read by North American doctors, they are less likely to prescribe hormones. Instead, they recommend herbal teas (Kaufert and Lock 1992). In Japan, menopausal syndrome is considered by many to be a luxury disease, characteristic of women who are selfish and have too much time on their hands (Lock 1986). This social class dimension is important to consider in any cultural context. Recently, the Women's Health Network has noted that the bulk of research into menopause has used Caucasian middle-class women as subjects. "Extrapolations to all middle-aged women then occur, although we know there are, for example, very different rates of osteoporosis, heart disease, and breast cancer among Black and Asian women than among Caucasian women (Lock 1993:357).

If Western women seek treatment for the decline in sexuality that they have learned is associated with menopause, Bengali women, according to Vatuk (1992), simply believe that sexual activity is inappropriate for postmenopausal women. By contrast, among the Lusi of Papua New Guinea, "menopause brings no radical changes. A woman no longer produces menstrual blood, but a postreproductive woman is not perceived as being less feminine than a fertile one. As long as she is sexually active, she continues to produce odors and substances that are contaminating and dangerous to vulnerable people" (Counts 1992:71). While Lusi women experience little change in status after menopause, for !Kung San women of northwestern Botswana, menopause is a time of blossoming. This is associated with a greater respect for the elderly among the !Kung than exists in many Western societies (Lee 1992). The improvement of life after menopause is characteristic of a number of societies around the world (Brown 1982; Kerns 1992; Vatuk 1992). Indeed some studies show that menopausal women can assume high status roles, as healers (Kerns and Brown 1985) or as midwives (Sargent 1989).

From a somewhat different perspective, Boddy (1992:147) argues that to define middle age universally for women as the time of life that surrounds menopause is to "succumb . . . to a Western biological model." Drawing on her research among the Hofriyat of northern Sudan, Boddy suggests that middle age can be defined in social terms as the "deactivation of procreative ability. . . . Menopause is but one event among several that might usher [a woman] into midlife, a status variously intermediate between bridehood and senescence, heralded either by legal or by physical cessation of reproduction and bringing with it increased personal autonomy and enhanced opportunity to manipulate the social environment for her own ends. However, if midlife is not coincidental with menopause, the status might also bring a loss of prestige" (1992:147).

What much of the cross-cultural literature on menopause demonstrates is that there is a close association between the conceptualization of menopause and that of aging, especially the aging of women. These conceptualizations have important implications for health care and medical treatment. Certainly many women "buy in" to Hormone Replacement Therapy because their culture has told them that menopause is ovarian failure, estrogen deficiency, and the onset of aging. Less frequently are women told that removal of the ovaries or the uterus can increase the risk of breast cancer or heart disease or that HRT can increase the risk of uterine cancer. The problem, as Tavris (1992) notes, is that HRT is being recommended for ALL women. "It is as foolhardy to argue that no women should take estrogen as to argue that all women should. The point is that these hormones are not a panacea or a cure for aging" (1992:1650). And yet, the negativism associated with aging, especially for North American women, makes HRT, together with a range of other surgical or medical treatments, highly sought after.

Margaret Lock (1993:367) suggests that it is the "potent fear of aging, coupled with a quest for immortal youthfulness and sexual desire, [that seems] to be