**AT YOUR CERVIX MADAM:
A SOCIO-HISTORICAL STUDY OF CERVICAL CANCER FROM THE
LATE NINETEENTH CENTURY TO THE LATE TWENTIETH CENTURY**

by

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ABSTRACT

This thesis is a socio-historical study of cervical cancer from the late nineteenth century to the late twentieth century. It explores the ways in which discourses have constituted knowledge, social practices and subjectivities in relation to cervical cancer. It also explores the ways in which power has operated on the bodies of New Zealand women. In doing so it criticises orthodox histories of medicine, problematises the knowledge claims of medicine and argues for a sociological account of medical knowledge. In this thesis discourses on cervical cancer have been subjected to a feminist-Foucauldian analysis which reveals their historical specificity and their social location. The gendered bodies of women are placed at the centre of this analysis. This thesis challenges constructionist accounts of medicine which do not pay sufficient attention to the role of gender relations in the construction of bodies. This thesis also develops against feminist theorists a view of women as actively constituting their bodies by responding to and challenging medical discourses whilst at the same time being shaped by these discourses.

In this study, cervical cancer is subjected to a sociological analysis which problematises its existence as an unalloyed biological phenomenon. It is argued that women's bodies have been the contested sites for knowledge/power and that the cervix and its diseases have been constituted as variable medical artifacts throughout specific historical periods from the 1890s to the 1990s. The study also shows however, the ways in which women have been active participants in the disciplining of their bodies. In this thesis, the medical profession, state actors and feminists are shown to interact in an interweave of power. In doing so the socially negotiated status of medical knowledge of cervical cancer is revealed.

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CHAPTER ONE

Bodies, Gender, Knowledge and Power: A Sociology of Cervical Cancer.

1. Introduction

This thesis is advanced on a number of fronts. First it criticises orthodox histories of medicine and develops a sociological account of medical knowledge. Second it challenges constructionist accounts of medicine that overlook the role of gender relations in the construction of women's bodies. Third it develops against feminist theorists a view of women as active agents in constituting their bodies, responding to and challenging medical constructions whilst at the same time being shaped by professional discourses. This thesis is a socio-historical study of cervical cancer from the late nineteenth century to the late twentieth century. It is a study of the relationship between bodies, gender, knowledge and power. It explores the ways in which discourses have constituted knowledge, social practices and subjectivities in relation to cervical cancer and in particular, the ways in which power has operated in the regulation and surveillance of the bodies of New Zealand women. It is argued that changes in discourses surrounding cervical cancer are not the outcome of medical discoveries nor do they represent a more enlightened and humane approach to disease management but are the outcome of the complex relationship between knowledge and power. It is argued that discursive practices have constituted the cervix as a variable medical artefact which has been created and recreated throughout the twentieth century. The argument is advanced that the cervix has undergone changes in the way it has been known and understood by the medical profession, feminists and women themselves and that these changes are linked with the interplay of power relations amongst these groups in New Zealand society.

This study departs from traditional histories of human diseases which have failed to subject the knowledge claims of medicine to scrutiny. This has led to an acceptance of medical knowledge as having an epistemological purity which positions it outside the domain of sociological analysis. There are many historical accounts of medicine and disease. These accounts are usually based on the premise that diseases are discovered, cured or managed by medical science in a linear, progressive and frequently heroic manner. In De Kruif's (1936:7), *Microbe Hunters*, scientists such as Pasteur and Koch are likened to pioneer explorers who 'fought death and found truth'.

In *Devils, Drugs and Doctors*, Haggard (1946), develops a teleological approach to the history of medicine linking medical progress with advancement towards a better civilisation. Similarly, Shingleton and Orr (1987), posit a linear progression in their historical account of the diagnosis and treatment of cervical cancer.

This historiographic approach has also been applied to cervical cancer by Alexander Chang (1988). He has traced the medical history of cervical cancer from the late nineteenth century to 1941. In his account Chang documents changes in medical theory and practice in relation to cervical cancer. He suggests that the medical history of cervical cancer represents a progression from 'unscientific' to 'scientific' thought. Allegiance by members of the medical profession to what he suggests were unsubstantiated aetiological theories of cervical cancer are considered by Chang to be indicative of a lack of sophistication in medical knowledge at the time. He does not however attempt to account for the social origins of these discontinuities but instead links medical 'progress' with the insights of individual practitioners and fortuitous medical discoveries. As these accounts suggest, many histories of medicine fail to acknowledge that medicine is not distinct from the social and that medical knowledge is negotiated within a given historical and cultural context (Wright and Treacher, 1982).

The specific focus of this thesis is cervical cancer. This disease is subjected to a form of sociological analysis which problematises its existence as an unalloyed biological phenomenon. Medical discourses surrounding cervical cancer are examined and it is argued that far from representing objective and rational science, these discourses are social constructions of reality. In other words, the 'obvious' and 'taken for granted' are subjected to a scrutiny which reveals the social and political context of these knowledge claims.

This thesis follows an academic tradition already established by a number of sociologists who have examined the social construction of illness and health care experiences. In a study by Karl Figlio (1978), the chronic illness of *chlorosis* in mid-nineteenth century Britain is shown to have been constructed in support of the ideological foundations of capitalism and patriarchy with medicine 'naturalizing' social relations. In an account of the disease *black lung*, Smith (1989), documents changing

medical constructions of this illness and links these with social and economic factors which are, in historical accounts of medicine ordinarily considered to be extrinsic to science. In a comparative study of medical concepts of *multiple sclerosis*, Nicolson and McLaughlin (1988), identify the political dimensions in the production of competing medical knowledges which propose contested theories of causation. Despite employing differing theoretical standpoints on social constructionism, these studies have in common a theoretical position which problematises bodies and their diseases and constitutes them as variable and uncertain artifacts linked to the exercising of power.

The sociological studies cited, represent a departure from earlier research into medicine which tended to link historical change with notions of individual genius, tenacity, courage and insight. In many historical accounts, diseases are treated as immutable biological realities which are linked with the triumphs of science. This has left the medical historian, as Wright and Treacher (1982) suggest, with essentially only one possible form of analysis, which is, to trace the social circumstances and aetiology of diseases in a manner akin to the epidemiological approach. This approach has been predicated on a view that the social remains distinct from medicine. Medical ideas are therefore, represented as unproblematically progressive (or conversely archaic and unenlightened) without the need for further explanation or analysis.

Calls for a greater level of integration between medicine, history and sociology have been gaining momentum in recent years (White, 1991). This has occurred alongside a recognition that medical facts cannot be taken as given and must be located within a social, political and cultural context. However, whilst expanding the context of medicine to include non-biological factors, early sociological accounts followed the historical tradition of accepting unquestioningly not only the truth of scientific explanations but also medical values, philosophies and needs (Turner, 1987:1). More recent sociological accounts of medicine have followed Turner's suggestion, that a sociology of medicine should primarily be a study in sociology rather than a study of medicine.

In response to the questioning of traditional approaches to the sociology of health and

illness, social constructionism has emerged as an increasingly critical sociology. This questioning began with the epistemological scepticism characterised by the debates of the 1970s. These debates were initiated by Szasz (1970), Illich (1975) and others who argued that medicine was not objective and politically neutral. Sociologists such as Zola (1977) and Friedson (1970) began to locate medicine within a socio-political context and questioned its technical neutrality. Zola also signalled his concerns about the pervasive nature of medical power and the tendency of medicine to adjudicate on matters of everyday life. Whilst these debates questioned the values which informed medicine, they did not challenge the epistemological basis of the science which gave medical knowledge its unassailable authority over the human body.

Many historical and sociological accounts of medicine have also neglected to acknowledge the role of gender relations in modern societies. Whilst early constructionist accounts demonstrated the links between medicine and class¹, they failed to incorporate the specific impact that medicine has had on women. Feminist approaches to a sociology of health and illness have countered this lack of focus on gender by exposing the ways in which women's bodies and experiences have been medicalised by coming under the surveillance and control of medicine. The feminist critique of medicine and science has also challenged the privileged position of medical epistemologies as value free and objective (White, 1991). These feminist critiques of medicine have been described by Lupton (1994a:131) as having gone to the heart of issues concerning the body. The experience of illness, the changeable nature of disease categories and their relationship to social control have been central to feminist analysis. Importantly also, feminist theorists have highlighted the political dimensions in relations between medical professionals and their patients.

Feminist scholarship continues to reflect a diversity of theoretical positions and debates in relation to the nature of gendered embodiment. However, acknowledgement of the central position of the body has provided the basis for a feminist sociology which has led to a reassessment of the history of medicine. A study of the metaphorical significance of women's bodies in nineteenth century

¹ See Figlio (1982), 'How Does Illness Mediate Social Relations? Workmen's Compensation and Medico-Legal Practices, 1890-1940', cited Wright and Treacher, (1982).

medical texts by Emily Martin (1987) is an example of such a reassessment. Ehrenreich and English (1976; 1990) have also added a political critique to the history of medicine by examining constructions of women's bodies as a product of gender relations. Similarly, Duden (1993), has traced the ways in which medicine has appropriated women's experiences of pregnancy and in doing so goes beyond traditional histories of birth and pregnancy which ignore the political and gendered nature of the practice of medicine. Recent feminist writings have increasingly focused on the ways in which culture constructs women's bodies so that they are understood as a biological given. Bordo (1988:91) in her study of *anorexia nervosa* shows the ways in which culture imposes its design on the female body and Sawicki (1991) from a Foucauldian perspective gives an account of the ways in which new reproductive technologies create bodies and subjects.

An acknowledgment that bodies are not passive, anatomical entities has provided the basis for a number of sociologists from a range of theoretical positions other than feminism to develop sociological approaches which recognise the body as a variable and socially constituted phenomenon (Nettleton, 1995). Increasingly sociologists such as Shilling (1993), have argued that the body should form a central focus for sociological inquiry. They do so within a critique of traditional approaches to social phenomena which view embodiment as a biological given outside the domain of sociology. Turner (1984) has also argued for the centrality of bodies in sociological analysis. He suggests that social systems must resolve a number of issues which are directly related to embodiment. These issues are, the reproduction of populations, the restraint of desire, the regulation of populations in space and the representation of the exterior of the body. These 'embodied' approaches have contributed much to recognising the social importance of the body and in developing a theoretical sociology which recognises the importance of the body to social theory. In many instances however, gender is a missing element in these epistemological frameworks.

This study places the gendered bodies of women at the centre of its inquiry. The thesis is defined in a case study of the development of medical understandings of cervical cancer in New Zealand. Cervical cancer is a phenomenon which appears to have all the hallmarks of scientificity. It is diagnosed by 'objective' tests and treated on clinically defined grounds. The thesis shows, on the contrary that cervical cancer

is shaped by the society it is located in, and that medical theories of it are also the product of changing balances within and external to the medical profession. Women for their part, through an analysis of popular literature are shown to shape their own understandings and to incorporate aspects of the medical model at the same time as it defines them in its own terms.

2. Knowledge of Bodies: Power, Discourses and Gender

Central to this thesis are the concepts of knowledge, power, body and gender. The theoretical insights of Foucault inform the sociological analysis of cervical cancer. This is particularly so in relation to Foucault's argument about power as a strategic relation which operates at the level of technologies and practices of individuals and institutions. However, what is lacking from Foucault's insightful analysis is an in depth consideration of the impact of gender in the relationship between power and knowledge and the disciplining of bodies. This thesis suggests that the gendered nature of women's bodies has been a defining factor in the way in which power has been exercised on their bodies with the cervix as a focus for power. However, that is not to say that power has been exercised in a unified or centrally orchestrated way. To the contrary it has been exercised within a context of shifting power relations which the medical profession, feminists and women themselves have been part of. It has been marked by political alliances, resistance and the paradoxes of unintended consequences with the cervix variably being treated as a social, political, moral and biological artefact. The cervix is currently a 'registrable organ' in New Zealand and is centrally codified by the state. The thesis shows the way in which the body is produced through the interactive relations of the state, the medical profession, women and feminist health activists. It rejects any essentialist account of either the body, or of patriarchy, or of professional power and identifies instead the social dynamics of their interactions.

This thesis also draws on the sociology of scientific knowledge. The work of Ludwik Fleck (1979), contributes to the analysis presented here. Fleck's account of the ways in which scientific facts emerge from the collective and highly political negotiations of competing groups contributes an important dimension to this thesis. Fleck, however, like Foucault failed to acknowledge gender as central to the process of the negotiation of knowledge claims within medicine. The importance of both Foucault

and Fleck's theoretical positions to a sociology of health and illness is to remind us that science and medicine are essentially social enterprises. It is argued in this thesis however, on the basis of insights from a feminist epistemological framework, that whilst all bodies have been subjected to increasingly extensive forms of surveillance and discipline, it is the bodies of women which have been subjected to the most pervasive and intense forms of monitoring and control. Drawing on Wright Mill's (1970), insight into the relationship between private and public issues, it is argued here that the private bodily experiences of women have increasingly become public issues and that medicine has developed as the primary institutional monitor and controller of women's bodies. In acknowledging the centrality of gender, this thesis draws upon feminist theoretical insights which place women's bodies and the fact of their gender as the starting point of sociological analysis.

Following from this, the thesis does not attempt to make judgements about any ultimate 'truth' of the cervix. Instead it eschews such an approach. It does not attempt to be prescriptive about how cervical cancer should be managed in the best interests of New Zealand women. What it aims to do is to trace the transformation of discursive practices around cervical cancer and to show the interconnecting network of power relations which have constituted cervical cancer and the identity of New Zealand women. The ultimate aim of this thesis is to demonstrate the social location of the medical fact of cervical cancer.

The thesis is structured chronologically in order to clearly demonstrate the continuities and discontinuities which have occurred in relation to constructions of cervical cancer. Structuring the thesis in this way also shows that historical or chronological ordering does not equate with medical 'progress'. Instead it clearly problematises the concept of medical 'progress'.

In summary, this thesis applies a synthesis of theoretical positions to the medical artefact of cervical cancer. It is argued that the cervix has not had a fixed, and immutable status as a medical and anatomical object. On the contrary, what has been seen, known and understood about the cervix, particularly in relation to cervical cancer, has continued to change from the late nineteenth century and throughout the twentieth century. That is not to say that medical vision, perception and knowledge

have become refined in a linear progression towards epistemological perfection but rather that the 'facts' of cervical cancer have been socially constructed in response to an ever changing medical gaze. It is shown in this thesis that medical constructions of cervical cancer have been contingent upon their social, cultural and historical contexts.

3. Structure of the Thesis.

Chapter One. Introduction. This chapter introduces the scope of the thesis and places it within a context of the sociology of health and illness and the sociology of the body. It is argued that whilst this is a socio-historical study, it differs from traditional histories of medicine by problematising medical knowledge. The thesis is positioned within an epistemological framework which acknowledges the theoretical contributions of feminism, Foucault and Fleck.

Chapter Two examines in more detail the theoretical and methodological issues which inform the thesis. It discusses the centrality of discourse to the study and the rationale for applying a synthesis of theoretical positions to a sociological understanding of cervical cancer. The methodology of the study is outlined and issues of rigour in qualitative studies are discussed.

Chapter Three begins the study by examining medical discourses in relation to cancer in general and cervical cancer in particular in the late nineteenth and early years of the twentieth century. It sets these discourses within a context of increasing medicalisation of motherhood in New Zealand. It is argued in this chapter that the construction of cervical cancer as a disease associated with maternity is indicative of an increasingly medically interventionist approach to motherhood. The medical problematising of women's bodies in relation to the cervix and in relation to motherhood is set within a context of public anxieties regarding the role of women and the fitness of populations. It is also linked with the professional strategies employed by the medical profession during this historical period to guard against boundary encroachment by other health practitioners.

Chapter Four demonstrates the social shaping that developed out of these turn of the century understandings and links these with changes which occurred in medical

constructions of cervical cancer during the period after the First World War. In this chapter it is argued that these constructions, increasingly took on a broader political character. Instead of being a disease of mothers, cervical cancer was transformed by the medical profession and the New Zealand Department of Health into a disease of all women. Under the auspices of an increasingly 'new public health' approach to the surveillance of populations, all adult New Zealand women were identified as being at risk of cervical cancer. Women were increasingly encouraged to co-operate with medicine in the interests of preventing illness in their families and themselves. In this context, many general practitioners viewed cervical screening as an important means of achieving their professional aspiration of being more extensively involved in preventive medicine. It is argued that the basis for these aspirations was contested by an academic elite who disputed the need for population-based screening. These members of the profession were in a politically advantageous position to exert influence over the education of medical practitioners as well as over the health policies of the state.

Chapter Five links post-war constructions of women's bodies with medical discourses in the 1960s and 70s which began to reflect anxieties about the sexually active bodies of New Zealand women. During this era cervical cancer was increasingly constructed as a moral problem and then in the later years of the twentieth century reconstructed as a 'technical' problem. It is argued in this chapter that these changes in perception of cervical cancer are not reflective of a more humanitarian and liberal approach to the practice of medicine, nor do they represent progress in the biological understanding of the disease. It is argued instead that they represent a change in the techniques of medical surveillance of women's bodies. As concepts of moral risk were replaced by concepts of technical risk, cervical cancer became increasingly constructed as a morally neutral, technical problem. This change led to an intensification of monitoring of women's bodies in the interests of locating the technically flawed cervix.

Chapter Six further develops an analysis of the moral-technical construction of cervical cancer by identifying the ways in which 'truths' about women's bodies were negotiated within the medical profession during the 1960s to the 1980s. It is argued that professional uncertainties about cervical cancer, increasingly threatened to

become public anxieties. This chapter examines the occupational strategies employed by the medical profession to deal with those members of the profession described as medical 'dissenters' who refused to accept orthodox constructions of cervical cancer. This chapter demonstrates that the medical profession is not a unitary body. It is argued that critiques which locate power in a unified medical profession as a form of professional dominance often fail to acknowledge this.

Chapter Seven follows the previous chapter by positioning feminists discourses alongside medical discourses in relation to constructions of the cervix and cervical cancer. Feminists are shown to have played an important part in challenging medical power and autonomy. It is argued that the cervix and cervical cancer have played an important symbolic role in the feminist political platform. It is also argued however, that not only has medicine co-opted feminist views of women's bodies, but that in turn, feminists have co-opted medical constructions of women's embodiment. It is suggested that in doing so, feminists have contributed to the medicalisation of women's bodies.

Chapter Eight examines the news media and the self-help literature in relation to media constructions of cervical cancer. This chapter argues that the media has largely perpetuated dominant metaphors of femininity, linking cervical cancer with lifestyle and individual responsibility. The role of the popular media in New Zealand in the medicalisation of women's bodies is also examined. This represents a departure from a direct focus on cervical cancer towards an analysis of discourses which, it is argued have contributed to 'body-consciousness' in New Zealand women. It is suggested that such discourses reflect a preoccupation with the representational body and that in recent years the internal as well as external body have formed part of this preoccupation. It is also argued that popular media constructions of women's embodiment have been strongly linked with prescriptions which have focused on women's social relationships with men.

It is suggested also, that the popular media has been an important platform for the distribution of a 'domesticated' form of medical epistemology. The popular media has constructed women as *loco medicus* and in doing so has encouraged them to construct themselves as the monitors of their own and their family's risky bodies. It

is contended that the media has played an important part in contributing to women's acceptance of increasingly pervasive forms of medical monitoring of their bodies. It is argued also however that in recent years the media has both encouraged and reflected an increasingly disaffected view of medicine and has contributed to the 'secularisation' or 'de-scientisation' of medicine.

Chapter Nine examines the medical technologies which have developed in relation to cervical cancer. This chapter describes ways in which many of the technological innovations which have occurred in relation to cervical cancer have been contested for political and socio-cultural reasons. As a result, the social location of technology is revealed. It is argued that these technologies have not so much, been 'discovered', but have instead, been 'negotiated' within a context of socio-political struggles which have led to their acceptance, rejection or modification.

Chapter Ten examines the Inquiry which occurred in 1987, into allegations concerning the treatment of cervical cancer at National Women's Hospital and other related matters. It is argued that the cervix and cervical cancer became the focus for wide public exposure to the relatively private issues of professional power and gender in medical practice in New Zealand. It is suggested that the Inquiry exposed for public scrutiny, the professional strategies which the medical profession has historically employed to retain medical control of women's bodies. It is argued also that the Inquiry contributed initially to the erosion of the sovereignty and autonomy of the medical profession, but served to enhance the professional aspirations of the nursing profession.

Chapter Eleven examines the establishment of a national cervical screening programme in New Zealand and traces the roles of the Department of Health, the medical profession and feminists in its implementation. It is argued that the establishment of this programme raised a number of contradictions for these three main protagonists. Members of the medical profession (many of whom were general practitioners) found themselves in opposition to a medical initiative which involved general practitioners in a greater level of preventive care. This was despite historical constructions of preventive care and specifically cervical screening as being beneficial to the professional aspirations of general practitioners. The Department

of Health found itself in a position of having to implement a centralised health strategy at a time when devolution and cost containment were health policy imperatives. Feminists were highly active in supporting the national screening programme without challenging aspects of it which could have been viewed from a feminist platform as compromising women's power and control over their own bodies.

Chapter Twelve further develops themes from Chapter Eleven, by drawing out the discourses which informed health promotion strategies employed to 'market' the cervical screening programme. It is argued that these strategies have had an inherently political focus in ensuring that women co-operated with the ideals of the national screening concept. It is suggested that constructions of the national screening programme as a 'safety net' against death, and of cervical cancer as a sexually neutral disease, were employed to win not only the bodies of New Zealand women but their minds also. It is argued that in the past, health promotion activities attempted to construct compliant subjects. In recent years health promotion strategies have attempted to construct women as committed and empowered subjects. This chapter analyses promotional discourses in relation to cervical cancer screening and demonstrates a number of paradoxes which point to the socially located nature of the promotion of the national screening initiative.

Chapter Thirteen. Conclusion. This section concludes the work by drawing together the threads of the analysis to restate the major premise of this thesis, which is that cervical cancer is an artefact of social relations and is not a socially neutral biological fact. The practices and technologies which have grown around constructions of cervical cancer have arisen out of social negotiations and socio-political struggles. It is argued in conclusion that knowledge, power, bodies and gender are inextricably linked and that a socio-historical study of cervical cancer provides important insights into these links.

In summary, Chapter One has set out the objectives of this thesis and the major theoretical debates which inform it. These objectives are, to examine the transformation of discursive practices which have constituted the bodies of New Zealand women from the 1890s to the 1990s and to link these with constructions of cervical cancer. Secondly to subject these transformations to an analysis which

draws out the power relations inherent in these discursive practices and situate these within a network of relations between the medical profession, feminists, bureaucrats and women. Thirdly to subject the claims of medical science to a level of scrutiny which challenges their epistemological purity with cervical cancer as a 'case in particular'. This thesis uses the insights of Foucault, Fleck and feminist theory to achieve its objectives.

CHAPTER TWO

Taking the Body Seriously: A Theoretical and Methodological Basis for a Sociology of Cervical Cancer.

1. Introduction

The purpose of this chapter is to lay out the theoretical issues which are relevant to a sociological study of cervical cancer. There are three epistemological issues which are central to this thesis. Firstly, the body is taken seriously as an object of sociological inquiry. Whilst the body is acknowledged as being a physical entity it is also acknowledged as being socially produced and problematic. Secondly, the gendered nature of bodies is central to the sociological analysis presented in this thesis. It is argued that an understanding of the gendered structuring of the body is essential to an understanding of the ways in which power operates on women's bodies. Thirdly, the knowledge claims of medicine are challenged as being highly political, problematic phenomena. Medical epistemologies in this thesis are treated as negotiated and socially produced. Cervical cancer is treated as a socially constructed medical category constituted by discourses but informed by the gendered nature of the bodies in which it is perceived to reside.

Part Two of this chapter addresses the issue of the body in sociology and argues for the positioning of embodiment at the centre of sociological analysis. **Part Three** examines the body as a site for the operation of power. Foucault's analysis of the interrelationship between power, knowledge and discourse is discussed in relation to the regulating and disciplining of bodies. **Part Four** discusses social constructionism as a theoretical tool for subjecting the knowledge claims of medicine to analysis. The theoretical insights of Fleck are acknowledged as forming a basis for the understanding of the socially negotiated status of medical knowledge. **Part Five** examines the gendered nature of bodies and argues for a theoretical convergence between the insights of Foucault and feminist theory. It is argued that this convergence provides a useful analytical position for understanding the intersecting networks of gender, power and bodies. **Part Six** outlines the methodological approach to the study. **Part Seven** summarises the major issues related to the theoretical and methodological issues which inform the research.

2. Problematising the Body

Concerns have been raised in recent years that sociology has not paid sufficient attention to the embodied nature of the human actor (Shilling, 1993; Turner, 1987; Lupton, 1994d; Armstrong, 1987; Zola, 1991). Social analysis has instead focused on social structures and subjective responses to bodily experiences such as illness (Turner, 1984). There has been a tendency amongst sociologists to regard the body as a 'natural', individual possession outside the domain of sociological analysis. From this perspective the body remains an unproblematic physical entity. By avoiding subjecting the body to analysis, sociologists have attempted to avoid falling into the abyss of biological determinism of positivist science (Lupton, 1994d). However what has occurred instead, is an analysis of social structure in which the body is implied but remains hidden and unexamined in the assumption that it is an unequivocal given. As a result, embodiment has remained largely untheorized and taken for granted. This has led Shilling (1993:20) to suggest that the body has been both present as well as absent in sociology. Its presence he suggests, is more than evident in studies of social mobility, racism or social inequalities in health in which there is implicit concern with the movement, location and care of bodies. These examples provide a basis for arguing that bodies are of importance to sociological analysis and that they should form the foreground rather than the background of inquiry. Shilling has in fact suggested a positioning of the body at the centre of the sociological imagination rather than at its periphery.

Since the mid-1980s, the body has become more central to sociology. It is now possible to talk of a 'sociology of the body' (Nettleton, 1995). A number of social changes have contributed to a greater level of interest in the body. One of the most important of these is feminism which views women's bodies as central to a political analysis of a gender structured society. Feminist discourses have politicised embodiment and in doing so have drawn attention to the ways in which bodies are the products of social beliefs and practices. Importantly feminist scholarship has also problematised taken for granted categories such as 'male' and 'female' and in doing so has raised questions as to the ontological bases of sexual difference (Shilling, 1993). Postmodernism, the cult of the consumer body, changes in medical technology which have impacted on human reproduction and the greying of populations are social influences which have brought the body to the attention of

sociologists (Turner, 1991; Nettleton, 1995). These social issues and the release of translations of the work of Michel Foucault have influenced the direction of sociological inquiry towards human subjectivity and the ways in which discourses constitute bodies (Lupton, 1994d).

3. Postmodern Bodies and the Ubiquity of Power

One of the major challenges to a naturalistic perspective of the human body has been postmodernism. Postmodernism calls into question a number of assumptions of modernism. As a theoretical perspective, it problematises truth or reality and posits the co-existence of multiple realities. It also problematises single, unified narratives of history emphasising instead discontinuity, particularity and relativism. In postmodernism, traditional ideas of legitimacy are viewed as being tainted by transcendentalism, foundationalism, myths or metanarratives (Wolin 1988:179). Postmodernism also calls into question hierarchies of knowledge which privilege some knowledges over others and in doing so breaks down the traditional boundaries between expert and lay knowledge (Nettleton, 1995). From a postmodern perspective, the body no longer has an unequivocal reality but instead can be viewed as a product of certain kinds of knowledge which are in flux. The body has a physical reality but is inscribed by discourses and is therefore a social artefact as well.

The work of Foucault have been especially significant in theorising the body as a socially inscribed phenomenon. Wolin (1988:179) describes Foucault as almost singlehandedly moving the discussion of power from its modern state-centred understanding to a postmodern or decentred version. For Foucault the body has been the site for disciplinary power since the eighteenth century. He identified the state as regulating, punishing and disciplining bodies through its institutions and state machinery such as medicine, education and the law. The behaviours of bodies have increasingly been observed, codified and regulated. Foucault described disciplinary power as a reconfiguration of sovereign power which was centralised within the king. Power was enacted in the name of the king on the bodies of the king's subject. Disciplinary power joined sovereign power as an extensive and pervasive form of power in which, as Armstrong (1994:20) suggests, 'the supreme body did not belong to the king but to everyone'. Through disciplinary power, bodies have been rendered productive and politically and economically useful (Lupton, 1994d:23) or have been

contained, immobilised or marginalised.

Surveillance is central to disciplinary power as a means of controlling bodies. Foucault used Bentham's design for an ideal prison, the *panopticon* as a metaphor for disciplinary power. Whilst sovereign power may have incarcerated bodies or physically brutalized them, the new power sought to control bodies by appraising them and transforming them:

In the prison and the hospital, bodies were observed and analysed with the purpose of effecting a passive and malleable body, but at the same time establishing those selfsame bodies as individual and discrete (Armstrong, 1994:21).

Foucault stressed that disciplinary power, is not a possession nor is it a force exerted over bodies. It is instead a means by which 'docile' bodies are produced. This can be expressed, in terms of bodies being ruled by ruling themselves (O'Neill, 1985). Turner (1982a:24) has argued that Foucault's account of the relationship between scientific knowledge and the control of the body is located within a tradition of social philosophy which has recognised the problem of human passions as being critical to social order.

Foucault identified three main instruments of disciplinary power. *Hierarchical observation* is a form of disciplinary power which is epitomized by the *panopticon* or the school classroom. In these contexts, 'officials' were able to observe all individuals. Power lay in the ability to observe the totality of individuals but it also lay in the potential for a form of surveillance which would result in those being observed monitoring themselves. This continuous form of power has been recognised for its potential for the collecting and collation of information. Not only does this highlight the links between technology, knowledge and power but it also highlights the web of power relations where knowledge gained from some populations becomes the normative expectation for others. The second instrument of power Foucault described is *normalising judgement*, in which the attributes and actions of individuals are assessed measured and classified in relation to those of others. The normative nature of this form of disciplinary power ensures that like the individuals being

observed in a panoptic sense, individuals who are subjected to normalising judgements become judges of themselves. The third instrument of power combines *normalising judgement* with *hierarchical observation* as in the *examination*. In this form of power, of which the medical examination is an exemplar, bodies are examined, codified and compared with normative bodies constructed from epidemiological data or other 'authoritative' discourses (Nettleton, 1995:113-114). Because disciplinary power relies upon attending to the norm, there has been a proliferation of 'normative judges'. These include for example, teachers, psychologists, psychiatrists, social workers and doctors, who have the role of differentiating, quantifying and ranking individuals. Hewitt (1991:229) suggests that normalisation has become one of the great instruments of disciplinary power. This power operates by being able to catalogue, predict and prescribe. In the postmodern world these objectives are frequently linked with a therapeutic model in which punishment has yielded to therapy (O'Neill, 1985:139).

The centrality of discourse in the operation of power is emphasised by O'Neill (1985:136). He suggests that the proliferation of institutionalised discourses on sex through legal, medical, pedagogic and media forums, raises important analytical questions as to why such a proliferation has occurred. One explanation is to interpret this phenomenon as evidence of a liberalisation of legal and moral constraints on sex. O'Neill however, raises further questions which he considers need to be posed from an analytical framework:

We then need to ask in whose interest this expansion occurs and by what specific bodily techniques the various discursive strategies are implemented. These questions lead us to the first striking observation. We have increased our control over sex by expanding and releasing a flood of sexualised discourse. The same is true of life. The expansion of scientific discourse about life, genetics, health, subsistence, home conditions, learning abilities, and the like serves to bring life within the orbit of state power and industrialization (O'Neill, 1985:136).

Noting Foucault's point about the constitutive nature of power, Hewitt (1991:250) describes the shift from sovereign power to disciplinary power in relation to the sexual body as the deployment of sexuality for enhancement rather than repression.

Foucault's notion of discursive formation provides an understanding of the process by which objects of knowledge, for example bodies, are defined in such a way that encourages and facilitates converging practices. Through the transmission of discourses, the doctor, the psychiatrist, the criminologist, the educator and hospital administrator increasingly become part of a discursive web which unites thought and practice in a seamless and circular network of power. Sociology has also been identified as one of the disciplines which has emerged as a manifestation of this discursive web (Turner, 1982a). In this network of power, practices provide the conditions for discourse and discourses feedback into practice to produce a discursive formation of institutions and actions which produce claims to authoritative knowledge and legitimates normative professional practice (Wolin, 1988:184). In *Discipline and Punish*, Foucault (1979) highlighted the importance of examinations, timetables, taxonomies, registers and systems of classification as vehicles for the detailed surveillance and disciplining of bodies. These technologies have resulted in active and unrestrained bodies being made 'docile' (Turner, 1982b; Armstrong, 1994). These technologies are often subtle, numerous and pleasurable and as Ostrander (1987:180) suggests reflect a 'chorus' of micropowers. He identifies the state as a point in the strategy of power that affects bodies but emphasises that it is not the primary organ of power because as Foucault argued, such an organ does not exist. Rather, beneath and surrounding the state as Ostrander argues operates innumerable techniques for ranking and controlling bodies. Foucault acknowledged however that where power is exercised, so too is resistance to that power. The capillary nature of a multiplicity of forms of power are paralleled by a multiplicity of forms of resistance (Smart, 1985).

4. Constructing Bodies

The work of Foucault has contributed significantly to a social constructionist approach to sociological inquiry. The social constructionist perspective is indicative of an increasingly critical approach to medical sociology and a sociology of knowledge which has emerged in recent years. Prior to the emergence of this more critical form of inquiry, sociology did not concern itself with the knowledge claims of medicine. White (1991:69) describes a 'great advances, great hospitals and great men' account of social change as typifying sociological accounts of medicine prior to the application of the social constructionist perspective. Subjecting the knowledge claims of

medicine to sociological inquiry avoids granting medical knowledge an epistemologically privileged position thus avoiding the tendency identified by White to treat diseases and bodies as natural objects and to view the social history of disease as being confined to epidemiological accounts.

The constructionist approach is characterised primarily by its problematising of reality. This is most visible in social constructionist accounts of the body and of disease. One of the most important claims of social constructionism is that there is no inherent truth which can provide a single valid account of embodiment. In particular, the social constructionist view opposes the traditional scientific viewpoint that the body can be adequately analysed as a biological phenomenon (Shilling, 1993). Secondly, a social constructionist perspective eschews the notion prevalent in traditional histories of the body which subscribe to the progressive unfolding of ever increasing valid and enlightened knowledge. Social constructionism moves away from the privileging of some accounts of the body over others. In doing so it raises questions about the authority of some discourses and the marginalisation of others (Nettleton, 1995). The most significant contribution which social constructionism makes theoretically is its challenging of the universal acceptance of the concrete reality of the body. Other systems of medicine which have constituted an anatomically different body such as the humoral system or acupuncture illustrate the potential for challenging the hegemony of the taken-for-granted nature of the anatomy of the body (Armstrong, 1994).

Social constructionist accounts of disease point to its social location by highlighting that diseases are products of social reasoning and social practices (White, 1991; Nettleton, 1995). This approach is described by Mishler (1981) as being the antithesis of the biomedical model which defines disease in terms of universal and culture-free criteria. The problematising of medical categories of disease results in their transformation from what Wright and Treacher (1982) suggest are 'out there' phenomena to social meanings which have been generated by the practices and interests of diverse groups. Social constructionism results then, in social factors being given a non-traditional emphasis:

No longer is there to be any question of restricting the use of social factors to

explaining the occasions when internal factors seem insufficient. In the new approach everything in medicine however seemingly technical and recondite is regarded as social...(Wright and Treacher, 1982:10).

The social creation of the 'facts' of medical science has resulted in social constructionist accounts of the ways in which authoritative medical knowledge is socially negotiated rather than emerging out of objective and empirical scientific processes. Ludwik Fleck (1979) has provided insights into the practices which result in what he termed the 'genesis' of scientific facts. In his discussion of the history of syphilis, Fleck showed that the development of the Wassermann serological test was the outcome of thought-styles which incorporated ideas from earlier thought collectives. Non-scientific ideas about the disease such as 'bad blood' were incorporated by bacteriologists and immunologists into a new thought-style about syphilis. Fleck historicises medical knowledge by suggesting that there is no linear progression in the development of knowledge. He also locates the development of scientific knowledge firmly in the social. Scientific facts are therefore not imposed by a naturally factual world, but are the products of thought collectives from which facts emerge (White, 1991).

Criticisms of the social constructionist approach have raised a number of issues. One of the most significant of these is the suggestion that social constructionism represents a critical form of inquiry but does not address the social location or relativism of its own knowledge claims (Bury, 1986). In reply to Bury's criticism of social constructionism, Nicolson and McLaughlin (1987) argue that relativism is part of sociological inquiry which, whilst needing to be acknowledged does not under circumstances of good scholarship, invalidate the worth of the knowledge produced. Kehoe (1992;1994) argues that sociological knowledge like medical knowledge is an historically specific product of a particular social milieu. She believes that it is important for sociologists to acknowledge the socially produced nature of their own knowledge claims.

5. Gendered Bodies.

Feminist theoretical perspectives have acknowledged the gendered nature of knowledge about women in a range of areas from popular culture to law and

medicine. However, prior to the mid 1980s, feminist theory tended not to recognise the historical embeddedness of its own assumptions nor to challenge the basis of scientific or medical knowledge claims. Feminist empiricism has not for example challenged the fundamental nature of scientific knowledge but has instead directed its critique towards influencing science to produce knowledge which reflects women's needs, experiences and reality. Feminist standpoint theories have gone some way towards a critique of scientific and medical knowledge by attempting to challenge the privileged authority of this knowledge. In doing so, they claim a position for women's knowledge in opposition to masculinist accounts and a recognition of a women's perspective in scientific and medical discourses (Bunkle, 1992). In recent years a number of scholars have seen the potential of a postmodern, feminist social critique for overcoming a tendency towards essentialism and ahistoricity in feminist theory (Nicholson, 1990). This has not however, led to a unitary feminist stance but has resulted in a growing body of literature assessing the potential of the work of Foucault and others for informing a feminist critique.

In recent years feminist appropriations of Foucault have been described as resulting in 'pathbreaking and provocative social and cultural criticism' (Sawicki, 1991:95). The adoption of Foucauldian theoretical perspectives as an adjunctive critique to feminist thought has been in response to a disenchantment with feminist liberalism which has been criticised for its appeal to essentialism and its tendency to adopt a rational teleology in its explanation of social phenomena. The search for *the* authentic female voice is an example of this (Martin, 1982). The ahistoricity of much of feminist critique has been criticised also for not taking into account the social construction of gender relations and embodiment (Sawicki, 1988). Marxism has also been criticised by postmodern feminists for its location of power in the centralized source of class which it is claimed ignores the ubiquity of power in the body, in knowledge, in the family and in technology and therefore discounts the potential for resistance at the everyday level of social relations (Sawicki, 1991).

Areas of compatibility and incompatibility between Foucauldian and feminist analysis have been identified by a number of commentators including Diamond and Quinby (1988) and Martin (1982). In both theoretical perspectives, the body is central as a site of power and domination and is considered to be constituted through routine

normative social practices of bodily management such as dieting and dress. Foucault emphasised however that whilst normalising activities constitute the subjectivity of the individual as well as subjection through the 'docile body', subjectivity extends beyond the immediate social practices which sustain the domination. Foucault eschewed the concept of power flowing from a centralised source as in the dominance of the ruling class in Marxism or patriarchy in feminism and emphasised the local and intimate operation of power at the microlevels of society. However, both feminist theorists and Foucault have acknowledged the centrality of discourse in sustaining hegemonic dominance of different groups over each other. This is particularly so in relation to medical, psychiatric and educational institutions since the nineteenth century. They have also recognised the potential for resistance in marginalised discourses in the appropriation of difference as a focus for resistance, as a form of 'reverse discourse'. Both Foucault and feminist theorists have criticised the ways in which the masculine elite in the name of Western humanism has proclaimed universal truths in relation to freedom and the 'natural' human being. Sawicki (1991:49) suggests also that Foucault and feminists share a perception of sexuality as an important arena for political struggle. Foucault has critiqued humanistic discourse and identified ways in which it has created the shape and form of the expression of modern sexuality. Sex, it is argued by Foucault, has become a focus for freedom, personal transformation and self understanding and a point of intervention into the lives of the individual and the family by professional 'experts'. The discourses and practices of these 'experts' have created dichotomies of well/ill and normal/deviant which feminists suggest have resulted in the creation of invidious categories in relation to women including 'nymphomania' and 'frigidity'. Feminists have recognised that the authoritative status of 'experts' has provided the basis for social control as disciplining practices have become legitimated on medical or moral grounds.

Both Foucault and feminist theorists have argued that the personal is political and have acknowledged that social domination occurs within the personal sphere (Sawicki, 1991:49). Foucault identified power as operating at the microlevels of society where personal experience constitutes the construction and maintenance of self. Postmodern feminists have also recognised the utility provided by an understanding of the way in which power interacts with identity, adding this to a long-

held appreciation of the connection between the personal and political:

Foucault's own labors in explicating how disciplinary power moulds through localized mechanisms of enticement, regulation, surveillance and classification are invaluable for demonstrating how specific historical and cultural practices constitute distinct forms of selfhood (Diamond and Quinby, 1988:xi).

Both Foucault and feminist theorists have been critical of biological determinism which in the case of some feminist perspectives, attributes a naturalness to male dominance and female subordination. Feminism has been criticised for implying a biological basis for feminine moral superiority or constructing a 'true self' as innately androgynous (Diamond and Quinby, 1988:xii). Most importantly both Foucault and feminists have been critical of the ways in which the growth of specific forms of knowledge such as medicine, sociology and psychology have been presented in standard histories. Although commonly perceived as evidence of social progress and the generalised outcome of the Enlightenment, feminists sympathetic to the Foucauldian position have suggested that these forms of knowledge have been instrumental in repressing alternative forms of knowledge and practices. From this perspective, knowledge about women has been viewed as not the disinterested outcome of the search for truth and reason. Instead it is viewed as being intimately linked with power with 'truth' emerging as an outcome of the knowledge/power relationship articulated by Foucault.

There are also 'obvious convergences' between Foucault's work and feminism in terms of focus and methodology as Bartky (1988:10-11) suggests. These convergences demonstrate that the intervention of experts and the construction of knowledge about the female body has been essentially the outcome of knowledge/power. For some feminist theorists, the history of the medicalisation of women's procreative bodies indicates a centrally orchestrated control of women's bodies. Postmodern feminists in the Foucauldian tradition see the control of women's bodies as a result of a shifting network of discourses and practices which have been dominated but not centrally controlled by the medical profession. Some feminists have been challenged by postmodern feminist theorists for their tendency to construct 'truths' about the 'naturalness' of women's experiences such as childbirth

and breast feeding. This lack of reflexivity in feminist theory has been criticised for leading to essentialism and universalism (Nicholson, 1990).

Some important areas of divergence between feminist and Foucauldian theory have been noted by feminist scholars. Foucault has been criticised for not exploring the contradiction that power does not subjugate everyone equally. Specifically he is criticised for not exploring in depth, the ways in which masculine authority is linked with discourse and reason in its domination of women. Feminist theorists point to the ways in which women's bodies are often a focal point for masculinist power. Foucault is also criticised for not analysing the specific nature of medicalisation in which the disciplined bodies of women have become more docile than the bodies of men. In these criticisms of Foucault, feminists add that they do not regard power as being held monolithically by men but that power within kinship systems in particular is vested in men as individuals and as a group (Sawicki, 1991:49; Diamond and Quinby, 1988:xiv). Foucault has also been criticised for not identifying the physical and sexual abuse of women as being indicative of women's bodies being the locus of masculinist power (Bartky, 1988; Diamond and Quinby, 1988). He has in concert with other male philosophers been denounced as not being able to acknowledge the masculinity and phallocentrism of his own position (Grosz, 1987). Even feminist commentators sympathetic to Foucault's position have pointed to omissions in his theoretical position such as:

... gaps in Foucauldian genealogies that purport to detail disciplinary power's operations in the deployment of sexuality while overlooking women's writings on issues like pregnancy, abortion, birth control, anorexia, bulimia, cosmetic surgery, and treatment of breast and uterine cancer (Diamond and Quinby, 1988:xv).

Whilst it can be acknowledged that there are convergences between Foucauldian and feminist thinking in relation to a critique of Western humanism, feminism extends beyond Foucault's analysis of the working of power/knowledge by introducing a specific analysis of gender. Furthermore feminist thinking questions what are considered to be the illusory assumptions of an autonomous and universal 'self'. Foucault, feminists argue, identifies the 'self' as white and male and point to the invisibility of women in his account of the construction of this 'self'. Likewise Foucault

is criticised for not acknowledging the relationship between masculinist power and language. Of particular importance to feminist theorists is the consequence of gender structured discourse and reason which has resulted in invidious distinctions between male rationality and female sensing, emotion and imagination. Foucault has also been criticised for not analysing the gender structure of micropolitics. It is suggested that he has ignored women's contribution and resistance in local struggles because these acts have been 'micropolitical' and often relate to the sustenance of others (Diamond and Quinby, 1988:xv-xvi).

On the other hand, both liberal and radical feminist theorists have been criticised, (notwithstanding the theoretical convergences identified above) for adhering to a traditional model of power as essentially repressive and located in centralised, male dominated institutions. In response to these issues, writers such as Bordo (1989:15) have suggested that there is a need for developing an effective political discourse of the female body which reflects both the 'insidious and often paradoxical pathways of modern social control' and the fact that power does not flow from a centralised source. In doing so, she argues for a reconstruction of the feminist body-discourse of the late 1960s and early 1970s which adopted political categories of the 'oppressors' and 'oppressed'. An appropriation of Foucault she suggests would highlight power as an interconnecting network and a constitutive force rather than something that men held monopoly control over.

One of the major insights attributed to Foucault is his articulation of power as operating at a micropolitical level in society as part of the daily practices of social relations. This challenges the traditional notion that power is repressive and centralised. For Foucault, 'power circulates everywhere, even through the tiniest capillaries of the social body' (Fraser, 1989:26). Feminist theorists recognise that from a Foucauldian perspective, 'the history of women's procreative bodies is a history of multiple centres of power and multiple interventions, with no discrete or unified origin' (Sawicki, 1991:80). They argue also that women's bodies have been subjected to a greater level of normalising discipline than male bodies. As Bordo (1988) points out however, this has historically occurred within a context of the dominated, willingly or unwillingly, giving momentum to such oppression. Women for example have colluded with medicalisation on the basis of their own needs and

motivations which in turn arise from what Kohler-Biassema (1989:100-107) a

Feminist theorists sympathetic to the Foucauldian notion of power as ubiquitous suggest that the disciplining of bodies is not solely linked with institutions such as the prison, the hospital or clinic. They argue that many women who seek personal transformation in the form of an idealized feminine body discover the imperatives to do so are often diffuse and difficult to identify. The absence of easily identifiable disciplinarians and obvious public sanctions disguise the nature of subordination and domination. This perpetuates 'a lie in which all concur' with make-up being seen as 'artful play' and 'one's first pair of high-heeled shoes as an innocent part of growing up, not the modern equivalent of foot-binding' (Bartky, 1988:75-76). Such practices are even more politically significant in that they take place within a pervasive cultural context which constructs women's bodies as deficient. For Bartky, this accounts for the often compulsive and ritualistic character of the technologies of disciplined femininity. One of the most powerful constructions of women's embodiment, has for instance been in relation to excess such as voraciousness, fatness and wantonness or in relation to excessive emotionality. In this context women's bodies are constructed as deficient in their ability to control themselves and in need of regulation by both women themselves and by men (Bordo, 1988:108). Medicine has been identified by feminists as contributing to these pervasive constructions. Women have, however, collaborated with these constructions which has resulted in the proliferation of normalising discourses and strategies of dress, deportment, diet and medical care. These rituals of practice have in many instances held primacy over belief:

Foucault constantly reminds us of the primacy of practice over belief. Not chiefly through "ideology", but through the organisation and regulation of the time, space, and movements of our daily lives, our bodies are trained, shaped and impressed with the stamp of prevailing historical forms of selfhood, desire, masculinity and femininity (Bordo, 1989:14).

As feminists have highlighted, women are increasingly devoting time and energy to the management and surveillance of their bodies in pursuit of an ever varying ideal of femininity. Such practices conform to Foucault's conception of the production of docile bodies in a disciplined society. At the level of daily life these practices leave

women less time to be socially oriented and engaged. They also serve to confirm a body-conscious subjectivity in which the pursuit of an unattainable ideal of bodily perfection is normalised as part of being female. The outcome of this process is one in which women constantly monitor and discipline themselves:

Viewed historically, the discipline and normalisation of the female body - perhaps the only gender oppression that exercises itself, although to different degrees and in different forms, across age, race, class and sexual orientation has to be acknowledged as an amazingly durable and flexible strategy of social control (Bordo, 1989:14).

Whilst many feminist theorists have adopted a postmodern view of the body, this has not led to a unitary theoretical position. There are those theorists who from a constructionist perspective view the body as an inscribed text and others who continue to adhere to an essentialist theoretical position (Lupton, 1994d). However, an appropriation of Foucault by feminism has already lead to some fruitful challenges to epistemologies both inside and outside of feminism. In this thesis, the postmodern convergence of feminist and Foucauldian theory forms the basis for a sociology of cervical cancer in which the knowledge claims of both medicine and feminists are subjected to analysis. In this thesis the gendered bodies of women are regarded as a primary site at which contesting discourses compete for meaning. This is identified as being particularly so in relation to medicine.

6. Methodological Issues

The objectives of this thesis are firstly to examine the transformation of discursive practices which have constituted the bodies of New Zealand women from the 1890s to 1990s and to link these with constructions of cervical cancer. Secondly, to subject these transformations to an analysis which draws out the political implications of discursive practices surrounding the body and situate these within the network of relations which has existed between the medical profession, the state, feminists, bureaucrats and women. The third aim is to subject the knowledge claims of medical science in relation to cervical cancer to a level of scrutiny which challenges their epistemological 'purity'.

This is a qualitative study which is based on a Foucauldian approach in its methodology. This approach, known as the genealogical method, discards many of the traditional precepts on which socio-historical studies are based (Hewitt, 1991). Whilst maintaining a clear chronological focus, this study does not attempt to establish clear links of cause and effect, nor does it search for signs of uninterrupted continuity in the way in which cervical cancer has been constituted. It does however attempt to examine the ways in which cervical cancer has become a medical artefact and a socio-medical issue in specific historical moments. Foucault's method is described by Silverman (1985) as helping to overcome the micro/macro polarity in sociology. By this he means the tendency of sociologists to treat social phenomena as purely structural or voluntaristic without providing sufficient explanatory linking between the two. Central to this study is a critical analysis of the discourses which have constituted cervical cancer and practices around it and which link structure and agency. The purpose of this analysis is to uncover the political elements of discourses which constitute certain types of bodies and to demonstrate the ways in which other discourses are marginalised. It has not been enough however to view cervical cancer in isolation from its specific historical period. Other discourses have also been examined to locate cervical cancer within a sociocultural milieu.

i. Methodological assumptions

The following methodological assumptions underlie this study:

Power

This study is primarily concerned with locating the ways in which power has operated on the bodies of women. Power in this study is assumed to be ubiquitous. It is not regarded as a possession which is intentionally held or relinquished. Nor is it assumed to be located or exercised by a central source. Power is assumed to circulate, to be mobile and to operate within the minutiae of individual practices. This study is not concerned with ideologies as overarching and covert interests which assumes, as Nettleton (1992) suggests, that 'real' meaning will be revealed once underlying interests are laid bare. Although Foucault acknowledged that ideologies are found in social institutions he eschewed the implication of an opposition between 'ideology' and 'truth'. Instead he emphasised practices rather than ideologies. Power in this thesis is considered to be related to practices and is also assumed to be both

repressive and productive. It is not considered to be the property of one group or class. Silverman (1985:89), describes this view as giving primacy to the idea of power as a web or network. An assumption of this study, is that individuals may exercise power whilst at the same time being governed by it. It is assumed therefore that power has both intentional and unintentional consequences.

Gender

This study considers gender to be a central variable in the exercising of power. It does not assume that gender is a stable entity, on the contrary, gender is assumed to be in flux. Unlike many Foucauldian studies, gender is considered to be an important element in the way in which power is exercised on bodies and in the way in which power constitutes subjectivities. It does not however take a biologically essentialist position, nor does it locate power in a central source such as patriarchy. Instead it views women's gendered bodies as being socially inscribed and a site at which contesting discourses compete for meaning and power.

Stability of the Body

In this study the body is not assumed to be a stable entity. Instead the body is problematised and shown to be constituted by ever changing discourses. This thesis does not however take the position that the body has no stable biological reality. What is not stable however is the way the body is perceived, experienced, talked about, acted upon and regulated.

Inevitability and Continuity

This study does not assume an inevitability or an unfolding of predictable events.² It does not view medical practices in relation to the cervix as being an inevitable and necessary outcome of need, discovery or humanitarian and liberal enlightenment. Instead it problematises knowledge and practice in relation to the cervix. It examines discourses which have constituted the cervix as a medical object and in doing so challenges notions of a linear and progressive character to these events. This study therefore assumes discontinuity rather than teleology.

² See Nettleton (1992), *Power, Pain and Dentistry* where similar assumptions form the basis of a Foucauldian study of dentistry.

ii. Methodological approach

The thesis employs a critical discourse analysis to trace the discursive formations which have occurred in relation to cervical cancer. As Lupton (1994a:30) suggests, discourse analysis is an interpretive methodology which privileges the role of language in shaping realities and in constituting subjectivities. Whilst medical, feminist and popular media have provided sources of data for the study, this is a thesis in medical sociology and not in media studies. The focus of the thesis has therefore not been directed towards an in depth analysis of the interrelationship between the media and society.

iii. Sources of data

Whilst historians make a distinction between primary and secondary sources, Armstrong (1990:1225) suggests that for the genealogical method such a distinction is unnecessary. Under this method, all sources are primary as long as the 'secondary' sources are treated as 'primary' for their own authorship. This means that instead of projecting backwards from the present, concepts and discourses are taken seriously within their temporal and cultural specificity. This attempt to understand presently constituted knowledge has been termed a 'history of the present' (Hewitt, 1991).

This study has conducted a critical discourse analysis of a number of sources of literature. These include medical periodicals and texts from 1890 until 1996. These include the *New Zealand Medical Journal*, *Kai Tiaki*, *New Zealand Nursing Journal*, *Public Health* and *Health*. A number of overseas medical journals were also sampled for the purposes of comparative analysis. This enabled a positioning of New Zealand medical discourses alongside those from overseas in order to establish the local character of narratives on cervical cancer and to situate these within an international context. Of particular value as a source of data in medical and health related journals was 'correspondence to the editor'. Particular attention was paid to this form of discourse because letters by individuals frequently departed from the scientific structure of the more formal papers, to reveal personal opinions, attitudes and emotional responses. Advertisements for medications or other medical items which frequently appeared in these journals were also examined. An attempt was made to access all of the above listed journals. This was not entirely achieved

because of incomplete collections but it was however substantially achieved.

A number of medical texts were also reviewed to provide insights into academic, instructional discourses in relation to cervical cancer. The authoritative, pedagogic approach of these texts contrasted with the more 'issues for debate' quality of discourses in medical periodicals. Reports from the New Zealand Medical Association were also a useful source of data in relation to medical discourses.

Because of the broad scope of this thesis, journals and texts were located using a number of key categories. These included, early attitudes to cancer in general; discourses on constructions and practices in relation to cervical cancer; professional boundary issues in relation to both the medical profession and nurses; issues of intra-professional conflict; discourses on women's bodies in general; discussions of changes and use of technology in medicine and of preventive medicine and screening.

Feminist literature has also substantially informed this study. The periodical *Broadsheet*, a New Zealand feminist magazine which has been in existence since the early 1970s was an important source of data. A majority of all the issues of *Broadsheet* which have been published were analysed. As the main public voice of the New Zealand feminist movement *Broadsheet* provided useful data on feminist discourses in relation to health issues, the medical profession, cervical cancer and feminist constructions of femininity. Other sources of data on feminist discourses included reports from *Women's Studies Conferences*, women's health conferences and government reports.

Examples of the popular literature were also sampled. The *New Zealand Woman's Weekly* was selected as a useful source of data to trace the discourses of popular culture in relation to women's bodies and their medicalisation. Specifically the link between medical and popular representations of women's bodies was explored in relation to Foucault's concept of discursive formation and networks of power. This magazine was chosen because it has been in circulation longer than any other women's magazine in New Zealand. It began in the early 1930s and continues to this day. Early copies of the magazine are scarce and it was not possible to locate all

issues from the 1930s and 40s. However all issues available at the National Library were analysed from the 1950s until the 1970s when every second copy was sampled. Specifically the magazines were analysed for discourses on women's bodies; the interface between women and medicine; constructions of femininity particularly in relation to private and public roles; technologies of the self and specific references to cervical cancer. Also sampled were the *Listener*, *Dominion*, *Evening Post* and *New Zealand Herald*. The *Listener*, a media and current affairs magazine and newspapers were not systematically reviewed but were sampled purposefully when a reference to an article on cervical cancer or some other relevant issue was cited elsewhere.

The self-help literature from the 1970s until the 1990s has also provided a useful source of data for this study. This body of literature has been opportunistically rather than systematically reviewed. However it has been an important basis for exploring the interface between the privately and clinically regulated body.

The use of media sources has both methodological advantages and disadvantages. These sources of data provide a wealth of information on historical attitudes and opinions. They represent an historical record which may be absent in other forms of data such as formal reports and records. However it must be noted that such sources capture only a limited 'slice' of the discourses occurring at a specific historical period. This is one of the major limitations of the use of these sources of data. There is also the issue, particularly in relation to the popular media as to whether the media shapes the medical profession and women, or conversely whether the profession and women shape the media.³

iv. Reliability and Validity of the Study

The rigour of a qualitative study cannot be measured in the same way as that of a quantitative study. It should be noted that quantitative studies are not themselves devoid of error or bias even though statistical tests are used. A set of strategies to achieve rigour in qualitative studies has been outlined by Sandelowski (1986, cited Walton, 1994:285). The first of these is credibility. Credibility is attained when the

³ See Chapter Eight for a further discussion of this issue.

descriptions and interpretations of the study are recognisable by study participants and/or by those who have an extensive knowledge of the body of knowledge being referred to and in particular its theoretical underpinnings. Secondly the 'fittingness' of a study is met when the findings are considered to correspond appropriately with the data presented. 'Auditability' is achieved when the researcher's pattern of analysis is discernable to those who wish to replicate or expand on the study. It would be expected that using the same sources of data and the same theoretical base, that subsequent analysis would reach similar conclusions. Another important test of qualitative research is whether the findings are worth paying attention to and appear to be authentic and convincing (Walton, 1994). Gergen (1985:14) acknowledges in relation to social constructionist studies, that these accounts cannot be warranted empirically:

If properly executed such accounts can enable one to escape the confines of the taken for granted. However, the success of such accounts depends primarily on the analyst's capacity to invite, compel, stimulate, or delight the audience, and not on criteria of veracity.

This study has attempted to ensure rigour in a number of ways. First by analysing relevant literature in a detailed and extensive manner. Second in 'showing the face of the data' by quoting extensively throughout the study and third by clarifying the theoretical assumptions which underpin the research. This is not to say that a study which uses discourse analysis as its methodology is without potential for methodological flaws. As with any other study there is a danger of the researcher selecting and analysing data on the basis of 'selective perception' where only that data which conforms with the major thesis of the study informs its outcomes. An awareness of the potential for this to occur has been carefully considered in the gathering and analysis of the data presented in this thesis. Nevertheless 'selective perception', which is frequently an unconscious process, is always a possibility. Lupton (1994a) points to the need for a high level of self-consciousness and reflexivity in carrying out discourse analysis as well as an awareness of the socially produced nature of knowledge. Lastly, it is important for all researchers, as Kehoe (1992:70) suggests, to acknowledge that methodology can never be seen as the application of a set of neutral techniques. The researcher brings with them their

constructions of reality shaped by the discourses of their own social, cultural and political context.

7. Conclusion

This chapter has laid out the theoretical and methodological underpinnings of this thesis. In doing so it has aimed to achieve a degree of transparency in relation to the major issues and practices which inform the study. Central to this thesis are the interrelated concepts of power, knowledge, gender and bodies. The work of Foucault, Fleck and feminist theorists form the theoretical basis from which cervical cancer is examined. The study combines the insights of a sociology of the body, sociology of knowledge and a sociology of health and illness as well as feminist theory from which to view its subject. It is a socio-historical study which attempts to uncover the social location of cervical cancer and trace the operation of power on women's bodies through a specific historical period. Discourses as documented in a range of medical and feminist literature are analysed. This is however a study in medical sociology and not in media studies. This chapter has also outlined the major methodological assumptions which underpin the thesis. The main sources of data have also been identified in combination with a discussion of issues of rigour in qualitative studies.

CHAPTER THREE

Cervical Cancer, Professional Power and Constructions of Motherhood in Late Nineteenth and Early Twentieth Century New Zealand.

1. Introduction

This chapter begins the analysis of medical discourses and the construction of objects of medical interest. It traces the ways in which the cervix came to be understood and known as an organ vulnerable to disease and to position this knowledge within the socio-historical context of late nineteenth and early twentieth century New Zealand. What the medical profession began to 'know' about the cervix was intimately connected with what the profession 'understood' about women as mothers. During this historical period issues of professional power and gender converged in a number of significant ways. Medical practitioners as a burgeoning professional group began to employ strategies to gain control of the medical work they shared with other health workers. The bodies of New Zealand women became one of the main contested sites for these professional struggles, particularly in relation to reproduction. Pregnancy, birth and mothering were all areas which were increasingly identified at the turn of the century as requiring medical intervention and expertise.

Medical discourses which had constructed women as inherently pathological in the nineteenth century laid the grounds for an intensification of surveillance of women in the twentieth century. Not only did this surveillance serve the cause of a range of social anxieties about the position of women in society, but it also served as a platform for medical practitioners to further their claims to professional status. An understanding of the ways in which the medical profession viewed and responded to cervical cancer provides valuable insights into the network of power which surrounded women at the turn of the century. Cervical cancer was not purely a manifestation of a pathological body, it was a socially located medical artefact which came to be understood by the profession as an exemplar of the dangers of motherhood. Cervical cancer along with the many other indicators of women's propensity for illness, formed part of the scientific knowledge claims which underpinned medicine's increasing professional power. As Foucault (1979) showed however, power is productive as well as repressive, with those on whom power is

exercised frequently colluding with this process. From a Foucauldian perspective, the history of women's bodies is a history of multiple origins, innovations and centres of power marked by resistance. From a Foucauldian feminist theoretical position, medical discourses which construct women's bodies are not assumed *a priori* to be the product of a patriarchal desire to control or usurp women's bodies. Whilst these desires may exist, they are not viewed as directing the historical process (Sawicki, 1991:80). As this chapter shows, women in their quest for emancipation, constructed some medical initiatives as progressive and beneficial and thereby contributed to increased levels of medical surveillance and management of their bodies.

The cervix has historically been an organ of strategic interest to medicine. Situated between the uterus and the vagina, the cervix acts as a 'gateway' which facilitates or impedes access to the uterus. Medical interest in the cervix has focused on the ability of medicine to regulate this access. As a conduit for the passing of menstrual blood, sperm, a miscarried foetus, or a baby, the cervix is associated with conception, life and death. It therefore has a symbolic significance to medicine which its size and appearance belies. As a result, medical discourses have constructed this organ in terms of its functionality in relation to reproduction and its utility to medicine. The cervix is for example, described in medical terms as being 'incompetent' when it does not retain a foetus or 'untried' in women who have not borne children. Its degree of 'dilation' is measured by medicine during the birthing process (Thomas, 1992:64).

It is argued in this chapter that whilst the cervix has historically been constructed as a medical artefact, it is also a social artefact. Constructions of the cervix and cervical cancer which emerged as dominant discourses at the turn of the century did not arise out of disinterested scientific discovery but emerged out of the socio-political struggles of a gendered society.

Part Two of this chapter begins the analysis of the socio-historical context of cervical cancer at the turn of the century by examining the social and professional position of doctors in New Zealand. The aspirations and professionalising strategies of the medical profession are outlined. **Part Three** shows the links between social anxieties, professional aspirations and the constructions of women's bodies at the turn of the century. Nineteenth century perceptions of the inherent pathology of

women's bodies formed the basis for unprecedented medical interest in women's bodies at this time. **Part Four** focuses on birth and traces the networks of power which included the state, factions of the medical profession and women themselves which resulted in birth becoming a medical event by the 1930s. **Part Five** shows the ways in which cancer was constructed as a paradox which required professional unity and public assistance to understand and eliminate. The growing authority of germ theory is discussed within a context of the growing authority of scientific discourses in general. **Part Six** draws the threads of the chapter together by presenting an analysis of the construction of cervical cancer in the late nineteenth century and early twentieth century. This section shows that what the medical profession knew and understood about cervical cancer was a product of social understandings about women's bodies as being inherently pathological. These understandings are also linked to what the medical profession understood about birth as a dangerous event requiring medical intervention. These understandings are situated within a context of professional power. **Part Seven** concludes by restating the major themes of the chapter which link bodies, power, knowledge and gender in an understanding of cervical cancer at the turn of the century.

2. Gaining Control of Medical Work. The Professionalising Strategies of the Medical Profession.

In 1860, doctors were one of a number of groups who administered to the health needs of New Zealanders. There was at this time, no system of national licensing, nor was there a professional organisation which represented the interests of medicine. By the early twentieth century however, the health professions were clearly defined by specialised education, licensing legislation and their relationship to each other (Belgrave, 1991). The medical profession faced a number of challenges at the turn of the century. In Britain, doctors enjoyed the patronage of families who from generation to generation not only shared their secrets with their medical attendants but remained loyal to them throughout their lives. The social status that this form of occupational relationship accorded the medical practitioner was missed by doctors practising in the new colony. Doctors found themselves geographically isolated from one another and apart from any other impact that this may have had at a personal level, at a professional level it impeded a unified approach to improving professional status (Thomas, 1900). Those doctors who were

urbanised were often retained by clubs or lodges and were paid to attend members and supply them with medicines. Lodges frequently exploited this situation by threatening that an increase in medical fees would lead to another doctor being retained. With little unity in the profession, such threats were liable to be carried out. Public hospitals existed for the poor and many doctors gave their services free. In an environment of little regulation, public hospitals also treated out-patients which deprived doctors of business. These factors further threatened professional unity (Wright St Clair, 1987:19-20). The disunity which resulted from these circumstances was regarded by some members of the profession as preventing doctors from reaching their 'righteous position' in New Zealand society (Thomas, 1900:3).

Another professional issue which concerned doctors was competition from other practitioners. 'Quacks', 'consulting' and 'prescribing' chemists, were identified as taking patients away from doctors:

It is undoubted that in both the educated and uneducated members of the community there is a strong bias in the direction of quackery and irregular practice (Thomas, 1900:9).

Attempts were made by doctors to discredit other health practitioners by suggesting that they were dangerous to the public. Mackie Begg (1909:42) for instance, suggested that gonorrhoea, was being treated in a 'light hearted manner' by chemists and unqualified people, and that this would result in patients dying or being incarcerated in mental institutions.

When the New Zealand Medical Association met in 1886 for the first time the matters which preoccupied it can best be described as 'boundary issues'. These related to concerns about the encroachment of other health workers on what medical practitioners regarded as their occupational territory. The concerns which these issues generated are indicative of a profession which had not yet been successful in controlling the allocation and conditions of medical work. As Turner (1987:135), suggests professionalisation relies on groups being able to employ strategies to guard against encroachment by other occupational groups or the lay public. New Zealand doctors had not been successfully in fully implementing these strategies

which Willis (1983), identifies as, limiting the type of medical work which other occupational groups can engage in, subordinating other groups of medical workers by controlling their work and excluding others from carrying out what is regarded as medical work.

Whilst encroachment by other health workers was a concern for doctors, there were other professional issues which preoccupied the profession. These included state interference, unjust insurance schemes in relation to sickness and invalidity and 'impositions' from Friendly Societies. Of these, state interference was to remain a major concern of the profession throughout the twentieth century. The profession was urged in the medical literature to unite and 'set its house in order' to deal with the threats that these and other issues represented (*NZMJ*, 1913:548).

One of the first formal professionalising strategies doctors attempted to implement was registration of doctors. This was finally achieved in 1914 when an Act of Parliament reinstated the Medical Board for the first time since 1869. Attempts by doctors to gain registration were met however, by a degree of scepticism by the public and politicians. The Medical Association's motives were questioned particularly in relation to attempts to limit the work of other practitioners such as faith healers and herbalists who were widely consulted by the public at this time. There were also concerns that altruism and pecuniary interests may compete in the matter of medical fees (Wright St Clair, 1987:59-60).

Increasingly doctors began to control medical work in New Zealand. They did this not through coercion but by controlling the technology of scientific medicine. This ensured that other occupational groups were marginalised as 'semi professions' in the expanding health care market (Belgrave, 1991:24). By the 1930s, doctors had succeeded in dominating the provision of health services as well as health policy development in New Zealand (Fougere, 1993). They dominated the hospitals and the Department of Health. They had succeeded in subordinating and limiting other professions such as chemists and opticians. They had largely excluded alternative practitioners who survived but were not able to flourish (Belgrave, 1991). The successes enjoyed by the profession during the 1930s and beyond owe much to the struggles which had been engaged in and won over the contested issue of medical

control of women's bodies. This was particularly so in relation to maternal bodies which became the focus for professionalising strategies.

3. Idealised Femininity and Medical Constructions of Maternal Bodies.

The bodies of New Zealand women were central to the professionalising strategies of medical practitioners at the turn of the century. The process of laying claim to medical work by doctors, involved not only the professional marginalisation of other health workers but also the demarcation of bodies into anatomical territories which were claimed as the preserve of medicine. The professional strategy of anatomical demarcation, not only occurred in relation to other health workers, but also in relation to medical colleagues.⁴ Gynaecologists in the early years of the twentieth century argued that their field of medical work should extend beyond the bony walls of the pelvis to take into account the wider 'constitutional derangements peculiar to women' (Hardie, 1914:66). In doing so they tentatively laid claim to areas which were the preserve of the general practitioner. Birth also became a contested area within the profession between obstetricians and general practitioners. Central to these professional strategies (whether internal or external to the profession) were discourses which constructed women's bodies as vulnerable and pathological. Towards the end of the nineteenth century and early twentieth century these discourses gained considerable social power providing the medical profession with ample opportunity to position themselves as the rightful guardians of the ill bodies of New Zealand women.

Concepts of illness which defined women as pathological were based on beliefs of biological differentiation and inferiority. It was not however until the eighteenth century that women were biologically differentiated from men. Prior to this, a one sex model of female and male bodies dominated medical and philosophical thinking with men's and women's reproductive organs being viewed as identical except for their anatomical positioning. The cervix for example, was not perceived to be a separate organ but was considered to be joined with the vagina to form an inverted penis. The absence of a language for female and male differences limited even the ability of

⁴ Professional struggles occurring within the medical profession remain an under examined area in sociology. This has led to unitary accounts of medicine which ignore the professional impact of such struggles.

Renaissance empiricists in constructing anatomical differences between men and women (Laqueur, 1990; Turner, 1991). During the eighteenth century, male and female biological difference began to inform discourses of male and female identity. The binary oppositions of male and female began to provide a basis for the evaluation and emphasising of difference. Biological dissimilarities increasingly informed understandings of social and cultural differences between the sexes. As a result, long held historical distinctions based upon perceived gender differences increasingly became focused on sexual differentiation (Laqueur, 1990). By the nineteenth century scientific discourses, which were gaining increasing authority, constructed women as passive in the process of reproduction, passionless in sex and constantly in a state of incipient pathology as a result of their reproductive organs (Martin, 1987; Turner, 1991). Accompanying these beliefs was a new rational approach to bodies which removed earlier prohibitions that had limited medical access to women's reproductive organs. In their biologically differentiated embodiment, women increasingly began to be subjected to the moral and scientific imperatives of medicine which were, to understand women's bodies through science and to control the inherent weakness and recalcitrance of these bodies (Moscucci, 1990).

By the nineteenth century, medical orthodoxy had established incontrovertibly that women were biologically and culturally different from men. Women were considered to be more frail and delicate and to possess a nervous system which was easily over stimulated. A woman's reproductive system was considered to control the functioning of her entire body. Beliefs in the primacy of the reproductive organs, also supported the notion that women's major role was to propagate the race (Bassuk, 1986:145). Idealised feminine characteristics such as nurturance, morality, domesticity and passivity were considered to have a biological basis (Rosenberg and Rosenberg, 1973:334). The assumption that women's reproductive organs were responsible for their greater susceptibility to physical and mental illness defined a norm for the female body as inherently pathological. Women's bodies were considered to be so unusual in comparison to the norm of the male body that a separate medical speciality was established (Clarke, 1983). The medical surveillance of women was increasingly legitimated by scientific discourses which demarcated the field of gynaecology as a 'science' of women (Moscucci, 1990).

Theories which guided medical practice in the late nineteenth and early twentieth century determined that women's normal state was to be ill. This theoretical view of women was advanced by medicine as a scientific truth. Ehrenreich and English (1990) suggest that this construction arose from deaths of women from tuberculosis and childbirth, but also that it was a construction which was commercially and politically advantageous to the medical profession. As a result of this construction women were disqualified as healers and thwarted in their attempts to compete with their male counterparts for medical work. At the same time however, they were well qualified as patients.

As women's bodies increasingly became the focus of medical attention, changes were occurring in the relationship between the medical profession and their patients. The location of disease in individual bodies and their organs which occurred by the end of the nineteenth century ended the long tradition of the patient's account of illness being central to medical practice. The end of this 'bedside' approach to disease signalled a new 'mode of production' of medical knowledge (Armstrong, 1983; Jewson, 1976). Clinical examination and later laboratory testing gave rise to the invention of normative bodies. The 'sick' man or woman became secondary to 'sick' bodies. For Foucault, such changes represent a 'political anatomy' in which the body as a target of power is surveyed, measured, compared and regulated (Smart, 1985:8). These discourses served to place women under the surveillance of the medical profession. Ill women were increasingly described as 'hysterics', 'hypochondriacs', and 'neurasthenics' (Bassuk, 1986:139). These descriptions allowed doctors to gain control over the language of the body disenfranchising both men and women from their accounts of the experience of the 'lived in' body. Importantly these discourses also structured women's subjectivities in a way which created female bodies as primarily fit for reproduction and as easily fatigued by any activity which appeared to negate this feminine role. This medical 'knowledge' arose out of socially located beliefs:

This view of woman's predisposed susceptibility to nervous debility transcended medical and scientific knowledge to include assertions that stemmed from deeply held beliefs about female and male 'natures', and the acceptable parameters of women's behaviour and influence (Cayleff 1988:1206).

Discourses which constructed women as ill also constructed solutions to their illness. The 'rest cure', leeching, cauterization, and ovariectomy procedures became common medical treatments for women's nervous debility (Bassuk, 1986:139). Moscucci (1990), suggests that the 'clinical' medicine exemplified by these treatments, brought about an increased focus on women's reproductive organs and a rapid expansion of gynaecological surgery in England from 1860. This represented a change in medical interest from the 'whole woman' to a study of women's pelvic organs. Attempts to make internal disease accessible to the senses brought about an increase in surgery and the use of instruments for diagnosis and treatment. The surgical opening of women's abdominal cavities, in the cause of performing Caesarian sections, ovariectomies and laparotomies became increasingly common in New Zealand medicine in the late nineteenth century (Donley, 1986).

The medical profession, of late nineteenth and early twentieth century New Zealand contributed significantly to discourses on gender difference. Not infrequently, these discourses constructed women in terms of binary oppositions. Typical of these were descriptions of women as, intelligent but lacking in logic, as morally superior to men but capable of falling to the depths of depravity in matters of the flesh and as physically able but prone to physical strains and nervous exhaustion (Barraclough, 1905; *NZMJ*, 1919). Nineteenth century medical discourses which had determined that biological differences between men and women disadvantaged women by making them frail, nervous and ill were frequently translated into specific social prescriptions (Smith-Rosenberg and Rosenberg, 1973; Cayleff, 1988). The medical profession translated what were perceived to be biological differences into social prohibitions. A Dunedin doctor for example, warned parents that higher education for young girls would endanger the establishment of the menstrual cycle (Stenhouse, 1886). Medical constructions such as these were however not only gender based, but were also class based. Middle class women were frequently constructed as the frail 'queens of the household' whilst working class women were often described as 'seductresses and carriers of shameful diseases' (Levesque, 1986:2). Such constructions increasingly gained the authority of science as rational notions of femininity.

The increasingly authoritative medical profession in New Zealand came to regard

itself as the guardians of women's bodies and by definition, as the guardians of New Zealand society. Post World War I concerns about low population levels in New Zealand were for example translated by the profession into concerns about women's lack of attention to their proper biological and social roles. Women had already shown that they were moving out of their 'proper sphere' by gaining the vote and there were concerns that they would increasingly abandon home and family (Dalziel, 1986:66). Such concerns provided an opportunity for doctors to inform women that marriage and children were not only a duty to the nation but were essential to their physical and mental well being. The profession were reminded in the medical literature of their responsibility to sound a warning to women that stepping outside traditional feminine roles would result in nervous exhaustion and loneliness:

The influence of the Great War on women at the present time is generally bad. They tend to forsake the lesser ills for what can properly be called the larger woes. Too many dislike home life and office work is their 'summon bonum'. It is here that the warning voice of the medical profession should be heard. We admit that there must be an increasing number of female typistes (sic) and so on, but we ought to say that their lives are not as healthy as those of home-staying women. Indeed it is only a question of time until the nerves of the typiste (sic) become shattered (NZMJ, 1919:264).

The 'warnings' of the medical profession were considered to be underpinned by the authority of science. Scientific theories of evolution and later the application of these theories to Social Darwinism and eugenics gave medicine a powerful platform to argue that women were biologically suited to the roles of reproduction and domestic service beyond all others (Labrum, 1992). The authority of science, the needs of the state and the health of women combined to position the medical profession as the arbiters of the physical and social health of the nation. Within this context doctors were urged to undertake 'missionary' work to remind women of their patriotic duty to marry and have children for their own health and for the health of New Zealand:

...married life should be exalted as a benefit to the state and to the individual, and for the physical well-being of women...(NZMJ, 1919:264).

Medical science was also invoked to ensure that not only were women aware of their proper social roles but that they were also aware that they needed the assistance of the medical profession to carry out these roles. The modern woman was constructed by medical discourses as in need of instruction in the roles to which she was biologically suited but because of the corrupting experience of modern life was no longer 'naturally' able nor even inclined to perform to an expected level.

Motherhood was a role not infrequently idealised by members of the medical profession:

However cynical a man may be in his feelings towards the opposite sex, there is always one woman at the mention of whose name his heart is uplifted and he seems to breath a purer atmosphere. Such are our mothers to all of us, and it leads us to regard motherhood as the noblest function in human life. With the mothers of our race lies the hope of our future (Barraclough, 1905:204).

Within a context of idealised motherhood, birth control was condemned by the medical profession as morally revolting and as a sign of national decay especially when practised by women of good circumstances. Post-war anxieties about population growth were reflected in concerns not only for the quantity of the population but also its perceived quality (Fleming, 1988; NZMJ, 1919). Members of the profession expressed concern that New Zealand would be over-run by the 'coloured races'. Advocates of birth control were described in a *New Zealand Medical Journal* as doing 'violence to everything that is sacred to the name of nature, morality, science and common sense' (NZMJ, 1922:342). Doctors increasingly saw their role as the guardians of women's fertility as well as the guardians of the morals of the nation:

As guardians of health and in some degree of the morals of the community we have to decide whether limitation of the population by artificial means is justifiable and desirable in the interests of the family and the nation (Riley, 1930:144).

Whilst the medical profession attempted to assert its control over women's bodies, women resisted. Some women for instance limited their families despite the risks,

through illegal abortions sometimes gained through the clandestine activities of doctors (Levesque, 1976). Brookes (1986:119) suggests that women had been successfully limiting their families for decades before the emergence of state concern with women's deviation from the maternal role.

Despite the attempts of some women to resist the increasingly dominant discourses of medicine, medical constructions continued to gain an authority which provided the justification for the management of motherhood at all levels. Women became the focus for the activities of a range of specialists whose role it was to monitor and prescribe appropriate technologies for home care, child rearing, domestic hygiene and diet using industrial models of routine and regulation. A *cult of domesticity* increasingly emerged which had the authority of science underpinning a network of power which structured women's lives as dependent and privatised (James and Saville-Smith, 1989:31-33). As women's colonial 'helpmeet' role which had emerged during the pioneering period diminished, the cult of domesticity provided a new role for women centred around caring for husbands and children. An expectation emerged that the idealised domestically oriented woman would not only assist the nation in its quest for population growth, but would also bring some greater level of social order in relation to men and children in the new colony (Olssen and Levesque, 1978).

The *cult of domesticity* occurred in response to social anxieties which were emerging in relation to the aspirations of women to enjoy similar freedoms to those enjoyed by men. Women as wives and mothers became the focus for a heightened level of surveillance. The medical profession was increasingly at the forefront of this surveillance particularly in relation to the initiatives of Dr Truby King who led a crusade in the interests of domesticity and motherhood in the early years of the twentieth century. King's impact in focusing the medical profession's gaze on women and on the relatively private space of the home cannot be underestimated. He authoritatively articulated the concerns of many men and women who saw civilisation as having undermined natural motherhood. Such concerns were further enhanced by predictions of a decline in the intellect and morality of generations who were perceived as becoming incapable of self-regulation and discipline (Olssen, 1987). Mother's bore the brunt of this criticism in the medical literature for their ignorance in

relation to raising children. They were blamed for a decline in the Anglo-Saxon race, a decline which was considered by the medical profession to be a consequence of maternal ignorance (Fell, 1908:22; *NZMJ*, 1919). Discourses which constructed women as incompetent served to open the previously private space of the family for professional and public scrutiny. It also provided a social and moral justification for medical intervention in areas which had previously been largely private family functions.

Plunket nurses and other 'specialists', came to be the visible face of the medical profession in New Zealand homes ensuring that the surveillance of mothers and children was carried out in an ordered, scientific way. Women were taught to act as *locus medicus*, or medical 'helpmeet', in their role as mothers in order to detect and prevent illness in family members. However despite the partnership implied in this arrangement, Matthews (1984:176) suggests that historically women have been at a disadvantage in the mother-doctor alliance:

By and large, medicine took the credit for whatever was deemed progressive and successful. Women took the blame for individual failures. The gender ideology championed the claims of the medical profession which guaranteed the health and safety of the mother and child if the mother obeyed all the tenets of ante-natal hygiene and followed the 'experts' regimes punctiliously.

As she suggests, the changeability and vagueness of some of these tenets as well as the difficult economic and social circumstances of many women meant that failure and subsequent blame was inevitable. In their role as lay guardians of health, women contributed to the intensification of the medical surveillance of their families and also of themselves. In drawing the doctor's attention to the health of family members they automatically drew attention to their own functioning as wives and mothers. By controlling and regulating babies through Plunket, the medical profession had succeeded in controlling and regulating mothers.

There was initial antipathy by doctors towards the initiatives of Plunket. The profession feared that Plunket nurses were encroaching on their sphere of interest which was, to have access to mothers and babies. Acceptance grew as doctors

realised that Plunket nurses would work in conjunction with doctors under strict regulations. Once the profession realised that they were able to subordinate and limit the work of Plunket nurses they accepted their involvement in medical work. The Plunket nurse was able to survey the spaces between bodies and monitor and manage the practice of motherhood. They therefore extended rather than impeded medical surveillance of women and children's bodies.

The efforts of Truby King and other specialists in monitoring women in the community represent a broader change in the relations between medicine and society. At the turn of the century, the medical profession increasingly moved out of the clinic and focused its attention on the spaces between individuals (Armstrong, 1983). In doing so it constructed new techniques to make the body legible. It also created new objects of surveillance (Armstrong, 1994:25). The new subjectivities created in relation to women as mothers were ones which discounted women's abilities to mother and care for children and constructed babies as vulnerable and precious national assets. These constructions opened up the social space occupied by mothering for professionals to exercise surveillance and control. Pregnancy and childbirth also became the major focus for the surveillance of women's bodies in the post-war period and constructions of cervical cancer were strongly linked with the perception of birth as a dangerous event which warranted medical intervention.

4. Constructing and Controlling Childbirth: The State, the Medical Profession and Women.

In 1920, the majority of births in New Zealand took place outside the clinical setting of the hospital. By 1935, 78% of babies were born within a hospital (Mein Smith, 1986:1). Such a dramatic transition has been described as the transformation of birth from a 'human experience to a medical-technical problem' (Kohler Riessman, 1989:196). Prior to birth becoming a medically managed event, it was predominantly a social event in which the major participants were the woman, her family, friends and a midwife. In New Zealand as in other Western countries, women's bodies and the experience of birth became the focus for a form of control which was technical and political and imbued with beliefs about the appropriate gender structuring of society (Turner, 1987). Childbirth became a highly contested

area of medical work in the early years of the twentieth century and as such played a significant role in the professionalising strategies of the medical profession. Maternity work became the focus for doctors' attempts to maintain control over their own sphere of work, the work of others and to control health care at a broader structural level thus establishing medical dominance over the production of health care in New Zealand.

The construction of birth as a medical event occurred within an increasingly interventionist approach to women's bodies in the late nineteenth and early twentieth century. This was reflected in the medical literature of the time where technical procedures in relation to birth or surgical procedures were described:

For the high operation I use Tarnier's axis traction forceps, latest model and for the other cases Simpson Barnes, combination forceps, with fixation screw. This last is of great importance, as it allows the head to be delivered slowly with one hand (the grasp in the handles being reversed) leaving the other hand free to protect the perineum (Alexander, 1894:159)

The surgical skills of gynaecologists and obstetricians were much prized in a profession keen to enhance its social standing. Medical accounts of such skills were described in terms of heroism and 'brilliance' (Hardie, 1914:66). Increasingly medical discourses constructed birth as no longer a 'natural' event but one which required the highly trained skills of a doctor. Midwives who had historically played a role in assisting women with childbirth were increasingly constructed by the medical profession in less than heroic terms as unscientific and unhygienic (Faulke, 1909). As Turner (1987) suggests, professional groups attempting to gain or maintain an occupational monopoly frequently use exclusionary or subordinating practices in relation to competing groups. Devaluing the role of the midwife and maternity nurse came to be an important element in the medical profession's claims to medical work involving pregnancy and birth.

The issue of maternal mortality was central to the increased medical management of birth. Maternal mortality became a concern for the state in 1921 when the Minister of Health learned of the comparatively high level of maternal mortality in New Zealand

in comparison with other developed countries. It was recognised that the aim of increasing the birth rate and populating the post-war nation with healthy children could not be achieved if women could not experience safe, uncomplicated birth (Mein Smith, 1986). Added to this were increasing demands by women themselves for a pain free, safe and more medically managed birth. Doctors recognised this trend:

Here in this city, in many instances the patient when engaging the services of the medical man stipulates chloroform is to be given and they mean by that complete narcosis. "I don't want to feel anything" is the cry, so as the "pains" generally go with the loss of consciousness, the forceps have to be used (Alexander, 1894:158).

For some women the new interventionist approach to childbirth was symbolic of emancipation and was eagerly sought after (Kohler Riessman, 1989). The new techniques were also thought of by the profession as being medically progressive and were not infrequently heralded in these terms in the medical literature. The use of chloroform by Queen Victoria during childbirth was heralded by the profession as an example to all women of the wonders of medicine (NZMJ, 1901). Such issues set the scene for what on the face of it appeared to be the employment of rational scientific technology for the betterment of women and babies. Issues of professional power were however largely at the heart of the medical management of childbirth. At the same time Belgrave (1991:24) suggests that the debate over midwifery and childbirth in the 1920s was not between doctors and midwives, but between a reforming Department of Health and the medical profession as defenders of professional privilege.

Responses to the maternal mortality scare were varied. Truby King as Director of Child Welfare in the Ministry of Health constructed maternal deaths as arising out of meddlesome midwifery and blamed general practitioners for their over use of forceps. The Health Department determined that puerperal sepsis was one of the primary causes of maternal death and that this occurred as a result of infection either during or after childbirth. A subcommittee to the Board of Health (a government body which arbitrated health matters), involving government officials and members of the medical profession was established to examine maternal mortality. The Board

concluded that the increased incidence of maternal mortality arose out of the 'abnormal virulence of bacteria' and women's lowered resistance to infection because of lack of domestic help and 'housing difficulties'. Unsuitable birthing conditions were also cited particularly in relation to private houses and public maternity hospitals. Doctors were identified as contributing to maternal mortality by the excessive use of 'anaesthetics and instruments'. The profession's response to this latter criticism was to indicate that they were urged by family, friends and women themselves to use such measures. The Board ignoring the social conditions which it had identified as contributing to maternal mortality recommended the collecting of statistical data on maternal death, more surveillance of private maternity hospitals, and called on the medical profession to give attention to the excessive use of instruments in midwifery. Increasing the skills of the midwifery nurse through extra training was determined as essential, as was the need for every mother to be attended by 'a highly trained midwifery nurse' (NZMJ, 1921:354-356). The sub-committee had sanctioned the medical management of childbirth by endorsing the role of the medical profession in the surveillance of pregnancy:

The Health Department urges all pregnant women to seek skilled advice during the latter months of pregnancy at ante-natal clinics wherever available, or at the hands of the ordinary medical adviser. Such examination would enable the medical man to detect many abnormalities, and consequently avert dangerous complications (op.cit:356).

The Department of Health concentrated its effort on the elimination of puerperal sepsis by monitoring doctors and nurses. For doctors, puerperal sepsis was a two edged sword. On the one hand it supported the view that birth was a dangerous event which required medical intervention, but on the other hand it threatened to undermine their professional standing and to increase surveillance of their activities. Oppositional discourses which countered the state view of maternal mortality began to arise from conservative doctors and later the Obstetrical Society which represented the interests particularly of general practitioners. They claimed that infection during birth arose spontaneously from women's own bodies (Mein Smith, 1986; McNaughtan, 1989). These constructions echoed historical beliefs about women's bodies as polluting, dangerous and potentially sick, and served to position

women as inherently responsible for their own deaths during birth. These constructions also confirmed the clinical intervention of the medical profession in birth as essential.

An important step in the attempts of the medical profession to gain control of childbirth was the formation of the Obstetrical Society in 1927. This event is described by Mein Smith (1986:41) as 'heralding the beginnings of the transfer of power from the Health Department to the medical profession'. The Society acted as a means to unify the medical profession against state attempts to control medical work and doctor's incomes. The Society aimed also to capture for general practitioners in particular, medical work which involved the care of pregnant women and their families. The formation of the Obstetrical Society was an important strategic step in the process of gaining further professional power because it provided doctors (particularly general practitioners) with an organised forum for challenging the Department of Health and presented an often vociferous, authoritative and united voice to both the government and the public. The stated aim of the Society was however 'to co-relate the efforts of individual workers and to promote the scientific study of obstetrics' (*NZMJ*, 1927:98). As well as challenging the state the Society also challenged specialist obstetricians and gynaecologists with whom general practitioners increasingly competed for the work which women's reproductive role generated.

One of the initiatives promoted by the Society was the education of the public into accepting that birth was a dangerous medical event, a view which contradicted the stance taken by the Department of Health. Pamphlets were produced and disseminated on issues, such as ante-natal care which reinforced the Society's stance. Doris Gordon, the energetic voice of the Society was vocal in her condemnation of government initiated maternity services which she argued were run by obstetricians and midwives who considered birth a natural process when the Obstetrical Society knew it was 'fraught with danger' (Gordon, 1926:286; Mein Smith, 1986). Gaining control of the work which childbirth represented was especially important to general practitioners. This work provided them with an important connection with the family. The Obstetrical Society represented this need by combining arguments which indicated an altruistic concern for patients with the none

too veiled professional interests of doctors:

Presently, 70 per cent of New Zealand women will have accustomed themselves to the Government clinics, we will have lost two-thirds of our scientific interest in the cases; will lose that vital something best called 'en rapport', and when we will have become specialised automatons, engaged for an hour or two at the confinement, the trusted "family practitioner" spirit will be dead, and we will no longer have any hold upon the family connection (Gordon, 1926:272).

The activities of the Obstetrical Society and women's increasing demands for pain relief during birth finally undermined the work of nurses and midwives who were prevented from administering anything but chloroform. This ensured that by the 1930s, the majority of births occurred in hospitals with doctors in attendance (McNaughtan, 1989). The advent of free ante-natal care in the 1920s as well as the social reforms of the 1920s and 30s, including the maternity benefit, assisted in the increasing expansion of the medical profession's role into the spaces between bodies as the medical gaze became further focused on the social world of the patient (Mein Smith, 1986:120-121). Ante-natal 'supervision' as it was termed increasingly involved women in an extensive range of surveillances of their bodies including, oral and dental hygiene, dress, psychological condition, diet, rest, exercise levels, care of the breasts, abdominal palpation, external measurement of the pelvis and internal pelvic examination (Tracy-Inglis, 1924). At the same time however monitoring of childbirth resulted in obstetrical work being increasingly open to scrutiny and as birth became more regulated so too did the professional groups who claimed maternity work as their own (Arney, 1982:123). For general practitioners the control of state maternity care was short lived. Specialist obstetricians and gynaecologists began increasingly to claim medical work associated with women's maternal bodies as their speciality (Donley, 1986).

The construction of birth as a medical event included not only pregnancy, the birthing process itself but also the after effects on women's bodies of what was perceived to be the trauma of birth. Within this context, discourses which had constructed cancer as an issue of concern for all bodies in New Zealand began at the turn of the century to locate cancer in the cervixes of women who had given birth.

5. Constructing the Cancer 'Problem'.

Cancer was a disease which perplexed the medical profession at the turn of the century. It represented a disturbing paradox to a profession growing increasingly confident in its ability to know and understand bodies. Cancer symbolised bodily disorder at a time when doctors were achieving greater professional prestige as a result of their claims to rational, scientifically based practice. The response of the profession to this paradox was to call for a united, collegial approach to combatting the disease. These calls were accompanied by statistical evidence which suggested that although New Zealand had the lowest death rate in the world from all causes, deaths from cancer were increasing proportionately (Hislop and Fenwick, 1909). Cancer was frequently described in the medical literature in terms of being a 'deadly' and 'prevalent' disease (Macdonald, 1890; 1891). Medical explanations of the cause of cancer tended to centre around trauma theory. This theory suggested that the disease was induced by inflammation through irritation and infection of organs which had been subject to greater or lesser forms of trauma.

The construction of cancer as a disease caused by trauma and subsequent infection was indicative of the explanatory power which germ theory had gained. By the end of the nineteenth century germ theory had largely displaced the miasmatic theory of illness. Beliefs that cancer was caused by bacteria led to conclusions that the eventual elimination of cancer lay in the laboratory and in the use of antibiotics and vaccination. Germ theory was also a basis for doctors to assert that medicine was a scientifically based discipline rather than a healing art (Tesh, 1988). Increasingly germ theory became an important legitimisation for the medical profession to move out of the clinic and into the spaces of home and community. Supervising the diet, clothing and residences of New Zealanders to ward off diseases such as *phthisis* was an example of this surveillance (Springthorpe, 1896:83).

Medical discourses in relation to cancer began to reflect the new scientific status of the medical profession in New Zealand. Cancer, once the illness of the patient, began to be described in the language of the clinic. 'Exigences of cell life', 'new protoplasmic organisms' and 'agency of micro-organisms' (Macdonald, 1891:95-96) are examples of medical vernacular of the time which symbolised cancer as 'belonging' to the medical profession. The scientific authority claimed by clinical

medicine held out a promise to the public and medical profession alike, of a world without illness (Tesh, 1988). Such hopes were not infrequently expressed in the heroic metaphors of war where germs were the 'enemy':

For centuries the germs of disease attacked mankind, a man knew not how to set up a defence against an unknown invisible foe, but during the last half century medical scientists have unmasked germ armies and shown how to defeat them. This victory is the greatest for humanity above all the victories of war since the world began (Elliot, 1929:77).

In response to the fear engendered by cancer and other diseases such as tuberculosis and venereal disease, the medical profession took the opportunity to forge links not only amongst themselves but also with the public. The profession urged the public to be 'vigilant' and to assist medicine in its fight against the disease (NZMJ, 1914a). Such initiatives were important in establishing the reputation of doctors as essential to the health of the nation in a general sense and more particularly as an essential source of help in keeping the body cancer-free. Cancer was not only viewed as a scourge of the individual but also of the state and by definition implied that the medical profession was not only indispensable to the public but also to the nation:

It is therefore of paramount importance that by mutual co-operation of the medical profession and the public such steps should be taken, on the one hand to point out and on the other hand to take notice, of these symptoms and signs, which cancer presents in its early stages, in order that by mutual help hundreds of lives at present sacrificed should be preserved to their friends and relatives and to the State (NZMJ, 1914b:219).

Moves were already afoot by 1914 to publish a pamphlet to enable individuals to identify cancer in themselves and others before the disease proved fatal (op. cit:219). This early initiative was the first of more concerted attempts in later years to inculcate in the public an awareness of the importance of self surveillance. Such initiatives were indicative of the medical profession's recognition of the potential of preventive medicine as a burgeoning field of medical work. The anticipated rewards for the

medical profession taking cancer seriously, were not only to treat the disease but also to prevent it (De Lisle, 1914). Preventive medicine was viewed as providing the opportunity to earn doctors the support of the state and therefore increase professional power:

Whether for weal or woe, there is no doubt that the State is gradually increasing its functions and largely in the direction of attempting to prevent disease and conserve the health and comfort of the people, and that being so, the medical profession if it acts wisely, will become increasingly important and powerful (NZMJ, 1914c:38).

Cancer of the cervix was one form of cancer which received considerable attention during the late nineteenth century and early years of the twentieth century.

6. The Maternal Cervix: Constructing Cervical Cancer.

During the late nineteenth and early twentieth century medical discourses constructed women's bodies primarily as 'maternal bodies' and ideas about cervical cancer were framed on this basis. Cervical cancer came to be understood as a gendered disease, not because it occurred in women only, but because it was associated with women's primary function of giving birth. The medical profession identified cervical cancer as a disease which resulted from chronic infection by 'bacterial' or 'septic organisms', or from some form of local irritation which, it was suggested, was associated with childbearing (Bailey, 1930a:720). These constructions of the disease meant that the cervix increasingly lost its neutral status as a gateway between the vagina and uterus and took on the meanings of illness. It became spoken of as a vulnerable organ, subject to trauma and irritation. This irritation was thought to lead to a *chronic endometriosis* or *cervicitis* which could eventually progress to cancer (Brown, 1935; Fenwick, 1913). Trauma theory increasingly gained authority as an explanation of cervical cancer within a context of the majority of women being susceptible to a damaged cervix:

It must be that cancer arises, either from some transitory effect produced at labour, the cervix subsequently appearing to be quite healthy, or from a chronic infective process, known to exist in 80 per cent of women which has as its origin trauma

during labour (Stout, 1935:101).

The profession believed that cervical cancer was rare in women who had not given birth (Brown, 1935; Stout, 1935). Doctors also considered that a falling birth rate correlated with a fall in the incidence of cervical cancer (*NZMJ*, 1926). The cervix lacerated during birth, was likened to a rough decaying tooth which could cause cancer through irritation of the tongue (Worrall, 1924). Theories of cervical irritation leading to cancer echoed early twentieth century beliefs that oral sepsis was responsible for a wide range of bodily illnesses (Dussault and Sheiham, 1982). The surveillance of the cervix which occurred as a result of trauma theory paralleled the 1920s emphasis on the surveillance of children's teeth in linking the health of individuals with national goals of a healthy nation (Robertson 1924:91).

Within a context of 'dangerous motherhood', the medical profession was urged to conduct obstetric practice with 'care and skill' and to surgically treat 'severe lacerations' of the cervix which could result from birth (*NZMJ*, 1926:17; Worrall, 1924:109). Cervical cancer was seen as a justification for a 'managed' birth in which 'the cervix was to be protected from trauma at childbirth', and tears of the cervix were to be repaired 'to prevent infection' (Stout, 1935:107). Trauma theory not only succeeded in linking childbirth with serious disease, it also ensured that the entire experience of childbearing became medically managed. The ante-natal care of women during pregnancy, managing the process of birth and dealing with the after

1987). Women with cervical cancer were also perceived by some overseas doctors to be excessively sexually excitable (Ricci, 1945). A paradoxical exception to the trauma model of cervical cancer appeared in 1919 which indicated that cervical cancer was more common in Jewish women than non Jewish women (Kessler, 1974:174). These alternative explanations of cervical cancer, did not seriously compete with the trauma model which was adhered to by the New Zealand medical profession. However, historical discourses linking cervical cancer with women's sexual behaviours formed the basis for later constructions of cervical cancer.

In his historical overview of cervical cancer, Chang (1988) locates beliefs about the disease at the turn of the century and early years of the twentieth century within a context of scientific naïvety but does not attempt to explain these beliefs further:

...the concept of chronic irritation or infection as precursors to cervical cancer was accepted world-wide by the majority of medical authorities and by those in New Zealand, despite lack of good scientific evidence (Chang, 1988:516).

An alternative approach to that taken by Chang is to socially locate medical explanations of cervical cancer within the socio-historical period of the late nineteenth century and early twentieth century. This acknowledges that scientific theories are not epistemologically pure but are outcomes of social processes. This perspective of medical science owes much to the Polish-Jewish, doctor Ludwik Fleck who in the 1920s and 30s proposed that scientific facts were not 'discovered' but came into existence as a result of social processes (Lowy, 1988). From this perspective, scientific theories and facts are not stable entities which are transformed by new discoveries but are subject to changes as a result of social processes such as religious, economic or political changes (White, 1992). That is, scientific facts are social constructions. In relation to medical science, a constructionist sociological perspective attempts to uncover ways in which the production of medical knowledge is a cultural artefact reflected in the production of disease categories and responses to them. As some commentators have clearly identified, the ways in which medical practitioners comprehend bodily phenomena and create a discourse around them is strongly influenced by their preexisting beliefs, the technologies with which they are familiar and their skills and priorities (Nicolson and McLaughlin, 1988). As Fleck

(1979) suggests, medical theories not only predispose the questions asked in medical inquiry but also the answers (White, 1991). Aggregates of individuals who share a particular perspective of a medical phenomena can be described (after Fleck) as being part of a 'thought-collective' (Lowy, 1988). Medical 'progress', as reflected in changes of perception and action, occur when one collective cognitive style is usurped by another. Those who resist the dominant medical discourse and make claims to competing forms of knowledge may find themselves stigmatised whilst the dominant discourse becomes more forcibly asserted:

During their training and specialization future specialists adopt a given thought style and learn to see reality in accord with it. A beginning student looking at a microscope preparation of bacteria has no idea what he (sic) is supposed to observe there. A long training is needed to teach him (sic) to be able to 'see' the right picture (i.e. for Fleck one in agreement with the current bacteriological tradition) (Lowy, 1988:142).

On the basis of Fleck's insights, it is argued here that nineteenth and early twentieth century constructions of cervical cancer did not arise out of value-free scientific discovery. They arose out of medical discourses which proclaimed women as inherently ill and constructed mothering and birth as requiring extensive medical management. Added to this were the professionalising strategies of a burgeoning medical profession keen to increase the social power and legitimacy of their knowledge claims to scientific medicine and to extend and protect the boundaries of medical practice. Constructing cervical cancer as a bacterial infection linked to the trauma of birth served to enhance both these aspirations.

The trauma model of cervical cancer eventually led to discourses which constructed the cervix as a new kind of medical object. The 'new' cervix became increasingly divorced from its role in birth and began to be described in the language of pathology. The 'non-normative' cervix took on a multiplicity of forms including those which were, 'lacerated', 'chronically degenerated', 'pre-cancerous', 'eroded' and 'shedding' of their 'epithelium' (Worrall, 1924:109). The authoritative voice of pathologists increasingly began to appear in the medical literature in determining the 'normal' cervix and the cervix which showed signs of a combination of 'sepsis', 'laceration' and 'erosion'

(Stout, 1935). The cervix became a disembodied medical object increasingly accessible to the medical profession both visually and discursively and increasingly inaccessible to women. The disembodiment of the cervix was exemplified by histological studies which began appearing in medical journals of the 1930s accompanied by photographs of the removed, dissected and pathological cervix (Bailey, 1930b:512). The cervix as an entity independent of the woman concerned, began to be described in terms of a 'life cycle' of cancer having four stages in the progression of the disease (Bailey, 1930a; Bailey, 1930b; Stout, 1935). This new language aided by the use of the microscopic replaced the old language of cancer of the uterus which focused on the physical signs which women themselves experienced, such as vaginal bleeding and pain. In his discussion of renal disease, Peitzman (1989) notes that these are signs of a change in the 'ownership' of disease. Cervical cancer was no longer the patient's disease but had predominantly become the doctor's disease.

Medical discourses which sought to identify the pathological cervix began in the 1930s to include language which described the cervix as 'precancerous' (Stout, 1935:108). The significance of this term is that the cervix began to be regarded as an organ with a 'narrative' of incipient illness which medical discourses sought to discover and describe in the interests of prevention. Nettleton (1992:31) suggests, the technology of preventive medicine operates at the level of individuals and also at the level of populations. Surveillance of populations and training of individual bodies are inextricably linked with the regulation of individual bodies leading to the docility of populations. This trend became apparent in New Zealand when in the years to follow the cervix became a target of medical power involving the bodies of all New Zealand women.

7. Conclusion

Women's bodies became the focus of medical power in late nineteenth and early twentieth century New Zealand. The increasing medical surveillance of women which occurred in the early twentieth century was not the outcome of medical progress spurred on by rational scientific discovery but represented a dominant mode of thinking about women, their bodies and their social position. Medical discourses increasingly created an epistemology with scientific and technological accounts of the body as their basis. Such discourses provided the basis for a unified reality of cancer which was underpinned by the authority of science and conferred prestige and status on the medical profession as they sought to gain control of medical work. Women's bodies became the major focus for medical power a time when women were moving away from the colonial 'helpmeet' role to one which challenged the dominant constructions of the appropriate place and use of women's bodies. Increasingly the 'mothering' bodies of women came under the medical gaze and were subjected to the technical rationalities of training for motherhood. The essentially private role of mothering became the focus for public anxieties about the falling post-war birth rate and contamination from 'inferior races'. Discourses which sought to constitute birth as a dangerous, medical event were aided by women who appropriated the medical narrative of birth as a process corrupted by modernity and saw in this a metaphor for freedom from the oppression of nature. Women's bodies became the contested location for the control of childbirth as an increasingly 'professionalising' medical profession established dominant discourses of birth, displacing those of midwives, and at the same time challenging both the state and women themselves.

Collective medical constructions of cervical cancer associated it with a pathological process which was precipitated by birth. Such constructions confirmed beliefs that birth was a medical event strongly associated with pain and illness. The cervix became separated from the body as technological constructions of its structure and dysfunction resulted in the binary distinctions of the normative and non-normative cervix. These constructions were based on increasingly complex scientific discourses. The cervix became a medical object to be observed, monitored, measured, repaired, controlled and removed. Discourses of cervical cancer, confirmed women as vulnerable, potentially sick and in need of surveillance and confirmed the medical profession as the legitimate surveyors of the vagina and

cervix. Medical discourses of cervical cancer in the 1930s, began to locate cancer not only in the cervixes of mothers but in the cervixes of all women. In doing so, cancer of the cervix had accompanied women out of the home and into the spaces of the community.

CHAPTER FOUR

Cervical Cancer and the Preventive Ideal in Mid-Twentieth Century New Zealand.

1. Introduction

During the late nineteenth century and early twentieth century, cervical cancer had been known and understood by the medical profession as a disease of motherhood. From the 1940s on, medical discourses began to construct the cervix as a new object of surveillance. Cervical cancer moved out of the clinic and into the community and became known as a preventable disease of all women. Accompanying this change were new discourses, subjectivities and disciplinary technologies. These emerged within a context of an increasing focus on social medicine and the prevention of illness. Curative medicine had constructed sick bodies whilst preventive medicine constructed potentially ill bodies, thus blurring the distinction between health and illness. 'Social medicine', as the new community focused medicine was called, redirected the medical gaze, from bodies to whole individuals, and situated them within a socio-emotional context. The family was viewed as central to this new medical field of relations.

Social medicine required new forms of surveillance and disciplinary technologies in order to track and monitor incipient and actual disease in the community. The state responded to the 'preventive ideal' which formed the basis of social medicine by constructing the public as rational, intelligent and responsive to education on health matters. In doing so it exhorted the population to become skilled at self surveillance and to co-operate with medical initiatives. The welfare reforms initiated in the 1930s underpinned these discourses by enshrining medical care as a universal need which was affordable and accessible to the public. The health education initiatives of the state in the mid-twentieth century were based on paternalistic welfarism and had an essentially optimistic view of human nature. The construction of the rational and intelligent individual which reflected this optimism, contrasted with earlier beliefs that the public needed to be coerced into healthy behaviours.

Both the state and the medical profession had, in the earlier part of the century, viewed women as requiring extensive monitoring and regulation in their roles as

mothers. This view did not radically change during the mid-twentieth century, but broadened to suggest that women required extensive monitoring and surveillance because they were women. Whilst the state constructed women as rational surveyors of health, the medical profession constructed them as irrational and out of control. This occurred within a context of women increasingly extending their social roles beyond that of mothering. In line with the 'whole person' approach of social medicine, medical constructions of women largely continued to emphasise their reproductive biology as the basis for their potential illness. However, a biographical approach to medicine began to emerge in the 1940s and 50s which suggested that women were predictably ill through different stages of their lives. Increasingly women became the triple targets for the preventive strategies of both the state and the medical profession. This occurred in relation to the living habits and diseases which they shared with men, their reproductive systems which were considered to be especially prone to disease, and in relation to their role as carers of husbands and children (Davies, 1984).

The advent of social medicine provided general practitioners in particular with the opportunity to 'rehabilitate' general practice from what was perceived to be an erosion of professional autonomy and status which had occurred in the early decades of the twentieth century. The 'whole person' approach to medicine gave general practitioners the opportunity to monitor individuals on the basis of the biographical approach to illness within the context of family medicine. The 'family' doctor, was in a position to monitor bodies, minds, relationships and emotions and as a result prevent disease before it occurred. The origins of the 'preventive ideal' which underpinned many of the initiatives of social medicine were not however entirely medical. They were based on a number of social objectives which not only emphasised individual responsibility but also family responsibility. Implicit in this approach was a confirmation of the structure of the family as comprising a male breadwinner, and female homemaker and child carer (*ibid*). This construction further confirmed ideas of maternal responsibility which had emerged in relation to pregnancy and child care and expanded women's responsibility for illness prevention to include a range of physical and emotional ills to which they and their family were susceptible.

The new social medicine and the preventive ideal which underpinned it may be viewed as a more humanistic and enlightened form of health care. However it may also be viewed as a new configuration of power in which populations have been increasingly educated in ways to govern themselves. This form of power as Rose (1990a:108) suggests, operates primarily through tensions which are generated in the discrepancy between how life is and how much better it could be. Discourses of preventive medicine were, (and continue to be) pervasive and prescriptive in form. Disciplinary technologies emerged in the post World War II period in relation to an ever increasing range of health behaviours including diet, hygiene, immunisation and regular x-ray screening. Doing the 'right thing' in relation to health came to be associated with being a good, responsible citizen. For women this included monitoring and surveying an ever increasing array of bodily and emotional functions.

Part Two of this chapter sets the scene for an analysis of the professional status of the medical profession within the context of the welfare state. In particular it highlights issues of intraprofessional struggles and shows that the medical profession is not a unitary body. **Part Three** identifies the scope of social medicine within a new configuration of 'patienthood' and the 'whole person' approach. **Part Four** outlines the role of the state in its support of the 'preventive ideal' and **Part Five** progresses this discussion by analysing health education discourses and constructions of subjectivity. **Part Six** positions women's bodies within a context of curative and preventive medicine and socially locates medical attitudes to women during the mid-twentieth century period. **Part Seven** links attitudes to cervical cancer prevention with initiatives of the state and the professionalising strategies of general practitioners. **Part Eight** concludes the chapter by arguing that constructions of cervical cancer as a disease of all women reflect the social location of the knowledge claims of medicine.

2. The Medical Profession and the Welfare State.

During the post-war period the medical profession became increasingly concerned about the intervention of the state in the relationship between doctors and their patients. At the same time, doctors were involved in struggles within the profession over status and boundary issues. By the 1930s, doctors operated largely as independent, fee collecting practitioners and controlled medical work (Belgrave,

1991). In 1935, the first Labour government began a process of social and economic reform which included health related initiatives. One reform, instituted a tax-financed health system aimed at providing access to free health care for all New Zealanders on the basis of need. Doctors opposed the implementation of this policy because they viewed state funding of health care as undermining their direct fee for service relationship with patients. They also viewed the policies of the Labour government as positioning the state more directly in the provision of health care and they feared the greater oversight and control of medical work which could result from this change (Fougere, 1993:116).

Notwithstanding concerns about state interference, doctors opposition to the health reforms appears to Bolitho (1984) to be somewhat of a paradox in that social security was likely to be financially advantageous to the profession. He suggests however, that opposition was based mainly on concerns that the welfare reforms would lead to greater workloads as health care became more accessible to the public and that this would lead to a less agreeable lifestyle for doctors. He further suggests that opposition to state initiatives were from a mainly antisocialist lobby of doctors who resented lay interference in medicine. It is clear from the literature however that the primary concern of the profession was the involvement of the state in medical relations. Fundamental to doctor's opposition was the issue of medical autonomy and the freedom to determine the conditions of their work. Doctors used a range of arguments against the Labour government's initiatives including claiming that 'free' treatment which the social security system offered was likely to worsen the health of the nation (Pickerill, 1943).

General practitioners in particular were anxious that their independence was being eroded. Their concerns were related to the impact of the welfare reforms on their relationship with patients and in terms of the power and status of 'specialist' medical practitioners. They blamed the government for what amounted to the 'secularisation' of general practice in which the mystique of medicine had been eroded. Concerns were expressed that loyalties to particular family doctors had disappeared under state medicine and that the relationship between patients and doctors had been reduced to a financial transaction:

Now we have nothing but cash stores, and the customer goes to whatever happens to be the nearest at the time (NZMJ, 1952:337).

'State medicine' was blamed by general practitioners for lowering the prestige of general practice in the eyes of the profession. General practitioners considered that they had become 'ordinary doctors' who cost little or nothing to consult whereas the specialist continued to be an expensive luxury who was correspondingly respected (NZMJ, 1954a:318). Notwithstanding these concerns, Fougere (1993:117), suggests that by the 1940s the Labour government reforms had the effect of entrenching the professional autonomy of doctors. General practitioners continued to have the freedom of being able to determine where and how they practised and to set their own fees within a context of being able to draw on extensive state subsidies. The reforms also strengthened their role as gate keepers in the medical division of labour.

A three year struggle between the state and the profession ended in partial compromise where all citizens would have access to public hospital care financed by taxation, with tax financed subsidies for those who used private hospitals. Primary care was to be subsidised on the basis of all or most of the cost of a consultation (Fougere, 1990). General practitioners continued to voice their philosophical opposition to social security but began to increasingly see social medicine as the means by which they could enhance their status both in relation to their own profession and the public. Cervical cancer was to provide one specific focus for the professional strategies which emerged from these oppositions.

3. Social Medicine and the Construction of the 'Whole' Patient

During the post World War II period a number of interrelated changes occurred in relation to the ways in which medicine regarded patients and their illness. Armstrong (1982:110-111), describes this change as the reconstitution of the object, consequences and effect of the medical gaze, resulting in the fabrication of patient subjectivity. At the same time as the patient began to be viewed as a thinking, acting subject rather than the passive carrier of disease, greater attention was directed at the social milieu of patients. Social medicine emerged as a new form of medicine within the context of a reconfiguration of 'patienthood' and the redirecting of the medical gaze to the social environment. Central to social medicine was an emphasis

on the prevention of disease and the surveillance of healthy populations. The problematisation of the 'normal', which was fundamental to this form of medicine was initially directed at women in connection with childbirth and at children who were constructed as national assets who required intensive monitoring for the health of the nation. Social medicine had the effect of making all citizens potential patients (Armstrong, 1995). General practitioners in particular began to recognise the potential of this new view of bodies for the practice of medicine. They saw in social medicine the opportunity to position themselves in a unique place in the medical market place as an overseer of the totality of the patient. This contrasted with the specialist practitioner and other health professionals who by virtue of the boundaries of their practice were unable to authoritatively claim the 'whole person' as their domain of concern. General practitioners began to lay claim to a unique understanding of 'people as whole men and women against their total background' (NZMJ, 1954b:327).

Medical discourses which identified a clinical interest in the 'whole person', also cited the social context of the patient as being central to medical inquiry. The family was therefore considered fundamental to the general practitioner's understanding of the subjectivity of patients:

So unless the doctor already knows the patient and his family, and his background at home and at work, he is handicapped in his approach to any illness and cannot treat the patient as a whole person (NZMJ, 1954a:315).

Social medicine created a space for a greater involvement of medicine in the family beyond mothering and the care of children which had characterised medicine in the earlier decades of the twentieth century. The family came to be increasingly viewed as a means to accessing bodies in society. The family also provided the means by which a biographical model of patient care could find expression. Individuals within families were identified as having a life span which needed to be medically mapped and monitored. General practitioners considered themselves as the most appropriate health practitioners to ensure that this occurred:

The general practitioner watches families grow from infancy to manhood and

observes the variations of individual physique and temperament in the different members of the family. He sees the beginnings of disease, the inter-relation of illness with environment and occupation, and the impact of family bliss or sorrow on health (Sheppard, 1952:151).

The themes of biographical medicine corresponded with the premises on which the welfare state had been based. The 'cradle to the grave' ethic of welfarism found expression in social medicine and the preventive ideal. The term 'family doctor' which was often applied to general practitioners legitimated medicine as having a proper place within the family unit. Monitoring the physical, social and emotional biographies of family members came to be regarded as a medical imperative:

To be in general a guide, philosopher and friend to the family-father, mother and children-in the various crises and difficulties that arise as the years go by (Robb 1944:252).

Understanding patients' 'distinctive personalities' and 'emotional make up' was also an important part of monitoring the physical bodies of family members (Sheppard, 1952:151). Social medicine therefore provided the medical profession with the platform to look beyond clinical bodies to community bodies. The new configuration of power which this change represented found its expression in illness prevention.

4. The State and Preventive Medicine.

Whilst general practitioners were establishing themselves as having a vital role in preventive medicine, the state had for some time been active in the prevention of disease. Public health in New Zealand was described in 1951 by an officer of the Department of Health as having historically passed through four phases. These included the sanitary phase with its emphasis on remedying poor housing and lack of drainage and clean water, the bacteriological period which focused on epidemiological and laboratory approaches to disease prevention and the third phase of 'personal health services' which included infant welfare and ante-natal clinics, school and tuberculosis services. Social medicine was postulated by Thompson (1951) to be the fourth phase in New Zealand's public health history in which individuals were situated within their total environmental. Thompson's historical

sweep of public health in New Zealand does little to illuminate the social or gendered location of these initiatives. During the late nineteenth century, and early twentieth century it was the bodies of women and children who were particularly targeted for the deployment of the monitoring and disciplinary techniques of public health and surveillance medicine. Women and children became medically problematic as scientific discourses deemed them to be harmful to themselves, (and in the case of women, to others) and to the aspirations of the nation.⁵ Social anxieties about the fitness of the nation were translated into regulatory activities which measured and monitored the bodies of women and children (Gunn, 1914; *NZMJ*, 1911; *NZMJ*, 1912). The state led the way in this regulation and through a range of legislative measures ensured compliance. The disciplinary techniques of the medical examination provided the means by which this regulation could be carried out.

As the surveillance of the New Zealand population gained momentum in the early years of the twentieth century a range of illnesses began to be constructed as having 'pre-illness' or 'incipient' states. These included 'pre-neurasthenia' (*NZMJ*, 1918a) as well as tuberculosis which was considered to lie hidden in the undiscovered 'potential' tuberculosis patient (Makgill, 1920). Such was the growing zeal for preventive medicine, that in 1920 a parliamentarian called for widespread medical surveillance of the population (Collins, 1920). The preventive ideal found its most assiduous expression in relation to the mothering bodies of New Zealand women. Prior to the 1930s however, preventive strategies surveyed women's bodies primarily through the bodies of their children. In the mid-twentieth century, women's bodies were less mediated by the bodies of children and were more directly surveyed by both the state and the medical profession. A new configuration of preventive medicine began to gradually usurp the coercion model on which these earlier preventive measures were based. The new form of surveillance medicine began to construct subjects who were rational, intelligent, responsible and therefore co-operative. There was an attempt by the state and to a lesser extent by the medical profession to construct individuals who in a process described by Rose (1990a:114) 'attributed a certain kind of subjectivity

⁵ See Kehoe, (1992) 'Medicine, Sexuality and Imperialism. British Medical Discourses Surrounding Venereal Disease in New Zealand and Japan: A Sociohistorical and Comparative Study'. PhD Thesis. Victoria University of Wellington, for a discussion of the Contagious Diseases Act, 1869 which targeted women for medical surveillance in relation to venereal disease.

to themselves and evaluated and reformed themselves according to its norms'.

5. The State and the Capturing of the Soul of the Citizen: Rationality and the Shaping of Co-operative Bodies.

During the early 1940s, the Department of Health began to place increasing emphasis on the education of New Zealanders in matters of personal and family health. In doing so it exemplified a form of paternalistic government which had reached its zenith in the social and economic reforms of the first Labour government. This was an essentially optimistic approach to health care predicated on scientific rationality and a deterministic view of the world as amenable to logic and planning. Whilst doctors had begun to recognise the potential of social medicine and the prevention of disease in the early twentieth century, it was the state which largely took the initiative in mobilising the population towards illness prevention through health education. It did so within a context of individual and family responsibility without any significant acknowledgement of the potential disease generating conditions of the workplace or the environment. The state's approach was essentially based on an individualistic model with a focus on personal attitudes and behaviours and the inculcation of new health habits.

Newspapers and radio broadcasts were used to disseminate health information to the New Zealand population. In 1948, the quarterly journal *Health* was published by the Department of Health specifically to inform the public about health issues. The disciplinary technologies employed in health education moved away from coercion and instead attempted to motivate, persuade and inculcate an attitude of co-operation where New Zealanders were encouraged to 'take an interest in their own well-being' (*Health*, 1948a:2). Through the discourses and technologies of health education, the health of the body became linked with ideals of personal fulfilment derived from rational behaviours which were socially and personally beneficial. This was particularly so for women who were not only urged to take care of their own bodies but also to take responsibility for the health of family members.

Whilst it was the state health education discourses which primarily constructed the intelligent and rational public, the medical profession began to recognise the

increasing sophistication of the public:

It is not as if we are dealing with a stupid or ill-informed public. On the contrary, never has there been such interest in medical affairs and matters connected with health, amongst ordinary men and women as we see at the present day. There is a constant spate of articles and information generally pouring out to the people in the shape of newspaper and magazine articles, novels, pictures, illustrations, radio talks and films (Robb, 1944:249).

Implicit in these changing health discourses was a social contract between the public, the state and the medical profession. Health education reminded the public of their duties in relation to health, the state guaranteed access to health services and the medical profession had the role of ensuring that health monitoring occurred. The network of surveillance implied by this social contract meant that medical power could infiltrate all corners of the community. The employment of health education by the state to win minds and monitor bodies can be regarded as a form of power which was both repressive and productive. Whilst ever increasing areas of the lives of individuals became monitored and disciplined through medicine, health education promised peace of mind and relief of pain as the reward for rational co-operation in identifying, for example, the symptoms of diseases such as cancer:

Much pain and anxiety would be allayed if more people heeded them. By doing so they can co-operate with the doctor, and the sensible person will-for his own sake-be the first to act on them (Health, 1950:2).

These discourses served to redefine relations between doctors and the public. The social distance which had characterised the relationship between the profession and the public in the early years of the twentieth century remained. However, what changed, was that the public and in particular women, were recruited as allies of doctors by becoming their informants on bodies in the community. The public were redefined as intelligent informants on health matters as opposed to earlier medical discourses which constructed them as either ignorant or innocent. The rational and intelligent patient, in possession of the facts, was given the responsibility of knowing what to do in relation to monitoring illness. This knowledge primarily involved

co-operating with the medical profession. Whilst initiative and active co-operation was expected by the public in relation to surveillance outside the clinic, passive co-operation with doctors was still expected within it.

The motto of the Department of Health's magazine *Health*, 'intelligence is the most potent force that can be directed against disease' (*Health*, 1948b:2), was indicative of changing constructions of illness. The authority of science had given the state and the medical profession the confidence to assert that disease was neither mysterious nor irrational. As a backdrop to scientific discourses, paternalistic discourses emphasised the beneficence of the Department of Health:

When we advise you to drink pasteurized milk, or to eat fruit, or visit the dentist, or have your children immunised against diphtheria, it is not because anyone in the Health Department has any financial interest in these things. We have only one purpose, to help you, to help children, to help the community towards health (Thompson, 1952:4).

The Department continued however to retain the option of coercion in matters where it was necessary:

The promotion of healthy living then, is our first aim. This done by education, propaganda, and a little bit of force (Wallace, 1953:3).

These health strategies played an important part in socialising New Zealanders into accepting that both the state and the medical profession had a legitimate role in what would previously have been considered private activities. The inculcation of health rules and habits, was part of the formation of a discursive network which involved not only the state and doctors but an increasing array of other experts who monitored the population. New professional groups emerged to monitor minds as well as bodies. These included industrial hygienists, medical statisticians, district nurses, health inspectors and dieticians.

The technologies of the self which these mid-century discourses encouraged, were part of what Freund (1982) describes as a process by which invisible forms of control

are internalised and taken for granted. Health education discourses normalised health habits and provided a vocabulary for individuals to reinterpret their experiences in terms of the binary oppositions of 'health enhancing' or 'illness inducing' behaviours as well as constructing the self as 'responsible' or 'irresponsible' in health matters. Central to the preventive ideal and surveillance medicine therefore, was the creation of the patient's individuality. The docile carrier of disease had, by the mid-twentieth century, become an individual who had motivations, emotions and attitudes (Armstrong, 1982). This change goes to the very core of the state's health education enterprise and preventive medicine. Whilst preventive strategies constructed 'normal' bodies, they also constructed individualised bodies. Health education discourses were tailored to sentient individual actors and increasingly the subjectivities of individual patients began to form part of medical discourses. By the 1950s, the Health Department no longer viewed the public as passively accepting information about health but as actually demanding it. The new 'demanding' subject was redefined as wanting health information in order to achieve the 'fullest enjoyment of life' and 'happier family living' (*Health*, 1958:9). The measure of the success of health education was reflected in the Department's view in the 1950s that New Zealanders had accepted that medical care was a 'community responsibility' (Eastcott, 1953:6). New Zealanders had internalised the subjectivities of social medicine and had accepted the disciplinary technologies of the preventive ideal as part of their lives.

6. Governing the Bodies of Women

Women's bodies increasingly became the focus for curative and preventive medicine, in the mid-twentieth century. Social medicine became the basis for the increasing monitoring of women's emotions, physiology and social relationships. Women's role as *loco medicus*, encouraged through Plunket and later through health education initiatives gradually broadened. Women had, in the earlier years of the century, been encouraged to think of themselves as mothers and wives first, but were increasingly encouraged to think of themselves as problematic individuals in need of medical assistance. This was encouraged by biographical constructions which problematised menopause and other bodily experiences. Within this context, the medical profession began to broaden its approach to the control of women through the use of a range of hormonal and psychotropic medications. At the same time as women were increasingly subverting the narrowly defined social roles of wife and mother, social

medicine was emerging as a pervasive form of monitoring bodies in the community.

During the inter-war period the role in which women were primarily engaged was motherhood. However, they were also beginning to enter paid employment as typists and office workers, but until the Second World War most of this employment was as domestic servants. During the interwar years, married women who worked outside the home frequently encountered ambivalent and sometimes hostile attitudes. Despite the fact that increasing numbers of women were seeking paid labour, rigid gender role divisions were maintained and women were still expected to marry and be supported by their husbands. Paid employment for women was regarded as a threat to the male breadwinner role and a disruption of domestic harmony (Aitken, 1996). The Second World War provided New Zealand women with opportunities which had previously been denied them. Many became accustomed to coping without their husbands in a range of areas and some took up paid employment. Whilst both women and men expected that women would return to their previous roles when the war ended, erosions of barriers to married women's participation in the paid workforce had occurred (Coney, 1993a). Despite continuing opposition to women's employment there was a gradual proportional increase between 1926-1961 in the number of women in paid work and an increase in the proportion of married women working outside the home (Montgomerie, 1989:69). The subversion of women's social roles which employment represented was matched by their increasing tendency to control their fertility.

The Labour Government had based its welfare reforms on the understanding that women's true vocation was motherhood. Maternity benefits and family allowances encouraged women's reproductive role through support for the nuclear family (Brookes, 1991). Increasingly however it was obvious in the declining birth rate in the 1930s, that women were successfully controlling their fertility. They were achieving this through a variety of means including abortion. Intensive debates which had focused on pregnancy and childbirth increasingly began to centre around the control of women's fertility. Amid concerns for a declining population and that women were avoiding their biological and social duty, public anxieties intensified. The Labour government came under pressure particularly from the Obstetrical and Gynaecological Society to launch an inquiry into abortion. The Inquiry also stimulated

debate about contraception. Many members of the medical profession were against contraception, in line with the eugenic and pronatalist views of the time. Some doctors believed that contraception should be supplied to the 'lazy, idle, drunken and incompetent' whilst other members of the profession doubted whether the lower classes were intelligent enough to use contraceptives (Mein Smith, 1986; Washbourne, 1932:417). Many doctors were reluctant to accede to women's increasing demands for contraception and as Brookes (1991) suggests, left the field wide open for those who did not share their qualms. Many members of the medical profession were vocal in voicing their opposition to abortion and contraception. They justified their involvement in this matter on the basis of their concern for what they considered to be the imminent extermination of the white race. Women were criticised by the profession in these earlier years for having developed a somewhat nonchalant attitude to abortion and contraception:

From 1925 onwards they (women) accepted birth control as an essential part of civilisation, and began to order an abortion to clean up a trifling paternal or maternal carelessness as calmly as they would order a tube of toothpaste (Gordon, 1937:39).

Health education discourses continued in the 1940s and 50s to exhort women to act responsibly in relation to reproduction. In doing so the Department of Health confirmed the role of the medical profession in matters of reproduction and at the same time, recruited husbands to monitor their wives's compliance with doctors' orders. The Department placed advertisements in the *New Zealand Woman's Weekly* reminding women that it was their responsibility to keep appointments with their doctor for ante-natal care. Husbands were informed that they were responsible for seeing that their wives carried out the instructions of doctors (NZWW, 1947b). In a network of surveillance, the state, the medical profession and husbands continued to play a role in ensuring that women's bodies continued to be monitored in what was perceived to be their primary function.

As women began to vary their social roles beyond motherhood, warnings of their physical vulnerability began to be increasingly sounded in both the health and popular literature during the 1940s and 50s. Women were reminded in the *New Zealand*

Woman's Weekly for example, that not having children would be emotionally and physically damaging to them (McWilliams, 1947; Solan, 1957a;b).⁶ They were also warned that they ran the risk of suffering from a physical 'crash' if they were employed and at the same time kept house:

She may be earning a good weekly wage as an addition to that of a husband who is earning quite sufficient for family comfort. For the time being that is very useful-makes it easy to buy that snappy little model hat,...But weighed against this financial advantage is the demand, both physical and mental, involved in running a home and holding down a job. The home should be a home in more than name only, and therefore time and energy should be devoted to making it so (Ryan, 1953:4).

The authority of scientific medicine was invoked in these discourses to remind women that there were likely to be detrimental biological consequences if they extended their roles beyond home and family.

Against this background, the biographical approach of social medicine resulted in the medical problematisation of stages of women's lives. The amorphous failing of women's bodies which characterised the construction of femininity at the turn of the century gave way in mid-twentieth century notions of specific crisis points in women's lives. These crises continued to be linked to women's reproductive role but ceased to be so specifically linked with pregnancy and childbirth. Instead they centred on the ways in which women's bodies and emotions interacted. Hormones were considered to mediate these crisis points. Teenage girls began to be constructed as being preoccupied, confused and fearful about menstruation and sexuality (Mason, 1965). The problematic teenage girl began to emerge as a social problem which required medical management as did the menopausal and premenstrually tense woman. Paradoxically whilst health education discourses constructed women as the rational surveyors of health, the medical profession increasingly constructed women as socially and physiologically out of control.

⁶ See Chapter Eight for a discussion of the role of the popular media in the construction of women's embodiment.

The menopausal woman was particularly indicative of the mid-twentieth century 'out of control' woman. Menopause epitomised the convergence of social and curative medicine in medical discourses during the mid-twentieth century. Women's bodies were constructed as failing as a result of aging and in need of the 'cures' of hormonal medication. Menopause was also constructed as causing social failure in the form of disrupted relationships which warranted medical attention. Women's disturbed relationships with others indicated the need for psychotropic drugs which would cure disturbed minds and prevent social disruption particularly in the family. The problematisation of the menopausal woman centred around a cluster of symptoms which primarily reflected loss of emotional control:

The menopausal woman consumed with cancer fear, with impending nervousness or craziness, but most often with a basic dread of loss of femininity and sexual attractiveness as her body ages (Romano, 1965:192).

Irrational and unstable women were portrayed in the medical literature as fragile, childlike figures needing understanding and affection during the unsettling times which ageing brought (Davidge, 1961:13). The degree to which menopause caused mental instability was often judged in relation to how well women were able to maintain relationships with others:

Serenity in the menopause....The menopause is a normal milestone in life, yet it is often accompanied by emotional disturbances with increased tendency to irritability and to disturbed harmony with friends and family (NZMJ, 1957:xii).

The quality of the relationship a woman had with her husband was considered to be particularly indicative of the crisis of menopause:

Past History: A menopausal woman who suffered much-crying spells, loss of appetite, headache, insomnia, tension, disinterest and irritability. She complained that she was so depressed she couldn't do her work. What's more, she couldn't tolerate her husband. Treatment 25 mg. Aventyl t.i.d. (NZMJ, 1968:suppl).

The solution to the social problem created by the menopausal woman was

increasingly constructed as pharmaceutical:

Life began at 40 but she soon became a misfit. The reason, failing ovaries. The specific therapy, hormones, the complete therapy, oestrogens and androgens, the prescription, Mixogen (NZMJ, 1967a:62n).

Nineteenth century medicine had constructed menopause as causing disease, whereas these twentieth century discourses constructed menopause as a disease in itself (MacPherson, 1978). Numerous other diseases joined menopause in linking women's bodies with their emotional state. 'Sterility', 'abdominal' or 'pelvic pain', 'inability to achieve orgasm', 'habitual abortion' and 'uterine inertia' were also constructed as female illnesses in which psychological factors were involved (Pacey, 1943; Cushner, 1965:178). Psychotropic medications were frequently promoted in the medical literature as appropriate for conditions as diverse as peptic ulcer, schizophrenia, premenstrual tension, neurasthenia and anxiety (NZMJ, 1961a:29m), with women most frequently being the target population for these drugs.

Within a context of their problematic minds and bodies, women were encouraged to regard doctors as paternalistic figures who could be trusted with the most delicate of confidences or medical need. Women were advised by *Health* magazine to regard the doctor as an important point of call for the 'emotional disturbances of middle age', and in doing so to be 'frank, really frank with him or her about everything that's troubling you' (Huppert, 1962:11).

The problematisation of women's bodies which occurred between the 1930s and 1960s created a discourse of women as troubled and troublesome. Women were no longer medical subjects primarily as a result of motherhood, but as a result of their biography became life-long medical subjects. This served to bring all women within the gaze of medicine irrespective of their parity. Within a context of social medicine, doctors began to follow the lead of the Department of Health in increasingly shifting their focus towards the bodies of well women. Cervical cancer became an exemplar of this approach.

7. Cervical Cancer and the Monitoring of Asymptomatic Women.

By the mid 1930s, the cervix was constructed by the medical profession as an inherently diseased organ. Eighty per cent of all parous women were considered to have an unhealthy cervix (Stout, 1935). Calls were made by the medical profession for vigilant monitoring of the cervix and an increasingly interventionist approach to the cervix emerged:

May I make a plea finally to the profession to treat all infective conditions of the cervix as pre-cancerous, and for the next few years attack them resolutely, especially by the application of the cautery. We will then see whether we cannot reduce the incidence of an insidious and deadly disease (Stout, 1935:108).

The construction of the cervix as an unhealthy organ in the majority of parous women represented a view that most women were likely to be exposed to trauma during birth, serious enough to ultimately cause cervical cancer. The escalation in constructions of the danger and prevalence of the 'unhealthy cervix' increasingly led to beliefs that the cervix should be removed unless doctors were 'absolutely certain' that it was in a 'perfectly healthy condition' (ibid). Medical practitioners were urged to keep the possibility of the pathological cervix ever in mind:

This should serve to stimulate all who are concerned with the public health to measures which will bring more women to treatment in the early stages of the disease. The individual practitioner, who may encounter such a case only at long intervals, should bear the possibility of cancer ever in mind and must make adequate examination to confirm or exclude its presence (NZMJ, 1938:314).

By the 1940s, constructions of cervical cancer as arising out of pre-cancerous lesions which could be observed and monitored were well established in medical discourses (NZMJ, 1945). The inspection of the vagina, cytological smear tests and biopsy formed part of an increasingly complex, technical surveillance and interventionist approach to the cervix (Fisher, 1955).

By the 1950s cervical cancer was being constructed as a preventable cancer, which justified the taking of cervical smears from women in which there was no 'clinical

suspicion of cervical carcinoma' (Carey and Williams, 1958:229). Cervical cancer had moved out of the clinic, into the community and into the bodies of all women. In doing so it had left mothering bodies and potentially resided in the bodies of well women. It had joined menopause and other 'illnesses' as a symbol of women's 'out of control' bodies. Medical discourses began to emphasise 'early diagnosis' and the 'new therapeutic weapons' available to medicine were constructed as holding the promise of a cure for the disease (Harbutt, 1955:357). Asymptomatic women began to be given smear tests. National Women's Hospital implemented a policy of taking smear tests from all women over the age of thirty who were attending gynaecological and ante-natal clinics (Carey and Williams, 1958).

By the 1950s the cervix had further become a disembodied object of science. The pre-cancerous and cancerous cervix lost its associations with motherhood and became an object consisting of histological layers which were subject to aberrant morphological features. The cells of the cervix were the major focus of attention as cytological testing became the arbiter of the normal or abnormal cervix. In this context, the 'pre-clinical' cervix emerged. 'Pre-clinical' was a term used to describe cell changes which could lead on to *carcinoma in situ*. The 'pre-clinical' cervix was constructed as pathological enough to warrant medical attention but not yet 'clinically' pathological. This construction of cervical cancer justified the monitoring of asymptomatic women.

Cervical cancer had become a disease which all women potentially harboured in their bodies, the clinical practitioner surveyed, and the laboratory technician and pathologist confirmed. However, concerns began to be raised in the medical literature that cytological tests did not always provide the 'true' picture of the cervix' (Harbutt, 1955:358). Concerns were also expressed that cervical cytology had led to unnecessary total hysterectomies being performed on women on the basis of a positive smear and in the absence of a biopsy (NZMJ, 1967b). During the latter years of the twentieth century the 'truth' of the cervix became a contested area of medical knowledge.⁷

⁷ See Chapter Six for a discussion of the debates which emerged within the medical profession from the 1960s on in which the 'truth' of the cervix was contested.

As a result of constructions of cervical cancer as a preventable disease which had a pre-clinical state, the asymptomatic woman came increasingly to occupy the attention of the medical profession in New Zealand and other Western countries during the 1950s and 60s. Medical discourses began to advocate regular screening of all women irrespective of their status as mothers:

Evidence from the literature suggests that a cervical smear should be carried out routinely at least once every five years and preferably once every two years in every women between the ages of 30 and 70 (Carey and Williams, 1958:235).

Regular screening of asymptomatic women however, required gaining access to the bodies of well women. The initiatives of the Plunket Society had achieved considerable success in persuading 'asymptomatic' women to seek medical care when they were pregnant and mothering children. It was estimated that by 1949 for example, that 82% of New Zealand mothers voluntarily took advantage of Plunket services (Deem, 1949). Persuading well women to attend for cervical screening became the focus of medical initiatives in the 1960s and beyond. This was done within a context of raising women's anxiety about the vulnerability of their bodies to the point where they would voluntarily seek screening. This involved persuading women to adopt a new 'health habit'.

General practitioners saw themselves as central to cervical cancer screening initiatives and regarded this as an area of preventive medicine which had the potential to enhance their professional standing. They regarded the narrow focus of curative medicine as having disadvantaged them in the medical market place:

It is a universal cry that general practice has become debased. This is because the doctor's function has become too narrowly based on the curative aspects of medicine.

A successful integration of positive health in which cancer prevention might form a convenient lever, could be the transforming force for an upsurge in general practice (Robinson, 1965:163).

General practitioners were keenly aware that what they needed were 'a series of fortifications' of their 'status and work' (Robb, 1950:576). This was particularly so in relation to their colleagues the hospital based specialist. Specialists were perceived as having the political advantage and status of an institutional base from which to approach the general practitioner who usually working alone (NZMJ, 1954a:318). General practitioners were also concerned to more firmly establish a role for themselves in an environment of the growing influence of other professional groups in the health field. Psychologists, teachers, clergymen and others were perceived as encroaching on the occupational territory of general practice (Robb, 1950). Ancillary helpers to the medical profession were also perceived as having the potential to undermine doctors (Smirk, 1950). General practitioners were also keenly aware of the specific losses they had suffered in the control of medical work. Much of this was in relation to the bodies of women. The loss of midwifery to specialists was particularly lamented. State initiatives in relation to the Plunket system and the school health services were considered to have robbed them of a share of medical work which they could have gained if they had taken an interest in the well child in the early decades of the century (NZMJ, 1954a:322). Against this historical background, taking an interest in the well woman was likely to have been viewed by general practitioners as a high priority. Certainly cervical cancer was regarded as providing the opportunity for them to become involved in a form of heroic medicine which had all but disappeared:

Medical men are overjoyed at the prospect that cancer of the cervix may join those other forgotten diseases like smallpox, diphtheria (sic), and typhoid which one never, or hardly ever, sees nowadays (Health, 1962:7).

During the 1960s, general practitioners began to take action on cervical cancer by monitoring well women. A survey was initiated by the College of General Practitioners in which seventeen thousand 'cases' were screened for cervical cancer in the first year of study. The study involved women aged between 25-40 years. Opportunistic screening was carried out when women presented for post-natal checks. The aim of the survey was to 'promote routine cervical cytology for early detection of cervical cancer and to study the incidence of cervical carcinoma in New Zealand' (Marshall, 1962; Marshall, 1964:18; McIndoe, 1964). Marshall was

congratulated by the profession on running a vigorous and large-scale cervical smear campaign (Wright St Clair, 1989). Gaining the co-operation of the nursing profession as women and as nurses was part of this campaign within a context of heroic medicine:

Registered nurses can assist in the success of these campaigns by setting the example and attending the clinics themselves, and also by spreading propaganda by word of mouth encouraging other women to attend also. Your co-operation in this respect would be most valuable and through your efforts many lives will be saved (Baeyertz, 1962:17).

The medical profession urged its members during the screening campaign to become more 'cancer conscious' in their preventive role particularly in relation to women:

The second essential is a well informed and cancer conscious medical profession. The great weight and burden of cancer detection rests heavily on the shoulders of the general practitioners. By providing 20 minutes or half an hour of their time to listen, look and feel, and take a cervical smear in women, they can detect 80% of the cancers that are detectable. They also have the opportunity to select people for specialist survey which will lead to further detection and earlier diagnosis (Melville, 1965:200).

As general practitioners took the initiative in relation to cervical cancer, the Department of Health began to promulgate health education material which constructed cervical cancer as an issue of 'importance' to women (*Health*, 1960:14). This contrasted with earlier health education material which indicated to women that their risk of contracting the disease was small and that it was appropriate for them to exercise a level of discretion over attending for smear tests. In later years the discretionary element in these preventive discourses disappeared and women were more vociferously urged to present for screening.

Models of successful health education campaigns in relation to cervical cancer were already in existence overseas. In the United States during the 1960s a national public education strategy was initiated by the American Cancer Society with support

from gynaecologists, to convince asymptomatic women that they needed to visit a doctor for cervical cancer screening at regular intervals. The mass media was engaged and *Life* and *Time* were used to educate the public on uterine cancer and medical prevention and treatment techniques. The term 'uterine cancer' was considered to be more easily understood by women than 'cervix' and 'Pap' smear or 'Pap' test more understandable than 'cytological examination'. Copywriters and advertising agencies were canvassed to check that the term 'Pap smear' was not offensive to women. Women's clubs, magazines and radio and television were also enlisted to raise awareness of what was constructed as a preventable disease. Women were encouraged to regard the 'Pap' test as a simple, quick and painless procedure. The cost of the test was equated with that of a hair do or manicure. Women were recruited to encourage other women to present for screening:

One theme has been the use of persons who themselves have had cancer detected by cytology, have been treated, and are now well and happy. Brief speeches-testimonials in fact-by women who have been cured and are in good health are very effective (Read, 1965:87).

Doctors were also urged in the United States, at conferences and through the medical literature, to acknowledge the value of cytology and cervical screening. The American medical literature in particular constructed cervical cancer as being at the point of having its 'epitaph' written as medical science stood on the brink of eliminating the disease (Lund, 1961). This public health campaign was judged in the United States by 1965 to have been a success in persuading women to acquire a new 'health habit':

Progress has been made, and all of us-particularly, gynaecologists, pathologists and cytologists-can feel pride in accomplishment, but we must reach the more than 30 million women who have never had a Pap test, and we must go back to those who should have it again. A new health habit had been formed in the United States by many millions of women-this has taken time, energy, personnel and money (Read, 1965:95).

The campaign in New Zealand was not as extensive or sophisticated as that carried

out in the United States. However, messages to women to have a smear test eventually lost the equivocation of earlier years and became more authoritative. In 1962, every women over the age of thirty in New Zealand was urged to have a smear test. Cervical cancer was constructed as a problem of such magnitude that a mass campaign needed to be initiated. The possibility of a 'mass search' for cervical cancer was likened in importance to the campaign of mass X-ray to detect tuberculosis (*Health*, 1962). Constructions of the rational individual which had characterised health education discourses since the 1940s were applied to cervical cancer. Women were increasingly presented with statistical data which stressed the dangers of the disease. Sometimes these discourses personalised cervical cancer with suggestions that in a 'town' like Dunedin, thirty women in every hundred thousand per year would develop cervical cancer (op. cit:7). Contradictory discourses emerged in relation to cervical cancer. Whilst women were encouraged to voluntarily attend for cervical screening, the medical profession followed a course of regulation and management of women to ensure that they had smear tests. The voluntarism implied by the health education discourses was in fact overlayed by medical paternalism and coercion. This pattern in relation to cervical cancer has remained unchanged throughout the twentieth century.

Much of the enthusiasm for cervical screening which developed during the 1950s and 60s emerged from National Women's Hospital and from Professor Carey who took up a chair in 1954. National Women's Hospital was at this time gaining significant cultural authority as an institution focusing on the care of women. Carey was highly enthusiastic about cervical screening and made exaggerated claims in the *New Zealand Woman's Weekly*, that Pap smears could save five lives for every smear taken (Bunkle, 1988). Carey's almost evangelical approach caught the imagination of general practitioners. The Wanganui cervical smear campaign set up by them resulted in a level of response from women that surprised even its organisers (*Health*, 1963).

By the late 1960s enthusiasm for cervical screening was however beginning to wane. The screening initiatives begun by the College of General Practitioners ended because of lack of interest from the profession. The medical literature was increasingly reflecting a more conservative and equivocal view of cervical screening

and in doing so, challenged beliefs that pre-invasive lesions of the cervix went on to invasive carcinoma (Green, 1966;1969;1972). Professor Green who had joined the cancer team at the influential National Women's Hospital had considerable influence in promoting these more conservative ideas. Green's views on women's bodies harked back to the pronatalist beliefs of earlier decades. He regarded women's fertility as their most precious asset and opted for conservative treatment of cervical cancer rather than radical solutions such as hysterectomies which would compromise fertility. Green was also against abortion and sterilization. His opposition to routine cervical screening began to permeate the medical profession (Bunkle, 1988). This occurred partly as a result of his personal and professional influence but also as a result of the training of doctors in this more conservative approach. Whilst there was some resistance to the stance taken by Green and his colleagues, under his influence, the promise of the preventive ideal that cervical screening appeared to represent, dissipated. For general practitioner's the power that they most resented in the 'specialist class' of the profession was eventually instrumental in thwarting their attempts to gain a foothold in what was perceived to be the prestigious place of preventing disease through the application of clinical methods such as cervical screening. Paradoxically, the medical regulation and monitoring of women's fertility had at this time, the unintended consequence of thwarting the medical monitoring of the cervix.

The preventive ideal which cervical cancer represented was to emerge again in later years, but before this occurred the focus of medicine became redirected towards discovering the aetiology of the disease. Cervical cancer no longer linked in the medical imagination with motherhood became linked with women's sexuality as the medical gaze sets its focus on the sexual bodies of New Zealand women. Cervical cancer accompanied women out of the home, into the community, with the medical gaze eventually focussing on the sexual bodies of New Zealand women.

8. Conclusion

Mid-twentieth century constructions and approaches to cervical cancer in New Zealand are reflective of a complex interplay of socio-political circumstances. Constructions of cervical cancer during this period are more reflective of oppositional strategies and social and professional issues than of scientific rationality. This is

exemplified by general practitioner's attempts to claim expertise in social medicine in opposition to what they perceived to be the unwarranted prestige of specialists. It is also exemplified by their attempt to undo some of the secularising influence of state interference in medicine by claiming the niche provided by cervical screening. The state maintained a high public profile in medicine through social security and through the promulgation of health education discourses. The state was seen to be active in promoting the health of the population and at the same time reinforced the ideal of the family on which its welfare policy was based. In doing so it responded to the social anxieties which accompanied women's increasing employment outside the home. Women continued to be constructed as carers of children and health education discourses in both the medical and popular media reminded them of the dangers of subverting this role. At the same time, health education discourses constructed women as rational monitors of health who would intelligently and diligently carry out the monitoring of family bodies. Most importantly, both the state and the medical profession constructed subjective and individualistic bodies which had needs which medicine could meet.

The medical profession reflected the social anxieties surrounding women during this period. New subjectivities emerged from a biographical approach to bodies which constructed women as predictably ill throughout specific periods of their lives. Fundamental to medical discourses in the mid-twentieth century was a view of women as being 'out of control' because of their physiology. This medical metaphor reflected anxieties that women's were socially out of control as they expanded their horizons beyond home and family. The imposition of medical power on women during this period took the form of medications, especially psychopharmacological and hormone drugs in an attempt to control recalcitrant minds and bodies.

Discourses in relation to cervical cancer, whilst motivated by a preventive rather than a curative perspective, can be viewed also as medical power operating on women's bodies. Women were encouraged to reconstruct their bodies as harbouring a potentially deadly disease and to acquire a new health habit as rational and responsible individuals. Discourses of rationality were particularly important in reconstructing the cervix as a medical object rather than a part of women's sexual anatomy linked with concerns of sexual modesty. These discourses contributed to

an acceptance by women that this part of their anatomy should be subjected to the rational processes of regular medical examination. Part of accepting this new subjectivity was to invite an increasingly technically invasive approach to the care of their bodies. Smear tests, colposcopy, biopsy and for many hysterectomy, were the outcomes of the acquisition of the new health habit advocated by the state and the medical profession. The productive nature of this power was the prevention of cervical cancer in some women. The repressive nature of it was reflected in anxiety, unnecessary smear tests, biopsies, radiation and radical surgery.

The discourses of the preventive ideal provided the medical profession with the rationale to begin to survey the bodies of large numbers of healthy New Zealand women. This medical surveillance of women's bodies provided general practitioners with access to women as patients irrespective of their childbearing status. An increasing number of other medical professionals also became involved in the monitoring of women's bodies. These included cytologists, colposcopists, surgeons and radiotherapists. Epidemiological studies of women in relation to cervical cancer further extended the medical gaze into an ever widening range of women's experiences and attempted to link social and demographic factors with the disease. These eventually focused on women's sexuality also. Within a context of women's increasing social freedom, medicine became a means for the surveillance of the biographical bodies of women.

Histories of medicine often construct a linear, progressive model of the treatment of disease. The historical period of the mid-twentieth century, exemplifies the social location of medicine and the discontinuities which pervade medical practice. Constructions of cervical cancer and approaches to the disease had much to do with gender and professional struggles. Medical events surrounding cervical cancer during this period can be described as being more linked with socio-political events than with science.

CHAPTER FIVE

Sexing and Desexing the Cervix.

1. Introduction

During the later years of the twentieth century the cervix became the focus for new knowledge claims centred around the aetiology of cervical cancer. These knowledge claims linked women's sexuality with pathological changes in the cervix and the eventual development of cervical cancer. This chapter examines the ways in which the cervix became sexually inscribed. It also traces the ways in which moral constructions of cervical cancer were eventually largely eclipsed by technical explanations of the disease. As a moral problem cervical cancer became associated with sexual promiscuity in women. As a technical problem, cervical cancer was constructed as a failure of nature. It is argued here that the difference in emphasis given to these two constructions of cervical cancer reflect changes in practices of power around the bodies of women. As a moral problem, cervical cancer invited solutions of punishment and exclusion which contradicted the objectives of medicine to invite and encourage women into the clinic. The construction of cervical cancer as primarily a technical problem however, provided the impetus and the imperative for information to be gathered about the phenomenon in an analytical and rational manner. Morally neutral, technical discourses implied medical care as opposed to medical moralising. The former encouraged women to be receptive to medical attention and the latter discouraged it.

Medical theories of cervical cancer in the mid and late twentieth century reflected a number of themes which had typified the practice of medicine since the nineteenth century. The 'viral' theory of cervical cancer like the germ theory situated illness within individual bodies. Whilst contagion had been a preoccupation of the state and the medical profession in relation to 'germ' diseases such as tuberculosis and venereal disease this was not the case with cervical cancer. Although cervical cancer was considered to be a sexually transmitted disease, medical attention was focused more on prevention by surveying the cervixes of women and controlling their sexual behaviour rather than locating the sources of contagion. Whilst medical discourses have suggested that there may be a 'male factor' in cervical cancer, there has been little attempt to follow this up with surveillance and prevention programmes for men.

The viral theory of cervical cancer was instead embedded in the increasingly popular 'lifestyle' theory of illness which suggested that healthy bodies depended upon healthy behaviours. Cervical cancer epitomised a breakdown not only in the body's defence against disease but in the moral foundations of women's lifestyles. Cervical cancer became the outward symbol of women's morally reprehensible behaviours.

Social medicine had provided the medical profession with the cultural authority to become involved in an ever widening range of areas of social life in the later years of the twentieth century. Governing of the body was increasingly augmented with what Rose (1990b) describes as the governing of the soul in order to shape the private self. Associating cervical cancer with promiscuity created a marginalised subjectivity which made governing of women's souls and their bodies problematic. Medicine could achieve its objectives of bringing women to the clinic, not through reprobation but through persuasion of its 'truths', the anxieties stimulated by its norms and the attraction of the self that it offered (op. cit:10). The medically constructed 'promiscuous' woman was unlikely to seek assistance from professionals who perpetuated a stigmatised status.

Constructed as a technical problem however, cervical cancer invited medical expertise of a different kind. Women, with what were considered to be precancerous conditions needed to be mapped in detail in order to locate the technically failing cervix. In time, the bodies of all women were regarded as requiring this surveillance in order to locate those who did not present for cervical screening because of anxieties, cultural sensitivities or ignorance. Women began to be invited into the medical encounter on the basis of a social contract which limited the problematisation of their sexuality. In doing so, they exposed their bodies to an unprecedented level of monitoring. Under these circumstances, the cervix had become much more than a gateway to the uterus but had become a gateway to the 'self'.

Part Two of this chapter locates cervical cancer within discourses of sexuality and viral theory leading on to **Part Three** which shows that medical adherence to the lifestyle theory of illness began to construct women as culpable in relation to cancer of the cervix. **Part Four** links medical discourses in relation to cervical cancer with social anxieties about 'problematic women' in the post World War II changes in

gender roles in New Zealand. **Part Five** analyses the change from moral to technical constructions of cervical cancer as indicative of a transformation in the practices of medical power. **Part Six** shows the cervix becoming reembodyed in the subjective woman as it lost its promiscuous history and **Part Seven** concludes the chapter by locating the sexing and desexing of the cervix within a context of the increasing surveillance of the subjective, idiosyncratic woman.

2. Cervical Cancer as a Sexually Transmitted Disease.

During the 1960s cervical cancer began to be understood and known by the medical profession as a pathological condition of the cervix which women acquired through sexual intercourse. The overseas medical literature reported that positive cervical smear tests were being found in teenage girls. These findings quickly provided a basis for the profession to contend that girls should be exposed to smear testing as soon as practicable:

A description of the findings of 77 girls who were less than 20 years of age when they were first discovered to have a positive cancer smear should support the contention that no age limit can be imposed on the application of this cancer screening method: if a girl is old enough to have a vaginal examination she is old enough to have a cervical cytologic examination (Ferguson, 1961:365).

The cervix of the adolescent girl was described as being particularly susceptible to the 'male ejaculate' and the 'unsanitary male organ', which after a latency period, could lead to cervical cancer. It was however the cervix and not male reproductive organs which was considered to need monitoring. A mathematical equation to determine the biological age as opposed to the chronological age of the cervix of a teenage girl was developed in the United States in an effort to link sexual activity to cervical status. The equation consisted of, 'biologic' age of the cervix = age of girl + K(f), (number of years of active sex life prior to age 20) (Friedell, 1966, cited by Fields, 1976:731). The technical links which the medical profession made between sexual intercourse and cervical cancer were translated into medico-moral prescriptions on appropriate sexual behaviour for young women:

There is enough material in recent literature to caution young women against

sexual intercourse at early ages. These several studies are concerned with causation of cancer of the uterine cervix, and results are all in the same direction (Rotkin, 1962:486).

At times, these prescriptions were overtly reflective of social anxieties about young women's perceived immorality:

...it may be suggested that all young girls who are attending obstetrics-gynecology clinics or any other health care centers should be screened for carcinoma of the cervix. This message should also be conveyed to the public, especially the teenage population of any "permissive society" (Sadeghi et al, 1983:729).

Medical discourses highlighted a moral dualism in relation to women's likelihood of contracting cervical cancer reminiscent of the 'madonna-whore' constructions prevalent in historical and literary accounts of women (O'Faolain and Martines, 1979). The disease was thought to be prevalent in prostitutes and rare in nuns, drawing attention to the medical consequences of lack of virtue in women (Jeffcoate, 1967; Keighley, 1968; Rotkin, 1962). Jewish women continued to be considered relatively immune to cervical cancer but this was thought to be as a result of having circumcised partners and the avoidance of contact with male smegma (Gusberg and Frick, 1970). Whilst the 'male factor' was sometimes discussed in medical accounts of cervical cancer of the time, the prominent focus of these discourses was on women's sexuality. This is exemplified by a paper in *Lancet* titled 'The Importance of the Male Factor in Cancer of the Cervix' which had as its opening statement that, 'a woman's sexual behaviour is a major determinant of her risk of cervical cancer' (Skegg et al, 1982:581).

Increasingly in the 1970s, cervical cancer left the sexual bodies of young women and began to inhabit the sexual bodies of all women. Epidemiological accounts began to locate positive smears in sexually active women who also shared other social attributes linked with their socioeconomic status and their relationships with men. These included factors such as, 'marriage, a broken marriage, multiple marriages, extra marital sexual activity, premarital sexual activity, early age of first marriage, early age of first intercourse, illegitimacy, multiple sexual partners of the women and

her husband, history of prostitution, history of syphilis, low socioeconomic status and urban residence' (Beral, 1974:1037). As these categories suggest, cervical cancer was constructed as prevalent not only in sexually promiscuous women but in women who were violating social norms in other ways also.

Along with their overseas counterparts New Zealand doctors also began to locate cervical cancer in young, sexually active women. Not all members of the profession agreed with the association of cervical cancer with sexual promiscuity however. George Green from National Women's Hospital argued that scientific evidence did not sufficiently support such a link:

Since it is known that cervical cancer is associated with early age of onset and frequency of sexual intercourse the most obvious explanation of the increased mortality from cervical cancer is the alleged increase in promiscuity in the last 15 years or so among young women. Quite apart from the disservice this explanation does to many patients, for lack of hard data on past and present rates of promiscuity (but no lack of unsupported assertions) it is almost as difficult to establish as refute (Green, 1979:91).

Groups of New Zealand women began to be identified as being particularly likely to have positive smears and eventually to develop cervical cancer. These included Maori women, hospital inpatients, women from low socio-economic groups, and those with promiscuous or juvenile sexual histories (Duncan, 1981:122). The identification of 'high risk' women led to suggestions that these groups should be singled out for cervical screening. An example of this, was the recommendation by members of the medical profession, that all women being admitted to hospital for any reason should have a cervical smear test as part of normal admission procedures (Duncan and Parker, 1981). Eventually the connection between cervical cancer and sexuality became so strongly linked in the medical imagination, that abnormal smear results in teenagers began to be regarded as evidence of early onset of sexual activity (Chang, 1985). The cervix had become sexually inscribed and carried not only a narrative of pathology but also a narrative of sexual promiscuity.

Medical research began to focus on finding a 'venereally transmissible oncogenic

agent' (Kessler, 1974; Rotkin, 1973). This research centred on the herpes virus type 2 with one American study basing its epidemiological studies around a profile of a typical marginalised young woman who was presented as the archetype of the at risk individual:

She was born in deprivation and exists in a low socio-economic stratum. There is a high likelihood that she is Spanish, black, Puerto Rican, or East Indian in the United States or elsewhere, but the prospect also is high that she is white if poor and uneducated. The cultural commonality is a low socioeconomic status, but women from higher stations in life are not excluded. She is exposed at an early age to male sexual aggressiveness as an environmental hazard. Although she is too young to be highly arousable, early sexuality is a folkway solution for companionship and an antidote for loneliness. Onset of coitus is during adolescence or earlier. Intromission sets up risk of cervical cancer. Exposure to a plurality of sexual consorts, each with a discrete probability of conveying a carcinogenic influence to her, increases the risk (Rotkin, 1972, cited by Rotkin, 1973:1355).

The herpes virus theory was eventually overtaken by beliefs that the human papilloma virus (HPV) caused cervical cancer. Both viruses were considered to be sexually transmitted (Chang, 1986). During the early 1990s the HPV lost its explanatory power as an isolated causative agent of cervical cancer and was replaced with a new theory in which the virus was viewed as interacting with 'cofactors' such as smoking and the use of oral contraceptives (Pfister and Kleiner, 1991:104). The Epstein-Barr virus was also later added to the list of sexually transmitted viruses which caused cervical cancer (Ida et al, 1991). The viral, sexually transmitted theory of cervical cancer has undergone a range of modifications but continues to be the most widely supported explanation of cervical cancer. This theory of the disease succeeded in linking a number of social anxieties and medical themes. These included, the infectious potential of the unseen microscopic world, the danger of women's promiscuous sexuality and the need for socially responsible individual behaviour in relation to health matters. The viral theory of cervical cancer constructed the disease in individualistic terms. As Tesh (1988) suggests, this view of illness generally focuses attention on technical, medical solutions aimed at a microscopic

cellular level rather than at the social and political causes of disease. Sexually transmitted viruses however have frequently been constructed as biological problems which have both technical and moral solutions. Viral theory may appear on the face of it to construct illness as a random, morally neutral and impersonal event but this is often not the case. Microorganisms which are considered to be sexually transmitted have historically resulted in the intensification of medical focus on the individual, their gender and their sexuality, often within a context of moral retribution and culpability.

The 'multifactorial' approach to cervical cancer which has become increasingly popular grew out of the tenets of social medicine. Cervical cancer became a disease which woman's sexuality, social and physical environment could at least partially explain. As a result, the 'whole' woman and not just the cervix has increasingly come under the surveillance of the epidemiological as well as the clinical gaze. The cervix has moved beyond being an organ of purely histologically interest and has become an organ of social and moral interest to the medical profession. Discovering the 'truth' of the cervix has opened up a range of disciplinary technologies which include encouraging and in many instances requiring women to talk about their personal behaviours. Some medical professionals began to have the expectation that their role in relation to cervical cancer included inquiring into areas of women's lives which were previously considered to be private and even irrelevant to medicine. Personal information came to be reclassified as clinical data:

A professional nurse who is familiar with the epidemiologic information concerning cervical cancer may be able to gather data concerning the patient's family, medical, social, and reproductive histories that may have been missed by others in the health care setting. The nurse providing health care to women should obtain a sexual history that includes, but is not limited to, age at first coitus, number of partners, exposure to STDs, and smoking history, including exposure to passive smoking (Yoder and Rubin, 1992:492).

This incitement to discourse which the clinical interview represented, enabled the medical profession to define the ways in which women should live their lives. This occurred within the context of the medically laudable objective, of safe-guarding the

health of the cervix. In doing so women were reminded that they were responsible for avoiding cervical cancer and were culpable if they did not.

3. Cervical Cancer as Personal Responsibility.

The collective term which best describes medical beliefs about the causes of cervical cancer in the late twentieth century is the 'lifestyle' theory of disease. Whilst cancer of the cervix was considered to be viral in origin, transmission and susceptibility to the disease were considered to be mediated by women's lifestyles. The lifestyle theory constructs disease as an individual, personal event over which the individual has a measure of control (Tesh, 1988). This theory prevalent in the mid to late twentieth century has encouraged what Crawford (1980;1987;1990), terms 'healthism'; a state where health is elevated to an important personal responsibility and life goal. Essential to this form of health consciousness is the inculcation of a sense of somatic vulnerability coupled with values of rationality and self-control. The 'moralization' of health behaviour as Crawford (1987:99) describes it, has become the normative and common sense basis for responsible body management in the latter half of the twentieth century. Medical discourses have been influential in promoting the 'lifestyle' theory of illness sometimes with distinctly moralistic overtones:

Everyone has a God-installed conscience that can help each to make right, health-giving decisions.

Today, in a permissive society, thinking men and women are becoming more conscious of the need to find the solution to the way we live. This is an individual responsibility we cannot morally or medically shirk (Harvie, 1977:574-575).

At the same time as health has been constructed in terms of personal responsibility, new subjectivities have also been constructed which have deemed some individuals virtuous whilst at the same time problematising others. In some instances, ill health has become a symbol of deviance, dysfunction and immorality:

...as we are increasingly defined as deviant (potentially sick) in our everyday behaviours, attitudes and feelings, we come to see ourselves as lacking. Not only do we experience the insecurity of imagined, future illness, the anxiety of

worrisome prognosis, but also the insecurity of the deviant, the anxiety of not fitting in (Crawford, 1980:382).

The lifestyle approach and its not infrequently 'victim blaming' discourses locate the responsibility for illness in a moral sense in the individual whilst at the same time transferring the financial costs of illness to the individual (Laurie, 1989; Tesh, 1988). For Crawford (1987), the economic consequences of the lifestyle theory of illness for the individual represents a conscious, pragmatic, structural solution to the escalating medical care costs apparent since the 1970s in Western countries. During the period of rapid expansion of health care in the early years of the twentieth century, regulation of the body involved seeking health care and complying with medical authority. Whilst these behaviours are still constructed as important to the preservation of health, a complex range of edicts on how to live a healthy life have increasingly been added. Crawford (1990:387) shows however, the paradoxical nature of these prescriptions for health. In earlier years the poor have been blamed for delaying or not seeking medical care and for resisting medical authority. More recently in times of greater fiscal restraint, the poor have been criticised for relying on medical services and not on their own personal resources.

Implicit in the lifestyle model of illness is the assumption that the individual has control over factors which medical discourses promote as unhealthy. In reality many of the prescriptions for healthy living involve a level of discretionary income which is unavailable to those for whom they are advocated. Such prescriptions are often translated by the middle class into patterns of consumption and behaviours that signify good education and sensible habits and as such have become symbols of middle class identification and upward mobility (Tesh, 1988). For others these behaviours are simply unaffordable. The lifestyle theory of illness has however served to give individuals a sense of control over their bodies at a time when unemployment, environmental pollution and nuclear threat have emphasised loss of social control. Gaining personal health through the discipline of exercise, dieting or attending for screening for those who can afford the time and money, has become comforting in discomfoting times with the body becoming a metaphor for the disciplining of unruly nature (Crawford, 1987; Tesh, 1988). These changes have also occurred at a time when medicine appears helpless in the face of chronic illnesses

such as some forms of cancer and cardiovascular disease.

The lifestyle model of illness has been underpinned by a diversionary form of politics in which the environmental and occupational causes of illness have been ignored in favour of changing individual behaviours (Crawford, 1990; Tesh, 1988). When illness became the province of the lazy, ignorant, promiscuous or genetically compromised, solutions began to be found in the monitoring and regulation of bodies and their social environment. Discourses of social medicine have constructed the lifestyle of the individual and their social milieu as the appropriate focus for medical inquiry. The exercising of medical power on individual bodies on this basis has resulted in a 'taxonomy' of bodies to be surveyed, often based on class, race and gender determinations.

The emergence of cervical cancer as a lifestyle disease has primarily focused on women's sexual lifestyles. Medical and popular discourses have made it clear to women that sexual restraint in the form of avoiding intercourse at an early age as well as avoiding sex with multiple partners will reduce their chances of dying from the disease. Healthy habits, such as attending for cervical screening, have been constructed as the expected rational behaviour of an intelligent responsible woman. What women were 'permitted' to do, (which was a feature of nineteenth and early twentieth century medical discourses), has been replaced with what women should 'choose' to do in terms of responsible body management (Ehrenreich and English, 1990:283). The construction of cervical cancer as a disease of excess echoes discourses which link many chronic diseases with excesses associated with affluence such as smoking and alcohol consumption (Knowles, 1990). Situating cervical cancer within a framework of excess has drawn attention to women's sexuality rather than the social inequalities which could contribute to women contracting the illness:

...even though some may complain about environmental hazards, people are really suffering from over-indulgence of the good society; it is over indulgence that must be checked. Further by pointing to lifestyles, which are usually presented as if they reflect the problems of homogenized, affluent society, this aspect of the ideology tends to obscure the reality of class and the impact of social inequality of health (Crawford, 1990:392).

As a disease associated with women's perceived sexual excesses, cervical cancer became an important metaphor in reflecting anxieties about changes in women's status in the second half of the twentieth century. These anxieties centred around women's sexuality and gender relations and have found their expression in pervasive forms of power which monitor women's bodies. Popular and medical discourses have constructed subjectivities around cervical cancer which have provided women with a language and identity in which to interpret their experience of the cervix. As a metaphor for social anxiety, the significance of cervical cancer like AIDS and venereal diseases has not been limited to an innocuous 'linguistic construction' but has had important sociopolitical repercussions (Brandt, 1988:422). Medical screening has emerged as a popular and acceptable technical solution to many illnesses including those which are considered to emerge out of the ignorance, recalcitrance or promiscuity of the individual patient. Screening discourses target subjects to be surveyed and sometimes result in exclusionary practices in relation to employment and the allocation of medical care (Crawford, 1990; Draper, 1991). In New Zealand, cervical screening has become a metaphor for progressive health care. Women have become screening subjects who now interpret the cervix in terms of the language of the clinic.

Darby (1992:25) suggests that there have been political repercussions from medical constructions of cervical cancer. She argues that medical views of the disease have arisen out of what she terms a 'misogynist' medical model. She suggests that there has been a pervasive suggestion that women bring cervical cancer on themselves by violating norms of sexual conduct. The disease she claims has become a 'badge of shame', with the implication that if women altered their lifestyles and were more sexually moral they would remain healthy. At the same time, women have had to live with medical prescriptions in relation to cervical cancer which have been imbued with the contradictory dualism of responsibility and uncertainty. Women have been told that their chances of contracting cervical cancer is intimately connected with their lifestyles without an acknowledgement of the impossibility of their being able to consistently control all the factors which may lead to the disease. As Graham (1979) suggests, the responsibility/uncertainty contradiction has historically permeated medical advice to women on disease prevention.

The location of cervical cancer within a model which focused on women's sexual lifestyles, reflected anxieties about the significant changes which were occurring in women's social roles in the mid to late twentieth century. The 'out of control' woman of the mid-twentieth century who was increasingly expanding her horizons outside the home, was in the late twentieth century even further subverting the prescriptions of a gendered society by claiming an unprecedented level of social and sexual freedom.

4. Problematic Women.

The cult of domesticity which had structured women's family functions before the Second World War and continued to do so in the 1950s increasingly gave way to the expansion of personal choice for women in the 1960s. Greater numbers of women began to seek employment outside the home. Child rearing became part of a woman's life rather than its total focus (Olssen and Levesque, 1978). Increasing numbers of women began to give birth to children out of wedlock. The number of exnuptial births doubled during the 1960s and by the early 1970s, one out of every eight babies was born out of wedlock (Kedgley, 1996:272). Women began to challenge norms of femininity in a range of areas including motherhood. This was reflected in changes in attitudes towards breastfeeding for example. Many women began abandoning breast feeding with only approximately 30 per cent of mothers continuing to do so in the early 1960s (Rutherford, 1963). One of the most significant changes which occurred was the increasing incidence of sexual intercourse outside the confines of marriage and the increasing use of a range of methods of fertility control which included the contraceptive pill. In 1979 it was estimated that two thirds of New Zealand women who considered themselves at risk of pregnancy practised some form of birth control (Kirkwood et al, 1979). These changes resulted in a range of social responses to women's increasingly vociferous claims to greater control over areas of their lives. The medical profession as it had historically done, played an important part in defining 'problematic' women and prescribing appropriate responses to them.

During the second half of the twentieth century new discursive categories began to emerge to describe women who were constructed as being morally problematic. Along with these categories, discourses developed which prescribed appropriate management of troublesome women with medicine being viewed as having the

authority, knowledge and expertise to be at the forefront of this process. It was young women in New Zealand who were regarded as being especially out of control particularly in relation to sexuality and motherhood. The 'adolescent mother' for instance became a highly visible symbol of the rising illegitimacy rate which was perceived to be a serious social problem for New Zealand (Mason, 1965:22). The medical profession was vocal in voicing its concerns about illegitimacy. Its role in social medicine was by the 1960s firmly established and the voice of the profession on social issues carried significant cultural authority. By the 1960s, doctors were active in attempting to mobilise public concern about unwed mothers:

...there is the problem of illegitimacy: I think I am right in saying New Zealand's figures are unexceeded by any other white country in the world, and the curve is still rising. There is surprisingly little concern about this trend with often disastrous implications (Platts, 1969:11).

Illegitimacy and its cause 'promiscuity' were largely constructed as problems associated with deviant women many of whom were considered to have come from unhappy home environments (Popenoe, 1960:39). Not infrequently medical discourses linked race and class with promiscuity and illegitimacy as statistics on 'exnuptual' births began to be increasingly collated and published (Mason, 1965). For some members of the medical profession, the adolescent mother began to acquire a subjectivity which described an individual with a flagrant disregard for the norms of middle class New Zealand. Her working class identity, promiscuous lifestyle and somewhat vagrant tendencies painted a picture of uncontrollability and marginal status:

If some of the far-out educationalists could see as we doctors do the tragic results of the series of depersonalized sexual exploits in which adolescents of the lower social economic strata become involved, i.e. their version of the meaningful relationship approach, they might moderate their views.

Many young girls from poorer homes are very difficult to reach by propaganda, they read little and often drift about the country taking different jobs and living in flats (Platts, 1969:11-12).

Concerns about adolescent sexuality had begun to surface in the 1950s and found very public expression in the Mazengarb Inquiry of 1954. This Inquiry was in response to what Coney (1993a:174) describes as a 'moral panic' which disrupted the comfort of the 'insular Victorianism of New Zealand adult life'. Concern about the sexual behaviour of teenagers in the Hutt Valley became the focus for these social anxieties underpinned by issues of gender and sexuality which primarily centred around young women and their mothers. Women working outside the home were considered to be contributing to unacceptable teenage behaviour as were the availability of contraceptives and the corrupting influence of the popular media. Female teenagers became the particular focus of the Mazengarb Inquiry. They were constructed as ignorant of reproductive matters, morally lax, sexually predatory and primarily to blame for the sexual immorality which the Inquiry had been established to investigate. The Mazengarb report suggested that girls who allowed males to be sexually intimate with them ought to be charged with a crime and it condemned the availability of contraceptives for adolescents. The former recommendation was not put into practice but the latter was enacted and contraceptives and contraceptive information became illegal in 1954 for those under sixteen years of age (Ibid). Attitudes towards contraception in the 1970s, placed young women in an impossible social position. Those who avoided pregnancy through contraception were described in the popular media as 'hard' types and those who did not use contraception and became pregnant were labelled by the more sympathetic and yet moralistic epithet of 'girls in trouble' (Owen, 1970:16).

The medical profession was at the forefront of determining the causes and solutions for promiscuity and illegitimacy. Medical discourses found the causes of lax sexual mores in a range of individual, social and political areas, but it was the control of women's sexuality which became the focus of medical attention. Some doctors saw the response of the government however as actively encouraging women to have illegitimate children and advocated instead a more punitive stance:

Everything is made as easy as possible for these young mothers, even to organizations which arrange for their accommodation and delivery in a distant city, or the country to avoid the stigma of detection. The state casts a benevolent eye

over the scene (Platts, 1969:11).

Social security and a too benevolent welfarism were considered by doctors to aid and abet illegitimacy:

Does our Social Security system actually encourage illegitimacy? Every unmarried mother has of right free medical and hospital care and Social Security sickness benefit for 12 weeks prior to delivery and, as she needs it, after delivery. Does this tend to make it all too easy? (Mason, 1965:23).

The medical profession began to suggest solutions to the problem of teenage pregnancy, some of which were distinctly punitive. Mason (1965:24) suggested for instance, that all girls under sixteen who became pregnant should be placed under probation to the Child Welfare Division. The 'social menace' which the single mother represented was however partially dealt with by the social pressure to hide her pregnancy and to have her child adopted. This solution was in part a punishment for the already stigmatised and often isolated mother and was also considered to be the best solution for the child. Stranger adoption was imposed on both Maori and Pakeha women by the 1955 Adoption Act (Coney, 1993a:78). There were however more progressive members of the medical profession who considered that assisting women to control their fertility was a preferred option to punishing those who did not:

Further until one year ago, the official position of the largest medical association in New Zealand was, that it was unethical for doctors to prescribe contraceptives to any single person not about to be married. The only possible interpretation of these curious attitudes is that premarital sexual activity is illicit and should be punished by pregnancy (Werry et al, 1974:853).

For those members of the profession who did not advocate a punitive approach to sexually active young women, sexual experimentation was constructed as a response to a natural, biological drive in circumstances of ample opportunity. Such a construction placed the medical profession in the role of 'friends and helpers' in providing education around sexual physiology and contraception (op. cit:857). By 1977, many members of the medical profession had accepted that sexual medicine

and particularly providing women with access to contraceptives was an area that doctors should be involved in, although there continued to be some degree of ambivalence about this involvement:

The prevention of conception is now embedded in our culture and so-called "sexual medicine" is as much part of medicine as the common cold...we will have to come to terms with it because this what the community expects (NZMJ, 1977:429).

Not only were doctors aware that the community expected them to be involved in contraception but they were also aware of the growth of the New Zealand Family Planning Association. This organisation had been formed in 1939 and provided women with the contraceptive advice lacking in their encounters with the medical profession. By the 1960s the loss of control of this work prompted the profession to pay closer attention to this area of women's lives (Hercok, 1991). Arguing that fear of pregnancy was among the causes of marriage breakdown, Dr Alice Bush urged medical practitioners to support doctors who wished to work for the Family Planning Association. She also urged the profession to claim this work as their own by taking the initiative and asking women as they left the nursing home, whether they wanted any help in planning their family (Bush, 1961:60-64). However, being more active in providing women with contraceptives, did not stop members of the medical profession from continuing to lament the social consequences of women's sexual promiscuity not only in relation to illegitimacy but also in relation to disease.

Social anxieties about promiscuity and pregnancy were further intensified by concerns about venereal disease. Venereal disease was regarded by some members of the medical profession as the 'fruit of promiscuity' (Platts, 1969:10). Venereal diseases were described in medical discourses during the 1960s as having made a surprising reappearance in the late 1950s after having shown a significant decline. The cause of this phenomenon was attributed mainly to changing sexual mores (NZMJ, 1969:234). A new feature of venereal disease in the late twentieth century were increases in the number of women presenting with gonorrhoea and other similar ailments. This trend was attributed to women becoming more like men in their sexual adventuring because contraception had reduced the fear of pregnancy.

Adolescents in particular were considered to have an unprecedented level of purchasing power and personal and sexual freedom. Promiscuity was thought to result from this freedom and the 'personal disaster', which venereal disease represented, was the 'bitter reward' (Harper, 1965:26).

Discourses of promiscuity in relation to venereal disease frequently singled out women, young people and Maori as groups in the community who required education and surveillance. Promiscuous, young women were described as being especially out of control (Platt, 1970).

Young women were likened to prostitutes in their transmission of contagion:

Prostitution is not alone responsible for spreading venereal disease. It is merely the most obvious form of sexual promiscuity. The occasional amateur also plays a major role. She is as much a cause of the spread of the disease among her contacts as is her professional sister among her large circle of patrons (Harper, 1965:25).

Women were identified as particularly 'problematic' in relation to venereal disease because unlike their male counterparts, they were considered to be the hidden carriers of contagion and could infect unsuspecting men (Platts, 1970). They were also held more responsible for sexually transmitted diseases because of the pervasive historical belief that men were unable to control their sexuality (Kehoe, 1988).

The defining of social problems as medical problems has, as White (1990:237) suggests placed social issues through the 'prism' of the biomedical model. In doing so the authority of the medical profession has become pervasive in its influence, particularly in relation to women. What has also occurred is the 'socialising' of medical problems where bodily illnesses have been placed through a moralising social prism in order to establish culpability and to focus surveillance. The linking of cervical cancer with promiscuity is illustrative of this process. Discourses of 'out of control' and 'problematic' women located cervical cancer within a context of the social problem of uncontrolled sexuality. The private histological status of the cervix had

become linked with very public concerns about women's sexuality. In doing so cervical cancer like venereal disease, invited not only medical solutions but moral solutions also.

5. Desexing the Cervix.

Some correspondents to the *New Zealand Medical Journal* advocated overtly moral solutions to the problem of cervical cancer. Dunn (1985:1054), for example suggested that having women give up promiscuous sex was the only way to prevent the disease. Increasingly however, cervical cancer began to lose its associations with promiscuity and began in the 1980s to be constructed as primarily a technical problem. As a technical problem discourses on cervical cancer de-emphasised the moral context of the disease and emphasised the scientifically neutral context of the cellular abnormalities of the cervix. However even seemingly scientific and technical constructions of cervical cancer hinted at underlying moralistic concerns. With the increasingly used acronym *CIN* (not infrequently pronounced 'sin') to describe 'cervical intraepithelial neoplasia' a technical 'aberration' of cellular development, medical discourses took on a curiously moral air. The detection of *CIN* in young women, for example came to be vociferously advocated by some medical commentators:

The fact that CIN can arise and progress rapidly is a compelling argument for advocating smear testing of all sexually active females which should include teenage subjects annually rather than at longer intervals. The proposal to include young females may not be welcomed by all members of the community but to ignore the growing sexually active teenage population would be a head in the sand stance and the future consequences of undetected CIN could be devastating (Chang, 1985:107).

The change from moral to more technical descriptions of cervical cancer is indicative of a transformation in the practice of medical power on women's bodies. This transformation may appear to represent a more humanistic and liberal approach to a medical problem. Arney and Bergen (1984a) suggest however that this analysis fails to identify the political significance of such a change and represents a teleological view of scientific inquiry as moving towards a socially conscious

perfection. Constructing what were previously moral problems as technical problems they suggest, in their discussion of teenage pregnancy, invites different solutions and therefore different disciplinary technologies:

..a moral problem invokes a different kind of solution than does a technical problem. Moral problems create oppositions to the natural order of things and invite punishment and practices of exclusion. Technical problems require analysis and knowledge. Technical problems are deviations from a natural order. They are not excluded or punished for their lack of conformity. They are instead, subjected to technologies of correction and normalization designed to get them to conform to their true nature, the truth of which is known to the experts (Arney and Bergen, 1984a:11).

The young promiscuous woman who exposed herself to cervical cancer was constructed as morally aberrant. Exclusionary discourses described such young women as 'promiscuous', 'permissive' and 'high risk' and as having contracted a sexually transmitted disease for which they were largely responsible (Rotkin, 1962:486; Sadeghi et al, 1983:729). They joined the ranks of women who were morally problematic as evidenced by illegitimate births, venereal disease and uncontrolled sexuality. Knowledge of the immoral, implied by these discourses is complete once the behaviour is identified and classified as wrong (Arney and Bergen, 1984a:15). Knowledge of immoral behaviours may titillate but the details remain hidden. Problems which are defined as technical on the other hand, invite a rational, scientific approach which compels analysis and knowledge of their most intricate details.

As cervical cancer lost its moral location and began to be described as a technical, medical problem, sexually active women became objects of scientific inquiry just as 'promiscuous' women had become objects of moral inquiry. Epidemiological approaches to cervical cancer continued to discover the contextual detail of the technical problem of cervical cancer whilst cytology inquired into the intricate details of technical changes in cervical cells. Colposcopy mapped the macroscopic detail of the cervix. As a further part of the technical model of cervical cancer, women were invited into a narrative of their sexual and social history. This was not within a context

of confessing sin but within a context of providing data for the analysis and exploration of a technical, bodily malfunction. Medical advice given in relation to sexuality and its link with cervical cancer became largely cleansed of the punitive discourses of the past and instead adopted the language of the technical. Within a context of increasing interest in the potential of routine screening of the cervix the technical construction of cervical cancer encouraged (rather than discouraged) women to expose their cervixes to medical scrutiny.

Changes in discourses of cervical cancer can be linked to a change in the organisation of medical power around the disease. Constructing cervical cancer as a disease of the promiscuous, created subjectivities of the 'immoral other', marginalised and shamed. Disciplinary technologies associated with this construction invited exclusion and silence (Arney and Bergen, 1984a). This construction was therefore problematic to those members of the medical profession who were increasingly interested in surveying the cervix using the technologies of cytology and colposcopy. Women were unlikely to invite the stigmatisation of being regarded as promiscuous by presenting for cervical screening. Power organized around a scientific discourse of cervical cancer as a technical failure on the other hand appeared to invite women into a 'stigma-free' medical relationship in which they could share their sexual and social secrets without fear of retribution. For cervical cancer to become a sexually transmitted technical problem, sexual intercourse had to become a morally neutral, technical act. The technical 'facts' of sexuality in medical discourses were increasingly separated from moral discourses. Sex became a matter for pragmatic, medical advice as opposed to moralizing prescriptions. However, the morally reprehensible woman of earlier years began to give way to new subjectivities. The non-compliant, irresponsible, risk-taking woman of the 1980s and 1990s replaced the promiscuous woman of earlier years but attracted less punitive discourse. Women who eluded the pervasive scrutiny of the cervix by not presenting for cervical screening were urged to co-operate with the benign intent of medicine. Discovering the woman behind the cervix became the focus of a technically oriented medicine. Only by doing so could the techniques of the clinic be tailored to meet the needs of the thinking, feeling woman.

6. Situating the Cervix in the Subjective Woman.

As cervical cancer began to be redefined as a technical problem women began to be increasingly identified as medical subjects. The woman with a positive smear reappeared within a context of neutralized sexuality and biology. Cervical cancer became an error of nature not an error of virtue. Within this context, attention turned to understanding the individuality of the woman to be screened. Only by understanding the individual, subjective woman could the 'truth' of the cervix be determined. Cervical cancer could only be known, analysed, discussed and managed if individual women would submit and contribute to a scientific discourse which invited rather than excluded them from the technical mapping of the disease.

The desexualised cervix became a medical object of inquiry, as it had been in previous years. Detached from its promiscuous past, the cervix became reembodyed in the thinking, feeling woman. Understanding the individualised, idiosyncratic woman became a medical priority. This priority was defined in humanistic terms as a progressive, liberal form of social medicine which countered the conservative, moralistic reductionism of the past. Understanding women's intentions, motivations and needs was to provide a more complete and individualised form of treatment. The medical literature reflected this approach with descriptions of the personal meaning of cervical cancer to women:

Genital neoplasia threatens not only a woman's life but her self concept, body image and her sexuality (Campion et al, 1988:180).

Whilst these discourses acknowledged women as individuals they failed to acknowledge the historical responsibility of medicine for the social anxiety which many women experienced as a result of a positive smear and the linking of cervical cancer with sexual promiscuity.

Women's personal views of their responses to the news of a positive smear began to appear in the medical literature. These were often within a context of their acknowledging the mental anguish of a positive result whilst at the same time lauding the benefits of cervical screening (Britten, 1988). Social science added to both the construction and surveillance of women's subjectivity through its research into areas

such as ascertaining the level of knowledge young people possessed in relation to the smear test, and into the psychological side-effects of mass cervical screening (Charlton, 1983; Reelick et al, 1984).

Acknowledging women's subjectivity meant also acknowledging their potential for non-compliance with medical advice and intent. In contrast to earlier discourses which had recognised, the passive, obedient patient, the rational yet feeling subject of post-war medicine which Armstrong (1982) has identified, had a mind and heart which had to be captured in the interests of co-operation with the clinic. To this end, surveillance of those women who were likely not to comply with cervical screening programmes became a focus for determining the what was constructed as the 'non-compliant personality'. Identifying attitudes, beliefs and behaviours which contributed to non-compliance lay at the heart of this form of research (Kegeles, 1967). The aims of this type of research were directly centred on gaining women's co-operation with cervical screening programmes:

Because of the limited information on psychosocial characteristics as related to acceptance of cervical cytology, findings from a community mental health epidemiology project were analyzed to determine whether selected behavioural and personality characteristics might yield additional clues for identifying persons unlikely to participate in screening and their reasons for non participation (Helsing and Comstock, 1978:550).

New discursive categories emerged to describe women who did not participate in screening programmes. The 'non-compliant' woman replaced the 'promiscuous' woman of the past in relation to cervical cancer, but unlike the promiscuous woman, could be remedied by the correct medical approach. Non-compliant women in medical and social science discourses were located within a social context of disadvantage just as the promiscuous woman had been in the past. Income, level of education and occupational class were not infrequently correlated with a low level of uptake of cervical screening (Kegeles et al, 1965:822).

Subjective women were also 'discovered' by medicine to have preferences in the way clinical procedures should be carried out. Respecting these preferences became a

priority for medicine:

The favourable response by most women to whom the speculum was demonstrated suggests that doctors should consider showing women the speculum prior to this aspect of the examination. Also, the study findings about speculum warmth suggest that physicians who do warm the speculum are respecting the comfort of women (Broadmore et al, 1986:10).

Meeting the individual, psychological, physical and cultural 'needs' of women became the new focus of medical discourses on cervical cancer in the 1980s and 1990s. These discourses also began increasingly to construct the subjective woman as a consumer of health products who had needs which medical 'products' could fulfill. Making cervical screening analogous to a marketable product to sell to women intensified the monitoring of women's needs and wishes (Chetwynd and Clarke, 1988). All these initiatives which encouraged discourse and the gathering of information are, as Arney and Bergen (1984b:170), observe evidence of the exercising of power:

Medicine does not simply allow patients to speak; medicine requires speech, for only through a patient's declarations are the intimate and private parts of the body as the patient lives it made available for medical praxis. Technologies of domination and control compel silence; technologies of monitoring and surveillance incite discourse. Everything, no matter how trivial it might seem, must be noted, recorded, and made the object of analysis.

Women's subjective experiences have increasingly formed the basis for the transformation of the technologies of medicine to enhance their educative, therapeutic and diagnostic potential. In relation to cervical cancer screening, such technologies have included 'active and specific invitations' to 'high risk' women to attend for screening, targeted media campaigns and health education initiatives including the use of home videos on cervical cancer (Bailie and Petrie, 1990:295; McAvoy, 1990).⁸

⁸ See Chapter Twelve for a discussion of the strategies which formed the basis of health promotion initiatives in relation to cervical cancer in the late 1980s and during the 1990s.

This expanded medical field of power has created its own objects of surveillance. The 'ignorant', 'frightened' and 'stigmatised' woman has been deemed to require special treatment to overcome her own individualised barriers to medical surveillance. Cervical cancer had been transformed from a moral problem to a technical problem of individuals with thoughts, feelings and needs. For medicine the challenge of immorality had been recast as a challenge of technicalities and individualities.

The construction of the subjective woman in medical discourses paradoxically became the basis for feminist resistance to medical power. The subjective woman according to feminists frequently had her rights and needs ignored and discounted by a patriarchal and sexist medical profession. The treatment of cervical cancer at National Women's Hospital was considered by feminists to epitomise this.

7. Conclusion

From the 1960s on, constructions of cervical cancer began increasingly to reflect social concerns and anxieties about women's increasing detachment from the prescriptive ideals associated with the roles of wife and mother. As women challenged earlier norms of appropriate sexual behaviour, surveillance began to increase in relation to their bodies in general and sexuality in particular. Cervical cancer joined venereal disease as a sexually transmitted disease which warranted moral and medical management with this management being the prerogative of the medical profession. Increasingly cervical cancer began to be redefined as a technical problem. As such, morally neutral discourses were an encouragement for women to seek medical assistance for a technical problem with technical rather than moral solutions. As a technical problem cervical cancer began to be situated within a context of co-factors which warranted the examination of the social context of the lived in body. Earlier medical discourses of problematic women gave way to discourses of the non-compliant woman. Understanding non-compliance or reluctance required an understanding of the subjective, idiosyncratic woman. The subjective woman was encouraged to speak her feelings, needs and values within the context of the medical encounter or at least to accept that medicine understood the needs of all women in this form of medical encounter. Medicine increasingly acquired not only the expertise of the cervix but also the expertise of understanding the total 'truth' about women. In doing so, medicine ensured that women understood

the 'truth' about themselves.

CHAPTER SIX

Contesting the 'Truth': Cervical Cancer and Disputed Knowledge Claims.

1. Introduction

This chapter identifies the ways in which knowledge about cervical cancer became contested within the medical profession from the 1960s to the late 1980s. Medical 'dissenters' who contested generally accepted views of cervical cancer and its prevention and treatment challenged the medical profession in a number of ways. First they challenged the consensus of what Fleck (1979) termed the 'thought collective' and the predominant 'thought-style' which informed discourses on cervical cancer. In doing so, they questioned the technical expertise of the medical profession and problematised the basis of preventive initiatives in relation to cervical cancer. Second, challenges to the knowledge claims of medicine were made not purely on technical grounds, but on moral grounds also. Citing concerns about the welfare of women, medical dissenters highlighted the potential abuse of medical technology in unnecessarily screening women for cervical cancer. Third, medical knowledge and practice in relation to cervical cancer were not only contested within the relatively closeted and esoteric domain of the medical literature but were also debated in the public forum of the popular media. This threatened to make the private uncertainties of the medical profession, public anxieties. All these factors had implications for the profession in its maintenance of social distance which had historically been based on a reputation of cognitive rationality and collegial consensus.

The contesting of the 'truth' of cervical cancer emanated from individual dissenters, but contradictory data about the efficiency of cervical screening also arose out of the 'rational' processes of scientific investigation. Research findings produced evidence which contradicted medical beliefs about the efficiency of cervical screening. The medical profession responded in a number of ways to the questioning of collectively held knowledge about cervical cancer. Contested knowledge was assimilated and transformed in ways which made it compatible with beliefs already held. Many of the views proposed by dissenters could not be assimilated however because they challenged the core of medical beliefs about cervical cancer. These views and those who promoted them were tolerated whilst the profession was willing to accept a level of uncertainty about the disease. Once a higher level of certainty and consensus had

been reached however, opposing views became increasingly marginalised and neutralised. Strategies of marginalisation and neutralisation were important to the maintenance of professional power.

Scientific controversies, such as those which emerged around cervical cancer, are frequently seen to be resolved by an appeal to the facts and the rigorous reasoning of scientific methodologies and debate. This view has been based on a presumption of science as objective, progressive and linear (Engelhardt and Caplan, 1987). The historiographic approach has traditionally viewed scientific debate and controversy as accidents or aberrations in an orderly progression of scientific development. In contrast, Mendelsohn (1987:97) suggests that scientific controversies are socially located and reflect the social interests of those involved. He also suggests that this type of explanation of controversies is not easily accepted within the scientific enterprise which has historically avoided any links between the intellectual and practical elements of science and goals, objectives and interests. Nevertheless, disputes which emerged in relation to cervical cancer are indicative of the social location of medical science as this chapter shows.

Part Two of this chapter, identifies the emergent debates which occurred in relation to cervical cancer from the 1960s on. It traces the ways in which challenges to the knowledge claims of medicine struck at the very core of medical orthodoxy and tradition by problematising medicine's scientific foundation and its historical role of protecting the bodies of women. **Part Three** focuses on the strategies employed by the medical profession to deal with and neutralise medical dissension. It also identifies the strategies employed by the profession to deal with evidence which emerged out of 'rational' science and contradicted the consensus view of cervical cancer. **Part Four** examines the impact of the challenge to knowledge claims about cervical cancer on the medical profession. **Part Five** ends the chapter by emphasising the social rather than the scientific location of the debate about cervical cancer and draws out the paradox that it was the actions of the laity rather than the medical profession which achieved closure of the debate.

2. Cervical Cancer: Consensus and Contention

During the late 1940s and 1950s the medical surveillance of the cervixes of New

Zealand women underwent a significant change. Members of the medical profession began to rely less on their own visual judgement as to the status of the cervix and increasingly on cytological diagnosis. This change reflected a growing uncertainty amongst the profession that the eye told the 'truth' of the cervix:

The difficulty, however, is that an early invasive case, not only may produce no symptoms, but may occur in a cervix which appears completely benign to the naked eye (Carey and Williams, 1958:227).

By the 1970s cytological examination of the cells of the cervix was routinely carried out throughout New Zealand (McIndoe and Williams, 1972). Cytology was accepted by many members of the medical profession as an appropriate form of medical technique to use in the diagnosis of suspected cervical cancer and in the screening of asymptomatic women (Giesen, 1972). Cytological diagnosis of cervical cancer had been proclaimed in the American medical literature since the early 1960s as revealing the 'secrets' of the cervix and potentially leading to a cure for the disease (Lund and Rochester, 1961:98). Despite the heralding of the new technologies available to medicine, some members of the medical profession questioned the efficacy of cervical cytology. One prominent member of the profession to do so in New Zealand was George Green, who had joined National Women's Hospital in the late 1940s and became part of the cervical cancer clinical team in 1955 (Bunkle, 1988). In the mid-1960s Green began to challenge claims that cytological screening campaigns would eventually eliminate cervical cancer (Green, 1966). He questioned the view that the pre-invasive lesions of the cervix which cytology revealed would lead to invasive cancer. He claimed that a body of opinion supported his belief that there was not a natural history of progression in the disease and maintained instead, that in many cases *carcinoma in situ* regressed rather than progressed on to cervical cancer (Green, 1974). Green considered that enthusiastic claims for the achievements of cytological screening were 'doctrinaire and debatable' (Green, 1969:157). He used his case against the natural progression of cervical cancer to question the need for regular screening for pre-invasive lesions of the cervix.

Green took a stance on cervical screening which had both a technical and a moral basis. He expressed concern that the medical responses to a diagnosis of

carcinoma in situ were too frequently leading to hysterectomy and were as a result destroying women's fertility. The preservation of women's fertility was for Green a highly important objective of medicine. He held conservative views on sterilisation and was vehemently against abortion. Such was the level of his commitment that he refused to work with colleagues who performed abortions, labelling them as 'murderers' (Bunkle, 1988:148). Bunkle suggests that Green's view that *carcinoma in situ* rarely progressed to invasive cancer was motivated predominantly by his fervent desire to save women's fertility. She concedes however, that his conservative treatment of women, which had led to a form of treatment called 'cone biopsy' instead of routine hysterectomy, had in fact benefited women by leading to less mutilating forms of treatment. By the 1960s, cone biopsy had become the standard treatment for *carcinoma in situ*. In later years concerns expressed by Green about the screening and treatment of the cervix became less linked with concerns about the impairment of women's fertility as this had become less of a threat. Instead he redirected his focus towards the morality of using what he considered to be questionable technologies which subjected women to unnecessary and repetitive tests, biopsies and undignified colposcopic examinations (Green, 1985). Green went from being the guardian of women's fertility to being the self appointed guardian of their honour.

During the 1960s there was still some uncertainty about the efficacy of the new technologies for cervical cancer. The 'facts' of cervical cancer which were increasingly linked with cytology were, to use the phraseology of Fleck (1979:157) being 'collectively created'. Fleck suggests, that scientific facts, begin with tentative signals of resistance by the thought collective but through collective interaction, become stylized and consolidated to emerge as 'truths'. Thought-styles link the individuals of a thought collective together by constraining inhibiting and determining thinking to the point where the conceptualisation of a particular epistemological area cannot occur in any other way. During the period of collective negotiation of the facts of cervical cancer a number of doctors expressed uncertainty about cervical cancer. Green's suggestion, during the 1960s, that a conservative approach was necessary until the relationship of *carcinoma in situ* to invasive carcinoma was better understood was not dissimilar to the views held by many of his peers. Hysterectomy in particular was seen by some doctors as being contraindicated until more was

known about the natural history and regression rates of *carcinoma in situ* (Baeyertz, 1965:624). Other commentators agreed with Green's view that a clear linear relationship between pre-invasive lesions and cervical cancer did not exist:

...since it may well be that only a small proportion of the pre-invasive lesions revealed by cytology ever go on to invasion there must be a cautious approach to their diagnosis and treatment with, above all, careful follow-up of all cases (NZMJ, 1967b:886).

By the early 1970s the debate about the 'natural progression or regression' of early cervical lesions had become what the British medical literature described as a 'fierce controversy' (*BMJ*, 1976:659). The same epithet could be applied to the debates which occurred in New Zealand. New technologies became increasingly accepted by many members of the medical profession as having a vital role in preventing the progression of *carcinoma in situ*. Those who opposed the thought collective which adhered to the progressive hypothesis of cervical cancer increasingly began to be viewed as opponents rather than colleagues. From the 1960s to the 1980s, Green stood out as persistently challenging the view held by many members of the medical profession that cervical screening should be applied to asymptomatic women. In doing so he not only questioned the technical authority and competence of medicine but he also problematised its scientific basis. He suggested for example, that medicine had a history of incorrectly inferring a causal relationship between medical interventions and lowered rates of morbidity:

The history of medicine is filled with concepts that were assumed to bear 'propter hoc' relationships to new methods, with years elapsing before they were revealed as simply 'post hoc' ones. Nevertheless, without a previous control rate, many investigators are convinced that a falling incidence of invasive cancer bears a 'propter hoc' relationship to cervical screening, and many go further and estimate both the mean period of time required and the proportion on in-situ cancers that progress to invasion (Green, 1969:158).

He suggested instead, that the decline in rates of mortality from cervical cancer apparent in a number of countries had begun years before the advent of cervical

cytology (op. cit:157). He further concluded, that doubt was being thrown on the biological significance of the 'countless precancers being revealed by cytology' (Green, 1978:886). Other medical commentators acknowledged that the fall in death rates from cervical cancer had preceded the introduction of screening in many countries and lamented the fact that no randomised trials of cervical screening had been carried out prior to its widespread introduction. Without the validation of 'rational' science, the profession concluded that the contribution of cytology to falling mortality rates could only be guessed at (Williams, 1992:1503). However, such was the consensus which had developed, that many members of the profession were willing to conclude that cervical cytology had been an effective form of intervention. Whilst acknowledging the lack of evidence for the efficacy of cervical screening on a population basis, Green made it clear that he was not opposed to cervical screening as a diagnostic tool:

I have never ceased to urge that 'diagnostic' cytology is of the greatest value in the diagnosis of a case of cervical cancer. The wholesale and very expensive 'screening' of asymptomatic populations with the avowed aim of abolishing death from cervical cancer is a very different concept, the validity of which has rightly come under serious question from Auckland and many other centres (Green, 1972:449).

As well as challenging the scientific basis of medical beliefs about cervical cancer, Green challenged the moral foundations of medicine's approach to women. This latter aspect of Green's dissension was particularly significant. He accused medicine of technological interventions which were detrimental to women. He located medicine within a framework of abuse of women's bodies and sensibilities and problematised the historical claim of doctors as the guardians of women's bodies.

As the collective thought-style of medicine began to accept that cervical screening was an effective medical intervention which should be applied to all women, dissenters who opposed this stance increasingly came to be viewed as heretical and deviant in challenging these beliefs. This was especially so as Green and those who agreed with him were undermining the theoretical basis for population-based cervical screening which had gained increasing support during the 1980s. Without the

legitimation of the 'progression' theory, cervical screening initiatives lost their rational, scientific basis and could not therefore be justified. For those committed to cervical screening this was of considerable concern. As Mendelsohn (1987:92) suggests, experimental procedures and judgements, technical choices and commitments are influenced and structured by the interests of participants. It is when aspirations and outcomes of these goal directed activities are affected that a mere disagreement in science becomes a sharp controversy. Green vehemently challenged the aspirations of those who viewed cervical screening as an essential diagnostic procedure which should be applied to all women. In doing so he challenged the objectives of those who believed that preventing cervical cancer was an achievable and desirable aim of the profession.

As an 'outsider' in relation to the thought collective, Green received some support from other dissenting members of the medical profession. This support came from those who criticised the profession for exaggerating the extent of cervical cancer by labelling it an 'epidemic'. Concern was also expressed by Green and his supporters that cervical cancer was being linked in a moralising way with sexual promiscuity. Skrabanek and Jamieson (1985:654) two doctors who supported Green's stance, accused the profession of having a punitive approach to women by implicitly suggesting that the 'wages of sex' was a 'positive smear'. In contesting medical beliefs about cervical cancer, they joined Green in pointing out what they considered to be the contradictions and irrationalities in medical opinion and practice in relation to the disease:

Why then, do we fuss so much about cervical cancer? Every woman should have a smear, correct? Every woman should be reminded that there is a danger? Why? Is it because the fear of being eaten of worms is a healthy fear? Should one million New Zealand women over the age of 19 live in daily fear, though only 0.009% of them will enter the final statistics? Listening to and asking leading questions of a patient is far, far better than screening in the control of cervical cancer (ibid).

Cervical screening procedures were also identified as causing psychological harm to women. The aftermath of a diagnosis of a 'pre-malignant' disease and subsequent

colposcopy and biopsy were suggested as having deleterious, psychosexual consequences for women (Skrabanek and McCormick, 1990; Taylor, 1979). These issues were also developed by Green himself, alongside what he considered to be the apparent paradox in the medical promotion of screening for cervical cancer and not for breast cancer. The lack of focus on men was also considered by Green to indicate an unacceptable gender bias in the medical approach to the disease:

So what about the six-times more common and twice-as-fatal breast cancer? Or the male factor in cervical cancer (Green, 1985:968).

Dissenters also expressed concern about the technical efficacy of the cervical smear test. During the 1960s when uncertainty prevailed, the adequacy of the technical procedures which were used to diagnose and treat pre-invasive lesions and cervical cancer were called into question. False positive and false negative smear tests caused concern because it was considered they could mislead doctors about the status of a woman's cervix. Concerns were expressed that women would be subjected to unnecessary hospitalisation, anaesthetic and biopsy as a result of erroneous cytological results (Darby and Williams, 1965; McIndoe, 1966). These concerns continued to be expressed by dissenting members of the profession in the late 1980s:

The validity of the test is low for various reasons. Apart from problems of interpretation, many smears are technically unsatisfactory in that the endocervix may not be included, critical areas may be missed, or fixation may go awry. Therefore the test has low specificity and sensitivity, with a large number of false-positives and some false-negatives (McCormick, 1989:208).

The contesting of knowledge about cervical cancer continued over a period of more than two decades. During the 1960s and 70s those members of the medical profession who held dissenting views were tolerated as the profession developed a coherent and collective thought-style around cervical cancer. During this period, a degree of medical uncertainty about cervical cancer was acknowledged and differences of opinion accepted. During the 1980s uncertainty for many members of the profession had been replaced with conviction. Under these circumstances,

dissension was dealt with more harshly. Those who challenged the thought collective during this latter period challenged a more firmly established consensus on the pathology of cervical cancer and the efficacy of cytology. Varying scientific opinions had been replaced by orthodoxy. The professional questioning of this orthodoxy (sometimes carried out in the public forum) resulted in a number of professional strategies being applied to those who challenged the scientific authority and moral basis of medical practice.

3. Medical Dissension and Professional Strategies

The medical profession used a number of professional strategies to deal with members who persisted in challenging beliefs about cervical cancer which the thought collective adhered to. These included an appeal to scientific rationality to establish the 'truth' of the efficacy of cervical cytology. Suggestions were made for instance that research be carried out to examine the effect of cervical screening on the 'total female population' of New Zealand (Giesen, 1972:294). Other professional strategies included adopting arguments which countered and neutralised concerns about the technical efficacy of cervical cytology. Members acknowledged that cervical smear tests had a level of false positive and false negative results, but suggested that these were within acceptable limits and that the benefits of carrying out the tests outweighed the disadvantages. Cytological testing was also favourably compared with other diagnostic measures which relied on the much more error prone methods of subjective assessment. Diagnostic medicine was also constructed as always operating with an acceptable margin of error. Cytological reporting standards in New Zealand were affirmed as being as 'high as any country in the world' (McIndoe and Williams, 1972:129). These claims sought to reiterate and confirm medical beliefs about cervical cancer and situate them within an authoritative scientific discourse. In doing so the views expressed by Green and others were located outside of scientific orthodoxy in an attempt to marginalise and politically neutralise them. Constructed as idiosyncratic and scientifically flawed these views lost at least some of their power to challenge consensus. In other words, the views of the thought collective were linked with what Gilbert and Mulkay (1984:56-57) term an 'empiricist account' of scientific 'reality' arising unproblematically and inevitably out of the empirical characteristics of an impersonal world. Dissenting views on the other hand, were constructed as being contingent on the personal inclinations and particular

social positions of those who held them. Green and his supporters, within a contingent construction of reality, were considered to hold misconceptions, and to be intractable in the face of the obvious.

The medical profession employed other means to deal with knowledge claims which challenged the prevailing thought-style. These included assimilating conflicting accounts of reality. This occurred in response to the production of knowledge about the incidence of cervical cancer and its relationship with cervical screening. Puzzling and seemingly inexplicable data appeared in the medical literature suggesting that cervical cancer had been declining in the majority of western countries for some years prior to the application of cytology (Pettersson, 1991; Williams, 1992). This knowledge called into question the prevalent belief that cervical screening was the only means by which the incidence of cervical cancer could be reduced. Information which suggested the opposite, challenged not only the 'rational science' which underpinned predictions in this regard but also the 'moral basis' for the employment of screening technology. There appeared to be no 'rational' explanation for the decline in the incidence of cervical cancer prior to screening, as the profession had already noted in the medical literature in the 1980s (Duncan, 1981). Knowledge claims of this type were problematic because they emanated from reputable and orthodox medical sources and could not be easily marginalised or ignored. Further evidence suggested that patterns of mortality for cervical cancer in England and Wales had not changed despite the advent of cervical screening. This new knowledge challenged the stability of a medical consensus which was based on the prediction that mortality rates for cervical cancer would fall with the advent of screening (Draper and Cook, 1983).

The professional strategy employed to cope with these competing knowledge claims was to assimilate them into the prevailing thought-style in a way which enabled contradictions to be neutralised and beliefs about cervical cancer to be preserved. Explanations identifying the decline in cervical cancer as a 'temporary phenomenon' with mortality rates being on the rise again (for example in Sweden in the mid 1960s), (Johannsen et al, 1978, cited by Duncan, 1981:120) served to maintain knowledge stability. The data which highlighted the apparent lack of effectiveness of screening in Britain and Wales was assimilated into the thought-style by the advent of a

'reasonable interpretation':

In our view the most reasonable interpretation of the mortality, registration, and screening data-which is consistent with what is known about the epidemiology of cervical cancer-is that there has been among younger women a very substantial increase in the rates of carcinoma in situ which, together with the smaller increases in those for invasive cancer, suggest that screening is holding in check a much larger potential increase in the rates of invasive disease among these younger women (Draper and Cook, 1983:511).

The reported lack of decline in mortality and morbidity in New Zealand since the introduction of cervical screening was likewise assimilated by the thought collective. This was achieved by the argument that the New Zealand screening rate was low in comparison to other countries (Chang, 1985). Another argument was also mobilised by the profession to counter the assertion by Green (1978) that increases in cervical screening in New Zealand had not been met by a proportional decline in the number of cases of cervical cancer. This was based around the concept of 'unmet screening needs' in which 'high risk' groups such as Maori women, women over sixty and those with adolescent or promiscuous sexual histories were claimed to be falling through the screening net (Duncan, 1981:121). Another explanation put forward was that not only were women 'at risk' not having smears but that those with abnormal smears were not being appropriately managed. This latter view led to a reiteration in the medical literature of the circumstances in which women should undergo colposcopic evaluation. These included women with a 'clinically suspicious cervix' and women with the human papilloma (wart) virus amongst others (MacLean et al, 1985:757). Suggestions that 'high risk' women were not being screened and that abnormal smears were not being appropriately managed served to stabilise existing beliefs about cervical cancer and also served to remind the profession of the need to intensify their actions in relation to the disease. This occurred in the face of data which could have been interpreted as suggesting the opposite.

Some members of the medical profession were very aware of the desire of screening advocates to protect their beliefs from being contested and eroded, especially when these beliefs were held with what amounted to a religious zeal:

In "keeping the faith", screening advocates may find themselves forced to accept or reject evidence not so much on the basis of its scientific merit as on the extent to which it supports or reflects the stand that screening is good (Thompson 1973, cited by Sackett and Holland 1975:357).

However, this form of critical analysis of medical responses to contested knowledge was rare in the medical literature.

The medical profession employed a number of strategies to deal with competing knowledge claims but the views expressed by Green represented a particular challenge. This was to do with his tendency to criticise beliefs about cervical cancer on a variety of grounds. Firstly he challenged these beliefs on grounds of technical efficacy. Secondly he criticised cervical screening on economic grounds by suggesting that population screening for the disease would cost millions of dollars:

To apply more and increasingly expensive doses (screening of all women aged 18-65 before the end of 1986 would cost at least \$10 000 000) of the same medicine will bring lots of business to cytologists, colposcopists, clinicians, and clerical workers, but on past New Zealand experience, the million women 20 years and older being put in fear of cancer or "eaten of worms" are most unlikely to benefit to the same degree (Green, 1985:968).

This economic argument was particularly significant at a time when the costs of health care were increasingly under scrutiny (Fougere, 1990). It implied that the medical profession was advocating a technical intervention on spurious grounds which appeared to include professional self interest, rather than showing responsible concern for weighing up the benefits and costs. Thirdly Green, and others who supported his views of cervical cancer, located their arguments within a context of concern for the welfare of women. This was especially significant at a time when gender had become an issue of significance in a political climate stimulated by feminist health activism. Women were increasingly demanding a new medical morality from a profession which stood accused of sexist and patriarchal abuse of power in relation to women (Bunkle, 1988). Green's arguments appeared to be directed at both the moral and physical dignity and wellbeing of women and implied

that those who adhered to a different view of cervical cancer had an opposite agenda. Green's views placed him in a position of 'guardian' of women's bodies in contrast to pro-screening members of the profession who were constructed as having a blatant disregard for their guardianship role. Ironically, some of views expressed by Green in relation to women echoed those of feminists in their criticisms of the medical profession. Fourthly, Green accused the profession of avoiding the reality of cervical screening. In doing so he set himself up as one of the few members of the profession who understood the 'truth' of the cervix. He made the unsettling prediction that 'persistent avoidance of reality in cancer screening' would undermine the medical profession's credibility with the public (Green, 1985:968).

Green's views on cervical cancer were clearly not able to be assimilated into the thought-style which had emerged by the 1980s. His views were enduring, unfaltering and controversial. Attempts at coercion or negotiation had not brought these beliefs in line with those of the majority of the profession. Moreover, his stance on cervical cancer had been reported in the popular as well as the medical media (McIndoe and Williams, 1972). By involving the public in the private debates of the profession, Green contributed to the erosion of the social distance between medicine and the laity. His dissenting position as a prominent member of the profession indicated that doctors were not above discordant debates and revealed not only a lack of unity in the profession but a lack of certainty also. This occurred during a period when the authority of medicine was being increasingly challenged. The legitimacy of medicine was increasingly being questioned in the late twentieth century and there was a growing recognition that medicine could harm as well as good. In his criticisms of the interventionist approach to cervical cancer, Green's views echoed concerns about technological excesses, and the doubtful outcomes of interventionist and reductionist medical science.⁹ Brandt (1991:207) suggests that it had also become clear, that in addition to its explicit rationale, medicine served many purposes, constituencies, and interests. As a result medicine had become the focus for debate, ambiguity and at times, scepticism and hostility. Green's views did nothing to obviate these challenges to medical power.

⁹ See Illich, 1977, Rosenberg, 1986 and Taylor, 1979 for critiques of medicine in the late twentieth century.

Green became increasingly excluded in the 1980s, from negotiating the boundaries of collective knowledge about cervical cancer. His views on cervical cytology were eventually marginalised to a point where they were barely acknowledged as being worthy of debate. His beliefs were firmly designated in the medical literature, as having been 'clearly shown to be wrong' in a scientific sense. In the light of this authoritative assessment, general practitioners were advised by medical commentators to ignore dissenting views and to 'embrace the concept of cervical cytology and act on it' (Duncan et al, 1985:821). Green was further marginalised in the medical literature by the suggestion that he had also demonstrated poor scientific acumen in being unwilling to change his views in the face of new scientific evidence. Eventually, his position within the profession came under intense scrutiny, not because of the content of the knowledge claims he made in relation to cervical cancer but because of the way in which he attempted to test his beliefs. His scientific and ethical standing was called into serious question with reference to experiments he had carried out at National Women's Hospital to test his regression/progression hypothesis. Green's views had been tolerated by the medical profession on the basis that his 'errors' were in the realm of scientific and technical judgement. In the mid-1980s there were tentative suggestions by members of the profession however, that he had been morally and ethically in error in the way he had set out to test his views of progression. Green's experiments at National Women's Hospital had involved the conservative management of a number of women with *carcinoma in situ*. What was to become commonly known as the 'unfortunate experiment' was later publicly exposed as an issue of widespread concern about the unfettered power of medicine which at times resulted in the death of patients. During the mid-1980s a paper published on Green's research outlined the results of his conservative management of *carcinoma in situ* (McIndoe et al, 1984). The paper received a somewhat muted response from the medical profession. Some concern was expressed about Green's apparent breaching of ethical codes in the design and implementation of the research. However these concerns appeared to be almost secondary to the on-going dispute about his views on the prevalence of cervical cancer and the efficacy of screening. Questions were raised about moral and ethical issues to do with his research but in comparison to the intense and lengthy debate which had ensued for some twenty years these moral and ethical issues were barely acknowledged by the profession:

The case for the effectiveness of screening does not rest on the unfortunate experiment at National Women's Hospital, in which women with abnormal smears were treated conservatively and a proportion have developed invasive cancer .

If the experiment was incapable of falsifying Green's hypothesis, why was it carried out? Moreover, if invasion could not be excluded confidently at the outset, were the patients warned of the risk that was being taken? (Skegg, 1986:26).

It was not however until public disclosure of Green's work by members of the public that the tentative concerns expressed by the medical profession became the basis for widespread anxiety and anger about the research which Green had carried out at National Women's Hospital.¹⁰

It was the public outcry which resulted from the exposure of Green's medico-moral error and the subsequent state initiated Inquiry which finally silenced the debates on cervical cancer. These debates were not resolved because of the presentation of new and authoritative scientific evidence. What occurred instead was that closure to the debate resulted from a socially rather than scientifically situated event. This was the Inquiry into Green's research at National Women's Hospital. As Mendelsohn (1987:101) suggests, events such as the judgement of a commission can give credence to one party as opposed to another. The Inquiry authoritatively determined that Green's views on the value of cytology in population-based screening were wrong. This largely ended the debate. Other views held by Green became discredited by their association with his stigmatised identity which occurred as his research at National Women's Hospital came under scrutiny. Green's ability to authoritatively challenge the thought collective had ended.

The Inquiry concluded that Green had not only been technically in error in his beliefs about cervical cancer but that he had also been ethically and morally flawed (The Committee of Inquiry (1988). This resulted in some members distancing themselves even further from his views although many others continued to support him. Bosk

¹⁰ See Chapter Ten for a discussion of events at National Women's Hospital which led to the Cervical Cancer Inquiry.

(1979:171), suggests that moral error is more harshly judged by the medical profession than technical error because of its potential for undermining the professional relationship between doctors and patients as well as undermining the status of the profession in the eyes of the public:

Moral error breaches a professional's contract with his client. He has not acted in good faith...For this reason moral errors are treated as more serious than technical ones. They undercut the very fabric of client-professional and professional-professional relationships. Hence the control of technical performance is subordinated to the control of moral performance; without the overarching moral system, the technical system is not amenable to control.

Whilst Green's voice may have been silenced, medical dissenters who shared his views continued to express these in the overseas medical literature. These views, which centred around the harmful effects of cervical screening, were picked up by both the medical and popular media in New Zealand. Skrabanek (1988), and McCormick (1989) two overseas commentators who were in support of Green's stance had their position discredited in the New Zealand medical media. They were accused of providing no new scientific evidence in relation to cervical cancer and of being unscientific and emotive. They were also accused of having selectively used the literature to support their arguments (Skegg, 1989:527). By the 1990s the debates which had pervaded the medical literature on cervical cancer for many years had largely disappeared. This had occurred not as a result of rational science but as a result of social and political factors.

4. The Cervical Cancer Debate and its Impact on the Medical Profession.

By challenging the dominant medical discourses on cervical cancer, Green and others had challenged a number of precepts of importance to the medical profession. The most significant of these were professional unity and medical authority. Starr (1989), suggests that an important basis for professionalism in medicine has been the perceived level of technical competence of the profession and its professional cohesiveness. The latter has been achieved largely by doctors adjusting their views in line with their peers. However the professional strategy of 'social closure' has also been important in the marginalisation of some groups and the inclusion of others in

relation to the rewards of professional power and status. Epistemological debates such as those involving cervical cancer had the ability to threaten social closure by opening the profession to public scrutiny and criticism. Medical controversies are frequently confined to the medical media. These somewhat esoteric debates are often technical and inaccessible to the laity. This has historically ensured that the public face of collegiality has been maintained and the 'private' disputes of the profession have not entered the public arena. Strategies of occupational control have structured the relationship between doctors and patients by designating medical knowledge as legitimate and valuable and patient's knowledge as 'lay' and less valuable. This is exemplified in medical discourses on cervical cancer which suggested that whilst the public should take responsibility for their own health, the laity 'is not equipped to evaluate scientific data' (*Contemporary Obstetrics and Gynecology*, 1980:144). The unified body of scientific knowledge to which the medical profession lays claim provides the basis for its authority and prestige and therefore must be protected by the profession (Turner, 1987). Members of the profession who challenged collective medical thinking on cervical cancer not only challenged professional unity but threatened the social closure of the profession. This was particularly so when these debates were aired in the public media in a form which made them accessible to the public and included expressions of doubt about the reliability and wisdom of cervical screening (*Auckland Star*, 1972; *New Zealand Herald*, 1972).

Significant also for the profession was the fact that debates around the appropriateness of cervical screening raised questions about the 'morality of the technical'. Green and others who held similar views questioned the morality of performing uncomfortable and embarrassing screening procedures on women when the scientific basis for their use was open to question. This aspect of the debate challenged the profession's status in relation to a historical tradition of caring for women's bodies. Green himself was based at National Women's Hospital, an institution which was symbolic of medicine's expertise and legitimate guardianship of women's bodies. Green's membership of this institution served to heighten the possible legitimacy of his claims and made them even more damaging to the profession.

The contesting of medical knowledge and practice which occurred as a result of

Green's views found echoes in more widespread criticisms being levelled at medicine at the same time. Feminist critiques of medicine were at the forefront of these challenges to medical power. Feminists criticised medicine for its monopoly on knowledge of women's bodies, its excessive use of technical interventions and its abuse of professional power. Paradoxically Green's criticisms of his own profession were not dissimilar to those being expressed by feminists. Green however, found himself deeply implicated in these concerns at a profound level in later years. Ironically whilst he argued for less intervention in relation to women's bodies and advocated a more moral approach to the use of technology in terms of cervical cancer, his own research was exposed as having been conducted with a blatant disregard for women's right to exercise autonomy over their bodies.

By the 1980s, the medical profession was increasingly confident in pursuing cervical screening as a treatment option and screening for cervical cancer was carried out opportunistically when women visited doctors for the contraceptive pill or other purposes (NZMJ, 1983). Cervical cancer was confidently described as a 'highly treatable disease' and screening programmes for early detection as being 'essential' (Gray et al, 1985). Indicative of the growth of the medical profession's unity and confidence in relation to cervical cancer was its call for the government to sponsor programmes to encourage all women to have smear tests. The profession began to advocate a more confident and authoritative approach to opportunistic screening:

...we can appeal to all practitioners who see women patients to ask them a positive question - "have you had a cervical smear in the last year? - and if not we will do one now" (Duncan et al, 1985:821).

Cervical cancer began in the 1980s to be described in terms of being an 'epidemic'. Chang (1985:107) expressed concern that an 'epidemic' of C/IN might be looming. For Skegg et al (1985:636) an impending 'epidemic' of cervical cancer was thought likely in women under 45 years of age unless a 'control' programme could be put in place. The construction of cervical cancer as an 'epidemic' was an important change in the exercising of what Foucault termed 'bio-power'. Discourses of epidemics serve to legitimate a range of actions in relation to illness. Singer (1989:49) suggests, that the construction of an 'epidemic' is frequently based on mathematical calculations of

risk and socially authoritative discourses about which members of the population are likely to fall victim. These discourses result in justifications for the mobilisation of resources and for the proliferation of techniques of surveillance and regulation. Foucault (1973) locates the construction of an 'epidemic' within a nexus of productive power rather than repressive power where individuals are trained, encouraged and rewarded for being responsible for monitoring and controlling illness. Importantly also, the construction of cervical cancer as an epidemic, further marginalised any vestiges of opposition to the medical consensus of how cervical cancer should be prevented and managed. Opposition to such a serious threat appeared reactionary, dangerous and abusive of the needs of women. The implication that cervical cancer was a sexually transmitted epidemic gave particular impetus to the medical profession's proposed initiative of urgently surveying all sexually active women. The power of the 'epidemic' construction lay in its effectiveness in mobilizing both the medical profession and women themselves in a structured routine of body management and surveillance. The 'computerised control' of women which some members of the profession had advocated in the mid 1980s eventually became a reality (Duncan et al, 1985:821). In the aftermath of the Cervical Cancer Inquiry and with the increasing support from women and eventually the government in 1989, a nationally co-ordinated cervical screening programme was implemented.

5. Conclusion.

The debate which emerged in relation to cervical cancer in the 1960s-1980s, is illustrative of the social location of medical science. The debate was not about the application of rational science to a medical problem but more about the protection of medical consensus against the intrusions of opposing epistemologies. Professional strategies which have historically been applied to protect medical boundaries against encroachment from usurpers outside the profession were employed to protect medical beliefs from dissenters within the profession. This occurred because challenges to the knowledge claims of medicine made by Green and others were challenges to professional power and unity. They represented a questioning of medical authority, certainty and collegiality. When scientific knowledge emerged from other than dissenting sources, medical consensus was preserved by the assimilation and neutralisation of these new knowledge claims.

Closure of the cervical cancer debate did not occur as an outcome of scientific events but resulted from social factors which publicly legitimated medical consensus on cervical cancer and officially marginalised opposing views. It was not the scientific laboratory which eventually determined the legitimacy of knowledge claims around cervical cancer but an Inquiry which had been initiated and presided over by the laity. Paradoxically it was the actions of the laity which brought to a close a debate which the profession with its claims to scientific rationality and its employment of professional strategies had been unable to achieve.

CHAPTER SEVEN

Feminism and the Social Construction of Cervical Cancer.

1. Introduction

In the latter half of the twentieth century the women's movement made women's bodies the focus of discourses and political actions. In doing so, feminists aimed to redefine the meaning of gender and to reform the structural basis of relationships between men and women. This included reforming the relationship between men as medical practitioners and women as patients. The cervix and cervical cancer were important to the women's movement in actual and metaphorical terms as part of the feminist platform of restructuring medical values, beliefs and practices in relation to women. Concerns about women's bodies and medical power crystallized into a women's health movement which evolved from the women's liberation movement of the 1960s and 1970s.

Part Two of this chapter traces the development of the women's health movement in New Zealand and identifies the issues which became part of its platform. **Part Three** examines the responses of the medical profession to the women's health movement and the boundary maintenance strategies which it deployed to contain and marginalise feminist health initiatives. **Part Four** identifies the ways in which the cervix became a politically significant organ to the feminist health movement in allowing women to appropriate medical techniques and gain visual access and knowledge of a hitherto hidden part of their bodies. **Part Five** analyses the response of feminists to cervical cancer. It is argued that rather than providing a cohesive critique of medical constructions of cervical cancer, feminists largely appropriated medical views and approaches to the disease thereby contributing to the medical surveillance and disciplining of women's bodies. **Part Six** concludes by drawing out the major theme of the chapter which is that, whilst medicine has helped to shape women's bodies, women themselves have been active participants in this process.

2. The Women's Health Movement in New Zealand

The women's health movement gained momentum in New Zealand in the early 1970s as part of feminist actions around the broader agenda of women's liberation. This

movement had its antecedents in the Women's Christian Temperance Union in its attempts to improve public health (Bunkle, 1994). Central to the women's liberation movement in the 1960s and 70s, was the underpinning belief that the personal experiences of women had political connotations. This principle formed the basis of a broad range of activities which aimed to raise women's consciousness of the relationship between their experiences as individual women and the broader structural bases of their inequality as a gendered group (Calvert, 1981). This in turn drew women's attention to areas of their lives which may have previously appeared unproblematic. Institutions such as family, religion, education and health were reconstructed as being implicated in the oppression of women. Women's personal experiences in relation to these institutions were redefined as having significance not only for them as individuals but for the political positioning of all women in society.

One of the major initial activities of the women's health movement was to raise women's consciousness of belief systems which operated to keep them in their subordinate position. Identifying and analysing the fundamental beliefs about women which underpinned medicine was an important part of this consciousness-raising process. Medicine and the medical profession, became the focus of critical analysis and debate in a number of private and public forums. An increasing number of feminist publications in the 1970s ensured that feminist perspectives which contested other views of women, gained visibility. The feminist magazine *Broadsheet* first published in 1972 was one major vehicle for challenging in particular, the discourses and practices of the medical profession (Dann, 1985; Macdonald, 1993).

The key thrust of the women's health movement was to assist women in gaining control over their bodies through knowledge and self-help:

The key concepts of what became known as the women's health movement were information, self-help, and women's autonomy over their bodies. Feminist women's health workers tended to see themselves as part of a long line of female healers and midwives suppressed by the church, state and medical professionals (Coney, 1993b:249).

The self-help aspect of the feminist movement had a dual focus which included

providing information and support to individual women and putting political pressure on systems which sustained medical power. These systems included medical research and training institutions and professional associations as well as state bodies such as the Department of Health (Dann, 1985). The feminist self-help movement had a subversive political agenda which aimed to question and challenge medical dominance. Along with other similar movements it placed a high value on experiential knowledge and challenged authoritative medical constructions of health and illness (Kelleher, 1994). The concept of self-help was located within a discourse of the historicity of women's oppression in relation to their embodiment. This established for women an historical basis for understanding the oppression which formed part of their life experience. Women began to recognise that their easily dismissed, isolated health experiences were part of the historical and collective experiences of many if not all women (Marieskind, 1975). Women's historical disenfranchisement as healers also formed part of the background to women's experience of powerlessness both as consumers and deliverers of health care.

The self-help movement which feminism helped to initiate differed from the self-help movement which had grown out of the consumer activism of the 1960s and 70s. This latter movement had its roots in concerns about the social causes of diseases and decried medicine's emphasis on technology and individualism. Calvert (1981:95) suggests that the political significance of the body was central to the feminist self help movement:

It, (the women's health movement) has concentrated on gaining power and control of the technology used to exploit women. It has also provided a theoretical structure on which to base its attempts at radical change.

A crucial part of this analysis is the view that women's bodies represent the first barricade in a struggle to free women from universal oppression. It is this point that removes the women's health movement from the self help/alternative health care movement.

Central to the 'self-help' concept was the belief that women's mental and physical well being was linked with their right and ability to control their bodies.

An emphasis on dissemination of information to women about their bodies was an early important objective of feminism in New Zealand. Groups such as *Knowhow* were established in 1973 in Dunedin and Auckland, with the aim of providing women with information on fertility, sexuality and other health issues (Coney, 1993b). Knowledge about bodies was recognised by many activists as the key to women gaining power. One of the major aims of feminism was also to reconstruct medical 'truths' about women's bodies. The oppressive nature of these 'truths' and the medical practices which surrounded them were located within a context of widespread oppression of women.

Constructions of women as individuals and more importantly as a group with interests in common was a powerful platform for persuading women that they had a right if not a duty to know and understand their bodies. The reclaiming of the body occurred within a context of constructions of women as an oppressed and relatively powerless group. In contrast, the medical profession was constructed as 'insensitive', 'patriarchal', and 'sexist' (Daly-Peoples, 1977).

Whereas women had been historically constructed as 'problematic' to the medical profession and to men in general, feminists promulgated constructions of the medical profession as 'problematic' to women. In doing so, feminism began to develop what Foucault termed its own 'reverse discourse'. Feminists began to speak on behalf of an oppressed group and demanded a legitimacy for its discourses as it sought to redefine and recreate knowledge about women. Whilst feminists appeared to reject the discourses of medicine and sought to construct a new narrative of women, what actually occurred was the appropriation of much of the language of medicine. Descriptions of women's bodies, their biological functions and pathological disorders which appeared in the feminist literature tended to largely echo medical constructions. What was different about the feminist viewpoint however was the political analysis which accompanied these discourses often in the direction of advocating that women take control of their bodies as well as the medical encounter. This appropriation of medical language by feminism had both advantages and disadvantages to the movement. It enabled feminists to lay claim to at least some of the knowledge base of medicine from which women had been excluded. In doing so the movement attempted to claim power through knowing bodies and through challenging what was

termed the 'medical monopoly' on health information. This monopoly was identified as a major factor which enabled the medical profession to have power over women and therefore contributed to medical power and privilege. Appropriating the language of medicine therefore enabled feminists to challenge doctors in an informed and authoritative manner. The disadvantage of this political strategy, was however that the feminist health movement risked cooption by medicine.

The feminist health movement provided practical challenges to established medicine by setting up alternative medical structures for referral, information dissemination and alternative health care options for women. Examples of these initiatives were the establishment in 1977 of the *New Zealand Women's Health Network* and the *Waltham Women's Self Help Centre* in Christchurch. *The Health Alternatives for Women (THAW)*, was also established in Christchurch with the aim of providing information and acting as a referral system for women. *THAW* used a feminist analysis as a basis for promoting political change. *THAW* representatives voiced women concerns as health consumers, on a range of local and national committees. The organisation became a major threat to the medical profession in 1985, by providing what it termed 'well women' medical services which included cervical smear testing, pregnancy testing, breast self examination and vaginal examination. After threats of legal action from local gynaecologists, this service ceased (*The THAW Collective*, 1993:281-283). By 1988 *THAW* recognised that its efforts in changing the attitudes of doctors had made some limited progress but concluded that the majority of doctors were conservative élitists who were reluctant to change:

They start with an open mind, but after several years of belonging to this male-dominated, élitist, capitalist and racist club, they become deaf to the needs of those who don't belong (Broadsheet, 1988:32).

The feminist health movement was an important rallying point for women in identifying the body as a focus for action against paternalistic medicine. It tended to engage with medicine within a common epistemological framework but expanded this framework to incorporate an analysis of the impact of medicine on subjective women. From this standpoint feminist activists constructed a form of medical knowledge which was not easily challenged by the medical profession. Often empirically based, and

within the framework of the biomedical model, feminist knowledge was frequently presented as pragmatic and authoritative. The addition of lay interpretations in feminist discourses of the impact of medicine on women, provided a moral basis for the challenging of the objectivity and authority of medicine. The inclusion of subjectivity in the knowledge base of the feminist health movement provided a standpoint which emphasised women as privileged knowers. Feminists problematised the male dominated medical profession and its male based epistemology. It criticised medicine for its reductive, mechanistic and depersonalised conceptions of women and their bodies. The increasing use of technology in the control of women's fertility has for instance been interpreted by some feminists as indicative of the attempts of men to overcome what are perceived to be the deficiencies of nature (Bunkle, 1994). This theoretical perspective has resulted in some members of the feminist health movement promoting an essentialist view of women as spiritual, caring and holistic with an innate knowledge of childbirth and healing practices. Bunkle suggests that whilst concepts of gendered knowledge have helped women to regain confidence in their bodies and their lay knowledge, it is a standpoint which identifies women with nature and reinforces gendered arguments which have historically attempted to exclude women from culture. This view also assumes a universalism of women's perception and experience and denies the political differences which exist among women on the basis of class, age, race and ethnicity. However it can be argued that the inclusion of a privileged gendered subjectivity in feminist discourses has provided the feminist movement with a level of indeterminacy which has not been easily challenged by the medical profession. Whilst remaining within the epistemological framework of medicine, feminists have added a dimension to medical knowledge which has lent legitimacy to a women's view of health. However in doing so it can be argued also that the feminist health movement has been largely coopted by medicine and that radical goals have given way to a reformism which has resulted in the increasing medicalisation of women's bodies.

3. The Medical Profession's Response to the Feminist Health Movement.

The history of medicine in New Zealand has been marked by the use of professional strategies by the medical profession to maintain control over medical work. An important strategy employed by the profession has been that of 'occupational

closure'. This strategy has enabled medical practitioners to gain and maintain a monopoly over the practice of medicine (Belgrave, 1991). This monopoly has been achieved by exclusionary strategies and interoccupational control over other groups involved in medical or paramedical work (Willis, 1983). Organised as a social movement, feminists challenged the traditional boundaries of medicine by reconstructing the role of the patient in medical care. Medical work had traditionally involved the supervision, control and containment of bodies. Central to this has been a construction of patients as co-operative with clinical procedures and responsive to medical advice. The feminist health movement challenged these understandings of the patient-doctor relationship and argued that women should be active participants in medical care. It problematised medical knowledge of women and in doing so challenged the professional boundaries which separated lay knowledge from professional knowledge. It did so within a context in the 1970s and 80s of a more general and pervasive disillusionment with medicine in which there were heightened expectations of medicine to cure and at the same time a growing scepticism about what medicine could actually deliver (Rosenberg, 1986).

One of the main challenges to medical boundaries, which feminists in New Zealand initiated was the promotion of self-help methods of health care. This involved appropriating knowledge and techniques from orthodox medicine as well as advocating alternative healing techniques. Women were encouraged to look beyond medicine for example in treating 'cervical dysplasia' and to consider acupuncture, naturopathy, and homeopathy treatments (*Broadsheet*, 1990). Even more challenging to medicine was the establishment of medical services for women by feminist health activists. Offering health services for women placed the feminist health movement in a position similar to that of a competing, professionalising group claiming territory in the medical market place. The medical profession responded in ways which it had historically applied to occupational groups which had challenged its professional boundaries. These amounted to strategies of subordination, limitation and exclusion of competing occupational groups. Willis (1983) suggests that these strategies have allowed the profession to gain and retain dominance in the division of labour in medical care. Feminists not only offered competing clinical services, but in doing so they appropriated the biomedical model of illness and placed a feminist interpretation on this knowledge. They claimed an epistemologically privileged

position in knowing what was best for women and undermined the medical profession's standing as the experts on women's bodies. Doctors responded to feminist initiatives by raising questions about their political and personal motives. Efforts by feminists to set up health services for women were either ridiculed by members of the profession or constructed as dangerous and subversive to the gendered structure of society:

Any organisation whose object, or effect, is likely to emotionally isolate women from their menfolk-and I can see the proposed women's health centre breeding a lobby of man-haters-would help to achieve a disruption of present society. The old time missionary knew the score. Firstly disrupt the society to be taken over, then move in as a saviour with a new set of values (Harper, 1976:244).

The strategy of discrediting aspirants to medical work was employed by the medical profession in relation to midwives earlier in the century where they were described as dangerous, dirty and unfit to attend women without medical supervision (Donley, 1986; Mein Smith, 1986). Further examples of these professional strategies were in evidence when in 1985 the *Women's Health Alternative (THAW)* in Christchurch began to provide a limited medical service to women by offering Pap smears and vaginal swabs. The women offering this service had been trained by a 'sympathetic general practitioner'. Acting on a complaint from a gynaecologist, the Department of Health threatened *THAW* and the doctor who had trained the women with legal action. The service was subsequently stopped (Bird, 1987:32). A number of writers, including Willis (1983) and Witz (1992) have observed the importance of state patronage of medicine in its achievement of professional dominance. This has been particularly so in relation to the statutory legitimization of occupational boundaries:

Competitors have been subordinated, limited or excluded so as to maintain the dominant structural position of medicine through the patronage of the state, mainly in the form of licensing regulations which reproduce medical dominance (Willis, 1983:202):

The state's threatening of members of the medical profession with legal action when they actively supported women's health initiatives is indicative of the ways in which

the state and the profession co-operate to maintain professional boundaries when these appear to be weakened. Such actions send a powerful signal to doctors of the consequences of allowing usurpers to encroach on medical work.

Another initiative by the feminist health movement occurred in Nelson. This time, the Department of Health supported women in setting up a pilot programme to screen low income women for cervical cancer. The Department did so within the circumstances of the Cervical Cancer Inquiry and public pressure to provide adequate, accessible screening services. Money was allocated towards setting up a mobile, suitcase cervical screening programme. *Women in Nelson (WIN)*, the group who were instrumental in the establishment of the programme gained support from the local Area Health Board. On receiving a letter outlining the plans of *WIN*, opposition from the medical profession began to mount as one commentator observed:

Various doctor organisations, on receiving the WIN letter suddenly realized that the project was under way and they were in danger of losing a certain amount of power and profit because a lay group had been licensed to arrange cervical smear testing, which did not include them (Scott, 1989:107).

In an attempt to limit the role of *WIN*, doctors became active in determining the 'proper' role of the group. They defined the role as assisting them in identifying 'target' groups for screening, guiding women to the appropriate doctor operated screening service, working for a better utilization of existing services and educating women about cervical cancer as a sexually transmitted disease (op.cit:110). This is indicative of an occupational strategy which attempted to construct *WIN* as an adjunct to medicine, limit its work and subordinate the group to medical authority. The profession was also accused by feminist commentators of using a gendered strategy in maintaining their occupational boundaries:

...Nelson doctors did not hesitate to use a woman doctor to put a female face on the propriety of their opposition to the WIN project, in reality the propriety of keeping the power and profit of the profession inviolate (Scott, 1989:111).

Despite concerted efforts by doctors to lobby both the Area Health Board and the

Department of Health to prevent the *WIN* initiative it went ahead. The strategies employed by the profession failed on this occasion because state support of their case was not forthcoming. In a climate where state actors were themselves under considerable public pressure to be seen to be meeting the health needs of women the medical profession found itself without the support it needed. The profession was however willing to accommodate women's active involvement in health care when it wished to appropriate the skills which feminists had claimed as their own. Women's health groups were on occasions asked to instruct medical students in conducting internal examinations of women in a way which women would regard as sensitive to their needs. They were however prevented in the case of the Christchurch *THAW* initiative from teaching these skills to lay women (Bird, 1987:32-33).

The medical profession's concerns regarding the encroachment of women into their occupational territory was set within a context of growing disquiet on its part about the self-help movement. The greater level of knowledge and autonomy implied by self-help represented an unwelcome challenge for some members of the profession who considered the role of the doctor to have been secularised and commodified:

We as doctors have allowed ourselves to become used by the public and politicians as the passive suppliers of a service by failing to promote ourselves, and by trying to cater to every public fad and fancy, we have become grocers, giving the consumer what he wants. However the basic assumption that the consumer knows best is quite wrong. It is really just a political slogan with very little meaning, but with dangerous results (Climie, 1987:463).

Self-help initiatives threatened to routinize medical knowledge and challenge aspects of the medical model which had traditionally been based on a mechanistic view of illness. They subverted the mystique of medicine which had historically marginalised women and contributed to what was regarded by feminists as the undeserved prestige of the doctor as healer.

4. Feminism and 'Knowing' the Cervix.

The cervix became an important metaphor for the feminist health movement. It symbolised women's bodies as accessible and understood by the medical profession and as hidden and mysterious to women. Even before the Cervical Cancer Inquiry, the cervix had been acknowledged by the feminist movement as a 'political organ' which needed to be known by women. In 1973 an American feminist Lorraine Rothman, toured New Zealand talking to women about the self-help movement. She emphasised liberal values which included the right of women to know and control their own bodies and provided information and demonstrations of self-help techniques. These included, vacuum aspiration abortion, menstrual extraction and self examination of the cervix (Dann, 1985). Constructing women's bodies as 'knowable' was a fundamental element of the women's health movement and this was especially so in relation to the cervix:

...the act of cervical self-examination had a symbolic value which far exceeded its actual practical use. Women were claiming a tool and a skill which had previously been in the hands of male doctors. Self examination of the cervix was a symbol for self-examination of every aspect of women's health (Dann, 1985:82).

Whilst the medical profession could claim the cervix as being 'a readily accessible organ' (Duncan, 1981:120), women were unable to make a similar claim. The cervix was an organ which the medical profession had in historical terms viewed, defined and managed. Doctors had used technologies to view the cervix and they had historically claimed the right to describe its features and define its pathologies. The speculum was a significant instrument to this end. Its symbolic value to the medical profession and to women was not lost on the feminist movement. Feminists encouraged self-examination of the vagina and cervix through the use of the speculum and gave many women the opportunity to view an organ which they had never seen before. The viewing of the cervix and the use of a basic but important medical instrument represented a political act which challenged the medical profession's monopoly on the examination of this part of women's bodies. The speculum became a metaphor for women reclaiming their bodies from a position of knowledge and strength:

The instrument used to visualise the cervix, the speculum, has with good reason been co-opted by feminists to represent its appropriation as an instrument of liberation: a feminist poster proclaims, 'I am strong, I have my speculum, I can fight!' (Bickley, 1987:12).

The examination of the cervix also represented an important unifying activity for the feminist health movement. The privatisation of women's bodies had since Victorian times encouraged a sense of personal modesty in relation to bodies and sexuality. This has been augmented in the twentieth century by prescriptions in the popular media which have encouraged a sense of bodily inadequacy and competition with other women. The use of the speculum not only symbolised a reclamation of individual bodies but also represented a challenge to the privatisation of bodily experiences. It emphasised the collective nature of women's need to know and the importance of unity in the challenging of medical power:

I saw it happen this week when Carol, a woman from the Los Angeles Self-Help Clinic, slipped off her dungarees and underpants, borrowed somebody's coat and stretched it out on a long table, placed herself on top and, with her legs bent at the knees, inserted a speculum into herself. Once the speculum was in place, her cervix was completely visible and each of the fifty women present took a flashlight and looked inside (Frankfort, 1972:1x).

Practical demonstrations of the use of the speculum occurred in New Zealand at public events such as the 1977 United Women's Convention (Brown et al, 1978). The collective nature of these experiences served to support women in their challenging of traditional social roles and the institutions (such as medicine) which supported these roles (Marieskind, 1975:218). The use of the speculum by women also symbolically challenged medical authority by breaking down the mystique of the literally and figuratively shrouded medical technique of pelvic examination. Self examinations showed women that they could be active participants in understanding their bodies. These examinations were not infrequently accompanied by discussions of alternatives to allopathic medicine in the form of 'home' remedies such as yoghurt for vaginal thrush which further challenged medical sovereignty over the vagina and cervix. In doing so, feminists constructed cervical self-examination as being of

emotional as well as political importance to women:

Learning to do cervical self-exam with a speculum is an important part of the process of women beginning to take control of and responsibility for our own bodies...Self examination is also, for many women, an important emotional experience. Having a good look at our external and internal genitals is a very good way to start to change any fears and hatred for our female bodies which this male dominated culture has taught us (Barnett and Fox, 1986:8).

The metaphorical construction of the speculum as an instrument of power, also emerged during the Cervical Cancer Inquiry of the late 1980s as the medical profession began to be challenged on specific instances of unethical and insensitive treatment of women. In this context the speculum was constructed by feminists as 'biting back' and subjecting the medical profession to the indignity of lay opposition (Rosier, 1987a:5).

5. Feminism and the Construction of Cervical Cancer

Whilst the cervix was constructed as an organ symbolically significant in women's growing power over their bodies, cervical cancer was constructed by the feminist health movement as a disease which required co-operation and a level of dependence on the medical profession. As cervical cancer began to receive greater attention from the medical profession in the 1970s and 80s, the feminist literature paralleled this attention by providing women with medical details of the epidemiology, symptoms and screening procedures for the illness. Feminist descriptions of cervical cancer largely echoed medical constructions of the disease in describing its 'epidemic' nature. In some instances cervical cancer was linked in the feminist literature with women's sexual behaviour emphasising as did medical discourses its 'virtually unknown' status amongst virgins and nuns (Calvert, 1979:30-31). Women were encouraged to learn about the classification of Pap smears and how to appropriately prepare for a Pap smear test. This latter advice in the feminist literature, included avoiding 'penetrative sex for 48 hours' before a Pap smear and avoiding douches and baths and tampons (Calvert, 1978:37). Feminist constructions of cervical cancer drew on medical suggestions that male sexual partners played a

role in the aetiology of cervical cancer:

Exposure to uncircumcised males would appear to increase the risk of developing cervical cancer. It is now clear that there is a relationship between men and development of cervical cancer in women. Most of us have been unaware of this.....(Calvert, 1979:30-31).

The dissemination of information about cervical cancer was part of the feminist health movement's agenda of increasing women's power by assisting them to gain knowledge. The feminist and popular literature, enabled women to view their bodies through the eyes of the medical profession and in some cases socialised them into having a co-operative attitude to the clinic. Women were for example encouraged to embrace the Pap smear and regularly attend for screening. They were also encouraged to trust the '95-98% accuracy of smear tests' and were reminded of the health penalties which arose as a consequence of avoiding smear tests (Calvert, 1978:37; Charman, 1986). Having regular Pap smears was identified as a health habit which women should acquire (Boston Women's Health Book Collective, 1971). Concerns that were raised by feminists in relation to cervical cancer and cervical screening predominantly revolved around ensuring that women had access to both medical information and facilities (Barnett and Fox, 1986). In light of this women were encouraged to see themselves as needing to put pressure on the medical profession to meet their screening needs:

The overall message from the symposium is that any women who has ever had sexual intercourse is at risk of cervical cancer and should be regularly screened. But because of the somewhat offhand attitude of some doctors to the disease, women will need to educate themselves about proper diagnosis and treatment, and insist that their management conforms to accepted standards (Coney, 1987:14).

Calls for political action on cervical cancer before the Cervical Cancer Inquiry largely centred on supporting the medical profession in its lobbying of Government for a nationwide screening programme. Criticism of the medical profession focused on its ignoring of women's special health needs and the lack of facilities for cervical screening (Bickley, 1987; Charman, 1986; Coney, 1987). What largely went

unanalysed and unproblematised by feminists were medical constructions of cervical cancer and the frequently stated need for the intensive surveillance of the cervix. This is paradoxical in a social movement which had set itself the task of reforming medical constructions of women's embodiment. As a result of unquestioningly constructing women's bodies as needing this type of surveillance, it can be argued that the feminist health movement contributed to the further medicalisation of women's bodies. As knowledge which had once been the preserve of the medical profession became more accessible through the initiatives of feminism, many women began to view surveillance of the body as politically as well as personally desirable. Women joined the more general social trend identified by Crawford (1980) of viewing health as a life value to be actively sought after. Feminists however added a gendered perspective to this view and constructed healthy behaviours as having political as well as personal value.

The feminist health movement was not unaware of the potential for cooption by the established medical order and acknowledged that on occasions radical objectives could give way to reformist imperatives:

In attempting to go beyond theory to providing actual health clinics and health services, the women's health movement has become not only a visible front line for attack by the system. It has also become a focus for analysis and sometimes attack from the feminist movement (Calvert, 1981:95-96).

There were some feminist critics however who challenged the basis of medical knowledge about cervical cancer, but these were in the minority. Despite the debates emerging in the medical literature about cervical screening these dissenting views were largely absent from the feminist literature. Instead women were encouraged to increase their understanding of medical orthodoxy and to use this knowledge to take control of their bodies. Feminist commentators who did challenge medical knowledge about cervical cancer did so on the basis of misogynist constructions of women. One writer for instance argued that medical constructions of cervical cancer were 'another guilt trip' to be endured by women who blamed themselves for acquiring the disease (Hager, 1994:22). Darby (1992:25) highlighted the intensity of the efforts of medical

researchers in substantiating what she termed 'misogynist theory' in linking cervical cancer with women's promiscuity. In doing so she criticised medical ideology as well as scientific practice. She called into question the design of epidemiological studies which linked the human papilloma virus with cervical cancer:

Medical researchers remain undaunted, however, in their quest for a sexually transmitted cause of cervical cancer. As the HPV theory comes under critical scrutiny, new research now suggests a link between cervical cancer and Epstein-Barr virus (EBV). While EBV is not normally considered a sexually transmitted disease, at least one research team has argued that there is a possibility of it being venereally transmitted. Having run out of candidate STDs, medical researchers investigating the cause of cervical cancer seem content to classify any organism found in cervical tissue as sexually transmitted (Darby, 1992:25).

In Darby's analysis medical constructions of cervical cancer as a sexually transmitted disease colluded with patriarchal restrictions on women's sexuality by defining women's sexual autonomy as a health risk. She, along with other commentators suggested also that preoccupation with women's sexuality as a cause of cervical cancer had deflected attention away from other causes of the disease such as environmental factors and the iatrogenic effects of contraceptive drugs (Bickley, 1987; Darby, 1992). The class based nature of medical constructions have also been noted by feminists who have argued that working class women have been described by the medical profession as 'particularly promiscuous' (Darby, 1992:26). In similar vein, Bickley (1987:11) identifies the media as colluding with medical science in causing women who have had more than one sexual partner to feel 'guilty and frightened'. She also criticises doctors' definition of cervical cancer as a disease of the individual which ignores the social circumstances which make women vulnerable to the disease and minimises the profession's responsibility for taking action to prevent it. Bickley (1987:11) also suggests that medical discourses on cervical cancer create an expectation of compliance by women which she contends are based on false expectations:

The assumption nurtured by the medical hierarchy is that if a woman submits to cervical cancer screening she will be safe i.e. confirmed as free of the condition

for which she is being tested or able to be treated promptly. Unfortunately this is not so, and occasionally there are fatal consequences.

The emphasis placed on the medical profession as the most appropriate group to manage cervical cancer is argued by Bickley to have led to the increasing medicalisation of women's lives. She suggests that this outcome is based on the false premise that medical science is objective and excellent. She expresses concerns, that placing cervical cancer screening in the hands of general practitioners has increased their power to 'define and control the boundaries of women's health' and advocates class, gender and race sensitivity in the provision of Pap smears. She identifies also the obvious and symbolic power differential between women and their doctors during the procedure of collecting cervical cells for examination (Bickley, 1987:12).

Notwithstanding the critique of these feminist commentators, the feminist response to cervical cancer represents a paradox which Foucault identified in relation to medical surveillance in general. He suggested that modernity had spawned a culture of individual rights and in doing so had encouraged a more intense level of surveillance of individuals and populations as goals of equality are pursued (Turner, 1987). Ironically the more women were encouraged to appropriate medical knowledge about cervical cancer, the more medical constructions came to underpin feminist views of women's bodies. Feminists found themselves supporting members of the profession who appeared to be advocating for women by recommending an intensification of services for them. This resulted in feminists supporting in turn, an intensification of surveillance and control of women's bodies. Whilst feminists challenged the objectivity of the scientific basis of medicine they had no alternative body of knowledge on which to base an effective critique of medical views of cervical cancer. In this marginalised position they found themselves largely coopting medical explanations of the disease, and supporting the apparently benign and pragmatic position of ensuring that all women were regularly screened. There is little evidence that the feminist movement supported the positions adopted by medical dissenters who challenged the morality and rationale of subjecting women to extensive screening for cervical cancer. Even though the arguments of dissenters were represented as being based upon concerns for the wellbeing of women these appear

to have been largely overlooked by feminists in favour of the orthodox medical view of the disease. The more subversive positions adopted by feminists were directed instead at challenging the medical profession's monopoly on carrying out screening and in lobbying the Government and the profession to provide more sensitive and appropriate services for women. The outcomes of the Cervical Cancer Inquiry lent impetus to these latter objectives.

6. Conclusion.

The feminist health movement played an important part in challenging medical dominance in the latter years of the twentieth century. Whilst the movement problematised medical approaches and attitudes to women's bodies, it is argued here that feminism contributed to the surveillance and disciplining of women's bodies. This unintended consequence arose out of the appropriation of medical knowledge by feminists in order to know the body. It also occurred as a consequence of the reformist political platform of feminism which aimed to ensure that women's health needs were extensively catered for in a sensitive manner. This resulted in women's subjectivity and diseases (such as cervical cancer) coming to the attention of both doctors and state actors. Women themselves were encouraged into a heightened sense of body consciousness in which knowing and monitoring the body became not only personally valued activities but politically valued also. The cervix and the management of cervical cancer, serve as exemplars of the unintended consequences of social and political action. The cooption of the feminist health movement by medicine has led not only to the increased surveillance of women but it can also be argued has led as a consequence to an increase in medical power.

CHAPTER EIGHT

The Popular Media, Cervical Cancer and the Medical Monitoring of Women's Bodies.

1. Introduction

There has been a growing interest in the relationship between the media and medicine in recent years, but this area of social analysis has not received as much attention from sociologists as other areas of medicine (Bury and Gabe, 1994; Gabe et al, 1991). Lupton (1992:28) suggests that there has been a lack of critical qualitative analysis of the relationship between the media and medicine, with quantitative content analysis forming the basis of many of the studies which have been carried out. She argues that this methodology is limited in its ability to demonstrate the latent meanings and ideologies of media artifacts. She argues instead for an approach which focuses not only on the content of media representations but also their context:

Focusing upon the context in which health, disease and risk are discussed in popular cultural products, and identifying the systems of shared beliefs which give meaning to these representations, may provide better understanding of a society's responses to these phenomena (ibid).

From this perspective, media accounts do not merely reflect societal norms, values and beliefs, but also constitute them as part of a complex and constantly reflexive process (Lupton, 1994a:26). There has however been considerable debate in sociology about the degree to which this reflexivity operates. Abercrombie (1990) isolates one view of mass popular culture which he attributes to Adorno which suggests that consumers are deceived, controlled and made passive in the face of repetitive and seemingly real images. This perspective suggests that audiences are relatively inactive and uncreative in their responses to the media. An alternative view argues that the media is a site for struggles over moral, cultural and political leadership. Dominant and subordinated values existing in society are seen to be negotiated in this context with each affecting and being transformed by the other. Abercrombie suggests that this latter Gramscian view has advantages over the perspective represented by Adorno:

The Gramscian turn has a number of important advantages over the sort of approach to popular culture taken by Adorno. In particular it takes audience pleasure seriously and seeks to explain involvement in popular culture rather than merely deride it. Secondly it allows for the way in which dominant cultures have to accommodate subordinate cultures to be at all effective. Lastly, a Gramscian approach in practice does not insist that the messages of popular culture have to be homogeneous (Abercrombie, 1990:202-203).

Abercrombie suggests that no sociologist takes seriously the view that consumers of mass culture are passive recipients of media images. Instead, many now acknowledge that the problematisation of not only media content but also audience responses as being essential to understanding the relationship between the media and society.

A critical sociological approach to the mass media is primarily concerned with the political nature of media items. In acknowledging the power differentials which exist in the mass media, Lupton (1992) suggests that multiple and contradictory discourses compete for attention. She argues for an analytical approach which uncovers the values and beliefs which are privileged in media accounts and also for a questioning of whose interests are being served by the reproduction of these ideas. This chapter positions cervical cancer within a context of three forms of mass media. These are, the news media, the popular media exemplified by the *New Zealand Woman's Weekly*, and the self-help literature.

Part Two of this chapter examines the news media and its representation of cervical cancer. **Part Three** gives an overview of the genre of women's magazines in preparation for an analysis of the *New Zealand Woman's Weekly*. **Part Four** analyses historical constructions of women's embodiment within a context of idealised femininity in the *New Zealand Woman's Weekly* and argues that these constructions have been an important aspect in the disciplining of women's bodies. However, whilst it is argued that this magazine has been a site for the transmission of a domesticated form of medicine, it is also argued that these discourses have on occasions become the means for the dissemination and communication of women's struggles. **Part Five** gives an overview of constructions of women's bodies in the

self-help literature. Self-help discourses are identified as being largely affirming of medical views of cervical cancer. However it is argued that the more recent self-help literature locates cervical cancer in a broader project of personal transformation in pursuit of an idealised self. **Part Five** concludes the chapter by suggesting that the media has responded reflexively to issues to do with women's bodies and cervical cancer by representing a range of viewpoints. It is also argued however that the media has largely reflected dominant cultural metaphors of femininity and medicine and can be said to have contributed to the medicalisation of women's bodies.

2. The News Media and Constructions of Cervical Cancer

Medicine has proven to be a fruitful source of news for representation in the media. The popular idea that the mass media neutrally and objectively reflect the events of the world is challenged by Karpf (1988). She suggests that media representations establish a framework which shapes the ways in which issues are considered. Readers or viewers are invited on the basis of these frameworks to pose certain questions and ignore others. Hierarchies of media representations which silence some discourses do so within a context of promoting others (Lupton, 1994b:336). An example of this is the reporting of medical science and technology which have historically been represented in terms of progress and benevolence at the expense of an alternative view which acknowledges potential or actual medical and technological harm. The media has been seen to mediate medical relations by giving individuals a voice but one commentator argues that this is often done in a way which reflects dominant views of gender roles and consumerism (Gabe et al, 1991). In more recent times, the media has played a role in challenging the 'truth claims' of medicine by problematising the view that medical science is based upon a consensus of rational, objective and unquestionable reality (Karpf, 1988).

One of the significant issues behind news accounts of health and illness, is that they are usually presented with the weight of 'expert' opinion behind them. This gives these texts an authority and a 'truth' which can be politically advantageous in terms of lobbying for a particular stance in areas such as government policy. The news media can also make a public issue out of an event by challenging the 'public image' of professions, state actors or other social groups. This may result in some 'medical causes' being allocated resources:

News media attention to a health issue can result in funding being made more easily available for research in that area. Even if the results of medical or public health research are inconclusive or barely statistically significant, if they appear in a prestigious journal, have a well-known person as one of the authors, the subject is deemed interesting to the public, or the conclusions made by the authors are provocative, then they will be judged newsworthy (Lupton, 1994a:22).

Grew (1992:113) suggests that the news media has impact on both the public and politicians and can be described as a powerful source of political pressure. She suggests that extensive coverage given to the national cervical screening programme by the media ensured that it became a legitimate public and state concern.

The medical profession has what can be described as an ambivalent relationship with the news media. On the one hand doctors not infrequently complain that the media has been sensationalist and inaccurate in its lay reporting of medical events. On the other hand the media is recognised by the profession as being useful for health promotion activities and as a forum for lobbying for public support. Both of these competing positions have emerged in relation to disputes about cervical screening. In the 1970s, concerns were expressed by doctors that accounts of dissenting views in relation to cervical screening in the 'lay' press were dissuading women from having cervical smears and were causing misunderstanding about the value of cervical cytology (Giesen, 1972; 1973; McIndoe and Williams, 1972). Grew (1992:143) suggests that regular news accounts of research into cervical cancer at National Women's Hospital as 'barbaric and unethical' kept the issue alive. It is likely that the news media advantaged the cause of those in favour of cervical screening.

Karpf (1988) argues that news accounts of medicine commonly depict doctors as heroes and miracle workers and patients as grateful recipients. Disease is commonly represented as biomedical in origin and is individualised to the exclusion of the wider social context in which medical events occur. Lupton (1992) argues that news accounts often valorize medical technology and surgical interventions, frequently within a context of dramatic accounts of disease. This was so during the 1980s when the news media suggested that cervical cancer was reaching epidemic proportions (NZ Herald, 1984). Medical views were reflected in these accounts, with cervical

cancer being constructed as out of control in New Zealand unless screening coverage of women was increased. A headline in the *Sunday Star* in 1986, similarly proclaimed cervical cancer as 'the modern women's plague' and pointed to 'ominous' signs of an epidemic of cervical cancer if an effective screening programme was not introduced (Storey, 1986:A10).

Media discourses which represented cervical cancer as an 'epidemic' or 'plague' overlaid medical discourses with a dramatic narrative of women's risk in relation to the disease. The juxtapositioning of these discourses with those which located cervical cancer within a context of women's sexuality created powerful moral messages:

Medical people fear the worst because the lifestyle of many young women puts them at serious risk of cervical cancer. Early sexual activity and multiple partners are two factors linked with cervical cancer (ibid).

These moral messages reproduced beliefs about women as out of control in a medical and sexual sense and implied that cervical cancer was the outcome of moral laxity. The contribution of structural factors in relation to cervical cancer has been given far less prominence in the press. Lupton (1994c) suggests that news accounts of breast cancer were dominated by binary oppositions which implied that this cancer was a retribution for the rejection of motherhood and traditional feminine roles in favour of the material rewards of the working world. Similarly, it may be argued that press accounts of cervical cancer have emphasised a binary opposition between women's sexually virtuous lifestyles and their sexually promiscuous lifestyles. In this context, cervical cancer has also become a metaphor for retribution.

In most news accounts of cervical cancer medical technology is represented as offering the solution to the disease. News stories of the dramatic efficacy of medical technology have often been constructed within what can be described as the genre of the 'salutary case study', which depicts a prudent woman who consults her medical practitioner and saves her life. Typical of this approach was a headline of 'Patricia's test almost too late' (*Sunday Star*, 1986:A10-11). This 'real life' story portrayed a woman who had visited her doctor just in time to be given a smear test before her

cancer killed her. Case studies, such as this, serve a number of purposes in the media. They personalise and dramatise accounts of medicine and position 'real' people within a context of medical heroism and progress. By doing so, medical issues are taken out of the clinic and repositioned in the community, often within the context of the family. These accounts become not only informative, but instructive as the news consumer identifies with the experiences and responses presented. Rather than medical tales, these news items become moral tales.

News accounts of cervical cancer have however not only privileged medical constructions of cervical cancer, but have also presented other views. At the time of the Cervical Cancer Inquiry and the events which preceded it, feminist commentators and others who were critical of the medical profession were given prominence in the media. There was intense interest in the Inquiry itself and its aftermath. This included criticism of the medical profession and the government in their tardiness in establishing a national screening programme (Parker, 1989; Long, 1988; Little, 1989). News accounts also gave prominence to the women who were involved in Green's research at National Women's Hospital (Nichol, 1989). Within this context, the efficacy of medical technology in relation to cervical cancer was questioned. The accuracy of smear tests also came under scrutiny (Ross, 1992). The media interest in cervical cancer reached a peak in the late 1980s and early 1990s, with Grew (1992), locating seventy-nine newspaper articles on cervical screening between May 1990 and February 1992. It can be argued on the basis of the volume of news coverage that the media helped to keep the issue of cervical cancer alive after the Cervical Cancer Inquiry and may have played a part in prompting both state actors and the medical profession to be seen to be supportive of the national screening programme which emanated from the Inquiry.

The news media approach to cervical cancer is indicative of the media's propensity to draw on dominant cultural metaphors and at other times to challenge and subvert professional and other discourses. It can be argued that the media played an important part in making a public issue out of cervical cancer from the outset. It can also be argued that the news media contributed to cervical cancer becoming a private, sexualized issue for women in its emphasis on the moral implications of the disease. This is indicative of a view of the media as reflexive rather than

conspiratorial in its approach to news.

3. Women's Magazines and the Construction of Women's Bodies.

Women's magazines form a particular genre of popular culture. They have been variously described as a form of escapism for women and as a means of disarming challenge to social norms by vicariously satisfying women's needs and desires (Allatt, 1996:37). Central to women's magazines is the issue of women's bodies and the positioning of these bodies within a context of a gendered society. By representing typifications of gender roles, women's magazines provide readily available sources of instruction by mediating the complex world of changing norms and expectations. Such typifications have been appropriated by women in the interests of better fulfilling the roles of wife and mother and more recently in realising an idealised self.

Women's bodies are frequently represented as units of reproduction and production and as recalcitrant, sick and unstable in the popular media. It can be argued that this has increasingly contributed to a fragmented view of embodiment which in turn has led women into an intensification of self management and surveillance over increasingly smaller and specific areas of their bodies. In doing so, the popular media has echoed the views of the medical profession in constructing women's bodies as being in need of constant management and control by both doctors and women themselves. As a result, it can be said that women's magazines have been an important vehicle for bringing medicine out of the clinic and into the home. However it can also be argued that the popular media has at times been a very public site for women's struggles against dominant cultural views and institutions which have sought to limit their power.

Women's magazines have played an important part in responding to and shaping changes which have impacted on women in the twentieth century. These magazines have both constructed femininity and responded to changes in definitions of what it means to be a woman. A number of recurring themes have been central to these definitions of femininity. One of these is that women's existence is beset by problems for which magazines provide inspiration and creative solutions. Another prevalent theme is that women are a unified group confronted by problematic others such as husbands and children. Yet a third theme is that women's bodies are a problem

which must be managed within strict but ever changing norms of femininity. Women almost without exception, have been situated by women's magazines within the domestic sphere or in close proximity to it (Ballaster et al, 1991:13).

Women's magazines have established a grand narrative of a women-centred view of the world by detailing the everyday reality of women's lives. This has been done within a context of the transmission of pleasure. What it means to be female in a gendered world is represented through appealing narrative and illustrations. It is argued by McCracken (1993:3) that these pleasurable codes are political in nature:

Readers are not force-fed a constellation of negative images that naturalize male dominance; rather, women's magazines exert a cultural leadership to consensus in which highly pleasurable codes work to naturalize social relations of power.

These themes have formed the basis of magazines such as the *New Zealand Woman's Weekly* in its attempts to provide women with the pleasures of self identification, a sense of belonging to a community of women and the escape from the reality of daily routines. Since its inception this magazine has portrayed women as having to cope with a problematic self requiring intensive self surveillance to ensure that the expectations of the others, including husbands, children and also the medical profession could be realised. In earlier years women's magazines identified the 'other' primarily as men in the roles of fathers, husbands and doctors. The idealised self as 'other' has become a feature of the latter half of the twentieth century. Women have been encouraged through the popular literature to take responsibility for the ways in which others respond to them. They have also been increasingly encouraged to take responsibility for their own health and for the health of others. This has been so for cervical cancer as it has for other bodily disorders. It can be argued that women's magazines have therefore contributed significantly to the medicalisation of the bodies of women. They have served as a vehicle for the promotion of normative standards of how bodies should function in a physical, emotional and social sense. The authority of medical science has often underpinned constructions of femininity by presenting the 'unequivocal' and 'rational', 'scientific' 'truths' about women as benign and paternalistic advice. Within a context of domestic, personal and family relationships, medical issues have been constructed

as important for women to know about and act upon.

Women's bodies and their appearance, the tasks they perform and their potential pathologies have historically been targets for disciplinary technologies. In tracing the historical constructions of the bodies of New Zealand women through the popular media, it can be argued that popular discourses such as those represented in the *New Zealand Woman's Weekly* have been an essential component in creating the medically co-operative bodies of women. Long socialised in the art of self surveillance, women have become the target of systematised medical initiatives exemplified by the national cervical screening programme. The popular media has contributed to the acceptance of women of this form of surveillance through discourses which have constructed medical interventions as a part of the normal, routine rhythms and even pleasures of a woman's life.

Women's magazines have not however been unquestioning of medicine. In recent years women have been encouraged to become more sceptical and cautious about complying with medical authority. However such resistance has been set within a context of fear that the medical profession may, through acts of omission or commission endanger women's health further. In doing so, they have confirmed women's status as physically and emotionally vulnerable and incomplete. The inadequate surveillance of women's bodies by a flawed medical profession has been taken up by the popular media as a basis for women becoming more involved in intensely surveying and controlling themselves. The pleasure of these activities lies in a sense of performing important activities in the interests of the idealised self and in pleasing others.

The New Zealand Woman's Weekly has been in circulation since 1932 and has the longest publication history of any women's magazine in New Zealand. It provides valuable documentary evidence of the ways in which New Zealand women have been informed about themselves through a medium primarily aimed at entertainment and pleasure. This magazine has acted as a barometer of social expectations and values and has provided an important historical record of the extent to which these expectations and values have been accommodated or resisted (May, 1992). The magazine has been popular with New Zealand women. Evidence of its popularity in

the 1970s is provided by a survey conducted of 'women in the home' by the New Zealand Federation of University Women and National Council of Women, Country Women's Institutes, and the Society for Research on Women. The survey found that in 1974, of the thousand women randomly sampled, 557 regularly read a women's magazine and 402 read the *New Zealand Woman's Weekly*. The magazine was also found to be an important source of information for women:

It appears that women's magazines are the chief, and in many cases the only, material a woman reads. The popularity of the "problem page" is some indication of the reliance many women place on these magazines (New Zealand Federation of University Women, 1976:15)

An analysis of the content of the *New Zealand Woman's Weekly* provides useful insights into constructions of femininity. Women's bodies are central to these constructions, situated within a context of the authority of husbands and the medical profession, the defining eye of other women and of the self. The content of this magazine needs to be analysed with an understanding of power requiring constant maintenance through daily practices and through symbolic or actual references to the norms which support it.

4. The *New Zealand Woman's Weekly* and the Construction of Gendered Bodies.

i. Women's bodies and the preservation of the gender order during the 1930s

The bodies of New Zealand women were, during the 1930s, portrayed in the *New Zealand Woman's Weekly* as multifunctional units. They were bodies which could perform domestic tasks in the context of wife, reproduce in the context of mother and increasingly labour outside the home in industrial and business contexts. The advent of the working woman of the 1930s resulted in discourses which encouraged women to see work as a 'cure' for the 'pathology' of indolence and boredom, which it was argued afflicted those who stayed at home. Housework and looking after children were described by Wallace (1932:55) for instance as 'an unending monotony'. Modern women were increasingly constructed as restless and searching:

The restlessness of the modern woman is often really laziness - indolence of the mind which will disappear when she finds something to do (Kennedy, 1937:28).

During the 1930s women responded to the greater opportunities offered by urbanisation and the world of work. There was a decline in the number of domestic servants in New Zealand homes which reflected a decrease in family sizes and a change in the intensity of domestic duties as a result of improved plumbing and sewage facilities (Matthews, 1984). Women's opportunities began to expand beyond the hearth but for most, work outside the home was an interlude between school and marriage (Olssen, 1980:165). Whilst women who were employed outside the home were to an extent encouraged and acknowledged, this acknowledgement occurred within the context of an ongoing debate about proper roles for women. Central to this debate was the intensely political issue of gender relations. This is evidenced by a male contributor to the *New Zealand Woman's Weekly* who warned that employment for women seriously damaged the 'feminine image' in the eyes of men:

Now that the modern girl is stepping down from her pedestal, she is losing the respect her father and grandfather paid to womanhood (Farnol, 1937:28).

Ambivalence towards the use of women's bodies in the paid labour force is further reflected in references to women as having responsibility for maintaining an unproblematic gender order. They were to achieve this through understanding what men required of them and through monitoring their behaviours to ensure that they were gender appropriate. Whilst women were expected on the one hand to be capable in the home and in the business world they were nevertheless expected to preserve a relationship with men which did not in any way challenge a gender order which allowed men to consider themselves physically and intellectually superior to women. This contradictory mix of expectations is reflected in the advice offered to women by Dorothy Dix in 1934:

Don't be a dumb Dora - nor yet a highbrow. Men like girls who are clever enough to be bright and entertaining but they pass by the one who discourses to them about the Einstein theory.

Don't be hard-boiled - neither be too soft. Everyman's feminine ideal is dewy eyed innocence and sweet truthfulness yet he doesn't want her to believe more than half he tells her. Besides he expects her to have enough sense to look out for herself in these days of emancipated women (Dix, 1934:27).

Whilst women appeared to receive recognition in the popular media that their horizons were broadening beyond the domestic sphere, their major function was winning and holding the affections of men. Women were warned of the need to maintain an alert surveillance over their bodies for signs which may indicate that their value to men was diminishing. Illness, ageing and not having an appropriate hair colour, were identifiable bodily signals that women were not monitoring or managing themselves appropriately. Women were also encouraged in the interests of body management to increasingly develop a new role for themselves, as consumers. The woman consumer was encouraged to view the purchasing of health and beauty products (often in the form of patented medicines) as essential to her wellbeing and that of her family. Monitoring the body for signs of illness or declining beauty was a prerequisite for the purchasing of products which would assist women in maintaining appropriate and highly valued relationships with men. An advertisement for a product called 'Thyrodone' is indicative of this trend. The advertisement suggested that anaemic girls were not popular with men because their anaemia had sapped them of their 'vivacity and charm' (NZWW, 1937:44). An article entitled 'Lady Be Loved' suggested that women follow a routine involving a 'sensible diet, plenty of sleep, fresh air and sunlight' to avoid their 'porcelain colouring' turning to 'a ruddy, purplish-blue tint' (NZWW, 1939:15). Corpulence, nervousness, exhaustion and wrinkles were constructed as signs alerting women to the need for bodily vigilance and control. This was primarily within a context of being pleasing to the gaze:

The most important thing for women today is to be as slim as possible and generally speaking a delicately built girl has far more chance of finding favour in the modern male's eye than a generously proportioned one (Jang, 1935:22).

The media portrayal of the multifunctional bodies of New Zealand women in the 1930s was set against a background of the competing identities of mother, wife, consumer, worker and unemployed worker. Unemployment created changes in

gender relations through the competition for jobs as well as changes in family life, which began to erode the authority of husbands and fathers in the home (Olssen and Levesque, 1978). Multifunctional women constituted a reserve labour force. At the same time, as work grew scarce, women were portrayed as equally capable of reverting effortlessly to the roles of companions to men, housewives, mothers and consumers of the increasing number of commercial products. Between the 1930s and the 1950s, women as consumers were targeted for advertising which reaffirmed their gender roles as primarily that of wife and mother. Domestic appliances in the home were linked in advertisements with women's ability to win and maintain the affections of a man and to making family life better and safer (O'Donnell, 1986:175).

Women's magazines at this time assisted in maintaining the gender order by encouraging women to believe that no matter what roles they had in or outside the home, responding to the defining power of the male gaze was of paramount importance. Men as a result were confirmed in their role as having the status and authority in exercising a defining gaze. Women's bodies were central to the maintenance of this gender order.

The intense scrutiny of women as mothers in the 1930s was increasingly reflected in the popular media. A 'right' view of mothering increasingly bore the stamp of medical authority. The *New Zealand Woman's Weekly* was an important vehicle for the transmission of medical constructions of gender roles. Medical knowledge conveyed into the home succeeded in constituting new forms of knowledge amongst women as well as creating new needs, bodily disciplines and subjectivities. Women's need for protection and training by the medical profession (and also by their husbands) was justified on the basis that women had lost their natural ability to mother as a result of 'modern' living. Women were encouraged to maintain the gender order by becoming the kind of mother who would accept the benign authority and advice of the Plunket nurse, as well as that of her doctor and her husband. The popular media played an important part in transmitting the expectations of scientific motherhood to women:

The regular supervision of a baby by a Plunket Nurse is now recognised as a great advantage by the average mother.

An explanation of the importance of her own milk to the baby and the natural benefit to herself if she nurses her infant will surely influence her in adopting the right attitude of mind towards nursing. Over anxiety, undue excitement, overwork and worry should be avoided. Protection from overwork is particularly essential for the nursing mother and this is where good fathercraft comes in. Husbands should be alive to the need for maternal care (NZWW, 1935:23).

Whilst the popular media reminded women that they had a tendency to become tired and ill and to mother ineptly, men were increasingly reminded that they had a responsibility in monitoring the mothering skills of their wives. They were also reminded that they had an important role to play as fathers of their children. Whilst women were disempowered in their roles as mothers, men were increasingly empowered to take a more active role in ensuring that women mothered appropriately.

In summary, in its early years of publication, the *New Zealand Woman's Weekly* played an important part in encouraging women to view the management of their bodies as an essential pre-requisite for negotiating the changing gender order of the times. Women were encouraged, despite their increasingly diverse roles of wife, mother, worker and consumer to view their bodies as the means by which appropriate gender relations could be maintained. They were reminded in the popular media that they needed to be their own agents of surveillance. This was to ensure that they held the attention of men and that they mothered in a way which was appropriate to solicit the support and care of both their husbands and outside agencies such as Plunket and the medical profession.

ii. The Second World War: women's bodies and the war effort.

During the Second World War the bodies of New Zealand women were constructed as serving new and vital purposes. Increasingly the popular media reflected this change in terms of the usefulness of women's bodies to the war effort. In the early years of the war this took the form of representations of women's femininity as the repository of the nation's morale and virtue. By being appropriate in their behaviour and appearance women were portrayed as valuable and virtuous. By becoming employed outside the home, women were constructed as practically assisting the war

effort. As the war ended, the popular media encouraged women to view their bodies as being more suited to the roles of wife and mother rather than work outside the home. Employment outside the home began to be represented as a masculine domain. Advertising in the popular media during the 1940s drew women's attention to new ideals of femininity. As in the pre-war years, advertisements continued to encourage women to view their bodies as potentially sick or unattractive, however during the war this increasingly occurred within a context which linked women's beauty and sickness with broader social and moral issues. Women's appearance, mood and physical health came under surveillance in a way which acknowledged that war was a stressful experience, but that women had a duty to the nation to manage themselves in a stoical manner :

Cheer up Mrs Edwards. This is not worthy of you Mrs Edwards. Your job just now is to keep cheerful. A face like this brands you as a slacker - you have let worry and strain get you down. Snap out of it Mrs Edwards! (NZWW, 1940:44).

An advertisement for cosmetics in the *New Zealand Woman's Weekly* in 1942, linked women's appearance with the war effort. Women who were not actively assisting the war by working outside the home were encouraged to recognise that despite their inherent frailty, all women could do something useful. This included being pleasing in appearance to men. Advertisements identifying women's beauty as essential to men's strength and morale highlighted the centrality of women's bodies in gender relations:

When you listen to the War News you think, "How can I help more?". You feel apologetic because you are only a woman, but you have forgotten that morale is a woman's business, now more than ever. A woman's beauty stands for courage, serenity, a gallant heart, the things men need so desperately these days (NZWW, 1942:38).

Such advertisements echoed the guilt and resulting self-effacement of many women during the war. May (1992:37) argues that women's war was trivialised and women's work outside the home marginalised as 'extraordinary and out of character' in extraordinary times. Discourses in the popular media contributed to this trivialisation.

Metaphor was not an infrequently used semantic tool by which the popular media linked women's bodies with wartime anxieties. One such metaphor suggested that whilst men were fighting for their lives during the war, women had an equally important 'battle' at hand. This was to do with managing their sexuality appropriately. By being sexually 'loose' women were considered likely to compromise the value men would place on them as future wives. An article written by the movie star, Bonita Granville, indicated concern about women picking up sailors for 'cheap thrills'. Granville suggested that these 'girls' were discarding standards of virtue which were, 'as necessary to the preservation of a woman's happiness as helmets and guns to the preservation of a soldier' (Granville, 1943:23).

By early 1943 more than 70,000 New Zealand women had been industrially conscripted. Whilst this was an increase in the numbers of women working outside the home there existed some ambivalence on behalf of policy makers in registering eligible women for 'man-powering'. The conservative views which underpinned this ambivalence reflected attitudes which constructed women's domestic responsibilities as central to the gender order and resulted in a reluctance to challenge traditionally held ideas of appropriate roles for women. The work that women did carry out however tended not to challenge the established sexual division of labour of the time. The expansion of women's roles did give some legitimacy to roles beyond the family for women but this occurred within a general acceptance that war was an emergency which necessitated a modification of the usually accepted gender norms (Montgomerie, 1986).

Whilst acknowledging the changes in women's roles the popular media maintained a stance which ensured that women remained aware of the continuing importance of having a body which would attract and keep a husband. Women were alerted to a potential shortage of husbands which would occur at the end of the war. Men were identified as a scarce resource for which women would need to compete (NZWW, 1943a). Advertisements continued to be a major vehicle for this type of message during wartime by reminding women that their new found freedom was a temporary phenomenon and their primary function was to attract a husband. An advertisement for 'Lifebuoy' soap exemplifies this by portraying in comic strip form a woman in overalls working on an assembly line who is avoided by her workmates because of

body odour. After discovering 'Lifebuoy', the woman becomes popular with both her workmates and with men. One male suitor comments to the overall clad woman....'Patsy you're a sweetheart, I can just imagine how marvellous you'd look keeping house' (NZWW, 1943b:3).

The popular media also represented women's disenchantment and resistance to attempts to return them to a pre-war situation of domestication. An article printed for the benefit of New Zealand women by an English woman member of parliament, expressed the opinion that women had proven themselves during the war and that they had an important role in post-war reconstruction in roles as diverse as mothers, teachers and engineers (NZWW, 1944). Whilst these oppositional discourses did occur from time to time, discourses which affirmed the traditional gender division of labour and the use of women's bodies were more common.

An analysis of the popular media suggests that the Second World War had a major impact on the gender order in New Zealand and that the media itself played an important part in encouraging women to view their bodies as the currency through which relationships with men could be negotiated and maintained.

iii. The popular media and the postwar medicalisation of the family.

At the end of the Second World War many women left the paid workforce and returned to domestic roles. Women's bodies were once again constituted in terms of their value to men as wives and mothers and in their value to the nation in reproducing the population and the future work force. There existed, as May (1992:43) describes, an 'exaggerated emphasis' on family life in the postwar years arising out of a range of wartime experiences. These included an emphasis on romantic love and the confirmation of traditional gender roles despite a heightened consciousness of women's more diverse abilities. Many women in the postwar reconstruction period hoped for domestic tranquillity but they also aspired to new opportunities outside the home.

During the postwar period the popular media showed an intense interest in family life. As part of this interest it began to reflect a pervasive medicalisation of what were previously considered to be the private concerns of the family. There is

certainly evidence to suggest that the postwar practice of medicine followed two important trends as represented in the popular media. One of these was that medicine became linked with an increasingly greater number of individual and family experiences and in doing so gained in influence and authority. Secondly the responsiveness of medicine to the changing social times lent it an authority which enabled it to increasingly define private experiences as publicly acknowledged health problems. This was especially so for women. Anxieties about the postwar decline in birth rate led to often medically oriented explanations of apparent impediments to fertility and childbirth. Women were encouraged to not only accept individual responsibility for improving the birth rate, but also to support what were considered to be progressive medical actions for the welfare of women. The *New Zealand Woman's Weekly* in 1940s suggested that women contribute money, through organisations they belonged, to towards a chair in obstetrics and gynaecology. Statistics were cited suggesting that '11% of New Zealand marriages were sterile' with social factors such as overcrowding and the lack of domestic help for what was described as the 'arduous' task of motherhood being suggested as contributing to the low fertility rate, as were the stresses and strains of war. A proposed new hospital for women was identified as contributing to a 'better start for the new generation' and an 'advance New Zealand move' (NZWW, 1945:17).

The medical focus on motherhood helped to cement the postwar vision of a reunited family, which could take advantage of a New Zealand which provided good education and health services for children. It also helped to consolidate what May (1992:131) describes as the re-establishment of gender norms for men and women. Children were viewed as rightly being the beneficiaries of the peace and security won from the war. This was part of an increasingly child-centred view of family life. Marriage became idealised as an appropriate primary goal for women, with children as the expected pinnacle of this union. Maternal duty became increasingly prescribed and included the moral training and disciplining of children which it was hoped would lead to 'good' children. As a result of these prescriptions women, too, were subjected to the discipline of gender expectations associated with their maternal role (Matthews, 1984).

To achieve the aspirations for a family-centred, postwar New Zealand which included

arresting the declining birth rate, women were reminded that their bodies were by necessity subject to the scrutiny of the nation. The Department of Health made use of the *New Zealand Woman's Weekly* to communicate a strong message to women in 1947. A large and authoritative advertisement placed by the Department of Health entitled, *Abortion **Must** Be Stamped Out!* translated public concerns about women's fertility into private responsibilities. The advertisement suggested that one in every five pregnancies ended in abortion either accidental (miscarriage) or through criminal inducement. It also suggested that these statistics were 'inexcusably high' and that for every one hundred births there were seven 'accidental abortions' and thirteen 'induced abortions'. Admonishments for a body not appropriately used in the interests of motherhood appeared in the popular media:

Illegally induced abortion is a crime against womanhood and against humanity. Those who condone it are as guilty as those who practise it (NZWW, 1947b:48).

Women were informed in the same advertisement that accidental abortion could be prevented by antenatal care confirming that the once private role of mothering was now under intense public scrutiny. The advertisement concluded by suggesting that 'public conscience and public opinion can fight for safe and sane motherhood'. Readers were exhorted to keep the announcement for future reference. Such discourses left no doubt that it was women's duty to bear children and that their bodies were being monitored by the medical profession and the nation. It is likely that these campaigns played an important part in reminding women of the need to carry out both their maternal and increasingly their medical duties. These latter duties included seeking medical attention to avoid the stigma and social shame of having indulged in 'unsafe and insane motherhood'. Such campaigns contributed to a belief which had gathered momentum in the first half of the twentieth century that childbirth was not so much a natural event as one which required management, surveillance and education.

Despite information being more readily available, many women in the 1940s-50s still experienced pregnancy and childbirth as mysterious events. Decorum dictated that pregnancy should be hidden and many women were still too shy to go to antenatal classes. Pregnancy could also result in women losing their jobs and for this reason

some women preferred to keep their condition hidden for as long as possible (May, 1992:133). For many women, the medicalisation of birth had resulted in it becoming a regimented experience in which they were encouraged to be co-operative, passive and uncomplaining. The passivity expected of women during birth was also expected during pregnancy as an advertisement placed by the Department of Health in the *New Zealand Woman's Weekly* in 1947 suggested. In this advertisement men were encouraged to exercise their authority as husbands to support medical practitioners in monitoring women's pregnancies and women were reminded of their duty to take advantage of the medical services available to them:

Make regular appointments with your doctor or antenatal clinic.....and see that you keep them....And don't forget to visit your dentist either.

A word to fathers to be. You have an equal responsibility in parentage. See that your wife goes to the doctor and carries out his instructions.

Because there are certain functional strains that every mother to be must experience, your affectionate consideration and encouragement are especially important to her mental and emotional outlook (NZWW, 1947a:24).

The role of men as fathers underwent a gradual reappraisal as they returned home after the war. The postwar father was constructed as a provider and protector who could be playful with his children and provide a gentle form of discipline when this was needed. He was to be less of a disciplinarian than previous generations and acquire skills of sensitivity and understanding especially in relation to his child-centred wife who was increasingly constructed as being no longer capable of coping with the outside world (May, 1992:157).

The independent woman of the war years was reconstructed in the postwar years as unfulfilled and morally reprehensible if she did not choose marriage and motherhood. Pregnancy itself constituted a rationale for women to be kept under surveillance by their husbands and the medical profession. Women were expected to be the docile recipients of medical care during pregnancy and childbirth and to ensure that they avoided 'being a nuisance' (op.cit:136). Women who did not bear children or whose children were grown up were, in this context, constructed as potentially ill and in need of medical attention. The child-free older women and the menopausal woman

became the focus of postwar concern. 'Elderly' women between the ages of forty and sixty were portrayed in the popular media as feeling miserable, lonely, vulnerable and sick when their children left home:

Many women of this age group are extremely sensitive. They cannot help that: it is not their fault. The physical changes often upset their mental economy (NZWW, 1947c:11).

In later years women in this age group were considered to be suffering from an ailment known as 'empty nest syndrome' (Matthews, 1984). Women who did not marry or bear children were portrayed as cold, heartless and unhappy. One woman was described in the *New Zealand Woman's Weekly* as an 'icy-eyed brain woman' who turned to intensive study to gain a degree when her fiancée was killed overseas. This woman's 'frosty face' was regarded as evidence of an inappropriately used body and a wasted life (McWilliams, 1947:7). Women who chose not to have children were represented as not only deviant but as inflicting physical harm upon themselves:

The woman who deliberately refrains from having children in order to "keep her figure" is paying a higher price than she realises. In the end she will find herself not only without the youth giving company of a young family but her glandular balance may be upset with serious consequences for her health and possibly her figure too (Solan, 1957a:10).

Not only was pregnancy itself viewed as a physiological necessity but so too were the behaviours associated with mothering:

From the time she is a child her instincts show themselves as maternal and protective. She needs to love, nurse, tend and protect for the proper function of her body (Solan, 1957b:15).

At the same time as women were encouraged to regard motherhood as the most important and fulfilling role for them, they were also encouraged to ensure that their lives were 'husband-centred'. They were reminded that they were fortunate to have a husband and that they had a responsibility to care for their men. This was

particularly so in helping husbands readjust to civilian life after the war. This meant that women's 'war effort' work which had been situated outside the home was redirected into the home for the postwar rehabilitation of men back into family life (May, 1992). The *New Zealand Woman's Weekly* offered women advice on how to deal with this postwar 'work':

Her job will be an extremely delicate and self abnegating one to be sure but when it seems to her that she is doing all the work, bearing all the blame, she will remember those whose men will never come back, and will throw herself into the trying tasks that confront her, with renewed effort that springs from a thankful heart (Wigley, 1945:26).

Increasingly 'expert professional' opinion on a range of issues began to feature in the popular media. This frequently included advice on how women should behave as mothers and wives. A lawyer and member of the Hutt Valley Marriage Guidance Council, stated in the *New Zealand Woman's Weekly* his aversion to women remaining in employment after marriage 'unless there is a very urgent and temporary need' (Birks, 1962:13). Women also continued to receive advice on ways to manage their bodies in order to adequately fulfill the role of 'wife'. This involved good grooming and cheerful facial expressions. Women were told that these strategies coupled with a positive attitude towards the faults of husbands, would ensure a satisfactory marital relationship:

Decide to make a good try at being well groomed and cheerful, even if you do feel irritable and at odds with the world. We think that you'll find being dressed up and looking happy will make you feel better as look better.

Decide to make up your mind to forget your husband's faults and instead count his virtues. Soon you'll find yourself boasting to friends how wonderful he is. (NZWW, 1951:1).

Women were also reminded of the importance of marriage to a woman's wellbeing. Marriage was described by one author in the *New Zealand Woman's Weekly* as being a sacrifice for men, whereas failure to marry was a sacrifice for women

(Barttelott, 1951:14).

By the 1950s, the *New Zealand Woman's Weekly* had become an important popular vehicle for medical discourse. This is evidenced by a significant increase in the number of features representing the views of medical 'experts'. Women were encouraged to view medical opinion as relevant to an ever increasing range of human experiences. Articles related to bodily and emotional management, covered areas as diverse as how happy marriages cured chronic headaches (Graham, 1954) to the ways in which medication turned women criminals into a happy wives and mothers (NZWW, 1954a:13). Such articles linked health with an ever widening array of life experiences and advocated an increasing range of normative behaviours.

The new knowledge presented in these discourses played an important role in stimulating subjectivities. Rose (1990b:4), suggests that this form of modern knowledge, promotes self-inspection and self consciousness and seeks to maximise intellectual capacities and shape desires. The aspirations of authoritative experts and the projects of individual lives become connected in a way which masks the monitoring and governing power of the individualised pleasures of being 'free' to chose. The *New Zealand Woman's Weekly* was a medium which provided women with a range of pleasures from which to chose. Whilst these were connected with the responsibilities of being a wife and mother, they were increasingly presented in such a way that women were offered a range of options as to the type of woman they could become. The popular media was the means by which these choices were presented to women in an entertaining and pleasurable way.

A role for women which began to receive attention in the popular media in the postwar era was as *loco medicus*. Increasingly women's role expanded from ensuring that members of their family behaved morally, to ensuring that they remained healthy. Earlier constructions of femininity emphasised women's role as being one which maintained social order through feminine moral superiority and chastity (Reiger, 1985). This responsibility gradually gave way to new responsibilities during the postwar period where women were expected to monitor and maintain the health of themselves and their families. The *Cult of Domesticity* was augmented by a new construction of femininity which, whilst still emphasizing women's nurturing and

maternal capacities began to involve wives and mothers in an intensive degree of medical surveillance. Women not only became the surveyors of family health but also became responsible for the degree to which their families suffered illness. This new role ensured for example that women provided the appropriate psychological environment not only for their husbands but also for their children (May, 1992). During the postwar period children were viewed as psychological beings to be shaped and moulded by parents, in particular mothers, with the assistance of 'professional experts'. This contrasted with earlier constructions of childhood, when, during the latter half of the nineteenth century, children were viewed as chattels to assist in supporting the family economically. During the first half of the twentieth century children were regarded as social capital and a future investment for the nation. This latter era marked the end of the 'inalienable right' of families to determine the quality of life of children (McDonald, 1978:47). New subjectivities emerged which created mothers in the likeness of psychologists, doctors and other health care workers. Mothering involved conveying the gaze of the experts into the home. Magazines like the *New Zealand Woman's Weekly* provided women with the knowledge and encouragement to carry out this new role.

As well as being sensitive to the physical and emotional needs of children, women were also encouraged to monitor the bodily and emotional needs of their husbands. They were reminded not to do anything which would contribute to physical ill-health in men and as monitors of men's health, received advice on how to carry out this role. An item in the column *Family Doctor* in the *New Zealand Woman's Weekly* advised women to serve food to their husbands who had peptic ulcers which was 'not too hot or too cold' (NZWW, 1954b:56). Women were constructed as being so critical to the health of others that they were a vital factor in determining how long their husbands lived:

Do everything in your power to minimise emotional upsets.

Make every effort to eliminate the possibility of your being left a widow in your later years (Green, 1955:17).

Women were reminded also that their being overly 'ambitious' in the workforce could

be the cause of stomach ulcers in their husbands:

...few men recognise or are willing to acknowledge that trying to keep up with an ambitious wife might be responsible for their illness (NZWW, 1956:9).

Women's postwar role as *loco medicus* played an important part in maintaining a gendered culture which primarily reinstated men as breadwinners and women as mothering helpmeets. Constructing women as responsible for the health of men and children served to remind them that the healthy bodies of their family could only be maintained if they retreated from the public sphere and concentrated on their domestic role. Even when acceptance of women's roles outside the home was at a higher level in later years, women were still expected to fulfill the role of maintaining family health. These expectations were articulated in the popular media in articles entitled 'the most common mistakes women make about family health' (NZWW, 1974:101). Increasingly however the strict standards ordained by the medical profession, especially for the care of children, undermined the value of women's maternal role and placed the medical profession in a position of being the true and rightful protectors of the population (Matthews, 1984:198-199).

During the postwar era of the 1940s and 50s men and women occupied separate but complimentary spheres. Women were encouraged to be both child-centred as well as husband-centred. Medical experts played an important part in defining an ever widening range of bodily and psychological ailments which were women's responsibility to monitor. Women were encouraged to view themselves as sickening to others in a way which discouraged independence and ambition and encouraged mothering and nurturing of both men and children. The construction of women as *loco medicus* served to bring the clinical gaze into the home. *The New Zealand Woman's Weekly* played an important part in communicating medical doctrines in which medical definitions and solutions served to normalize family experiences and maintain the gender order.

iv. The Idealisation of Self and the Medicalisation of Women's Bodies in the Popular Media.

During the 1950s and 60s a campaign by the Department of Health attempted to educate New Zealanders to adopt a new approach to their bodies. Whilst women had been encouraged for some years to take responsibility for the health of their families, they as well as men, became increasingly encouraged to take responsibility for their own health. An analysis of women's magazines clearly shows a change in the way it was suggested that women interpret their bodily experiences and relate to the medical profession. Whilst pregnancy and birth had for many women become medical events, particularly from the 1930s onwards (Mein Smith, 1986), women were increasingly encouraged to regard other life events as medical experiences also. Both men and women, were encouraged to construct a subjective self which could be monitored and managed in partnership with the medical profession.¹¹ The popular media played an important part in assisting women to develop 'techniques of the self' which could be employed in the interests of a normative body. In the latter part of the postwar era these techniques broadened to incorporate an ever widening array of women's experiences. The government of the body as well as the 'soul', as Rose (1990b:11) argues, requires a new subjectivity:

The government of the soul depends upon our recognition of ourselves as ideally and potentially certain sorts of person, the unease generated by a normative judgement of what we are and could become, and the incitement offered to overcome this discrepancy by following the advice of experts in the management of the self.

During the 1950s the popular media began to substantially increase the range of articles it presented on health subjects. In the case of women's magazines, these articles also increased in detail, content and focus. Women were encouraged to adopt a subjectivity which acknowledged that they were 'ordinary' mothers and housewives but they were also 'individuals'. The subjective woman represented in the popular media was rational and sensible about bodies. She would abandon the

¹¹ See Chapter Four for a discussion of the ways in which new subjectivities were constructed in the interests of the 'preventive ideal'.

prudishness of the past and demonstrate a vigilance in monitoring the bodies of both her family and herself. As individualised subjects, women were constructed as having their own anxieties and needs in relation to their bodies which needed to be acknowledged and catered for. Whilst the popular media had constructed women as having needs and desires in the past, these were largely related to the perceptions of others. Increasingly the 'other' which women were encouraged to please apart from children and husbands was an 'idealised self' which was based on constructions of idealised femininity emerging from medical and psychology 'experts'.

The construction of the new subjective woman is evident in articles which began to appear in the 1950s and 60s in the *New Zealand Woman's Weekly*. What is significant about these articles is their presentation of medical and bodily issues in a narrative form. Women began to tell their own 'real life' stories. These stories often revolved around illnesses and women's individualised ways of coping. Experiences, anxieties and dilemmas were shared within a context of advice to women on what they should do in similar situations. These stories were often subtitled in dramatic terms implying 'battles' and 'victories', such as, 'a housewife tells of her own battle and apparent victory against cancer' (NZWW, 1954c:12-13), 'I Was a Cancer Victim Too' (NZWW, 1954d:18) and 'I'm A Drug Addict' (Ellis, 1954:10). These articles also began to feature photographs of women's faces, (sometimes partially hidden) to emphasise the personal disclosure implicit in the article. This type of article appears to have primarily aimed at including the reader in a community of women with similar fears and responses. It also served to normalise medical experiences as womanly experiences which needed acceptance and co-operation. Women were encouraged to rationally accept the benign intent of medicine:

To all women I would say: Don't be foolish about cancer. Go to your doctor at the very first sign that all is not well. Do exactly as he tells you, and remember, that if it does prove to be serious, everything possible will be done for you (NZWW, 1954c:13).

As well as being exposed to the health experiences and aspirations of other women, readers of the *New Zealand Woman's Weekly* were also increasingly exposed in the 1950s and 60s to information about the application of science and technology to

medicine. Technologies such as the linear accelerator used in radiation therapy were described (Fogarty, 1955:19) as were operating theatres (Hill, 1958:14-15). These articles created a climate of 'normalising' medical technology and encouraged women to view interventionist medicine as desirable. At the same time they were encouraged to regard surgery itself as a common medical experience for women. The *New Zealand Woman's Weekly* began to feature articles which had surgical operations as their focus. One article by the 'Doctor' suggested that women should not be afraid of surgery:

If you should have to undergo an operation in the future - please do not be afraid. Your are probably in much greater danger every time you cross the main street (NZWW, 1961b:61).

Another article informed women of the 'new miracles' of surgery (Harness, 1953:14) whilst another advised women on how they should prepare themselves for surgery (NZWW, 1964a). At the same time the expertise of the medical profession was affirmed:

So expert are these professional men and women that you should have no serious after effects (Lloyd, 1966:80-81).

Articles which attempted to allay women's fears in relation to surgical procedures, at the same time constructed medicine as a scientific and highly technological discipline practised by benign professionals. The construction of the 'professional' in medicine created an ambivalent status for women. Women were encouraged to construct themselves as subjective individuals with health needs and increasingly health rights and to actively pursue those as rational, independent individuals. At the same time they were expected to trust the medical profession in an almost childlike manner and to submit to the authority of medical advice on a wide range of personal experiences. Their passivity and compliance with medical advice was evidence of a rational acceptance that the medical profession was essential to the wellbeing of families but also that medicine was an essential part of every woman's life.

The new subjective woman increasingly began to be exposed to her 'intimate'

physical self in the popular media. In 1968 the *New Zealand Woman's Weekly* included a 'bonus pullout booklet' which documented details of a range of women's health issues. This booklet included information on menopause, premenstrual tension, ovulation, menstruation, cervical cancer, pregnancy and birth control amongst other health issues (NZWW, 1968:1-16). These articles reflect a change in the ways in which women were expected to view their bodies. Women were invited to compare themselves with the detailed and authoritative bodily norms they encountered through the media and to report any deviations to their doctors.

Cervical cancer was one of many diseases which began to be featured in the popular media in the 1960s. Statistical evidence of the prevalence of cervical cancer was presented as rational information about a disease which was identified as a serious risk to all women. Women were exposed to the clear and unequivocal message that they were at risk of a wide range of illnesses and that they had a responsibility to monitor their bodies and to take action to prevent disease:

In the last thirty years deaths from this disease (cervical cancer)-once the chief cause of cancer in women have declined by almost 50%.

Health authorities estimate that about 200-250 new cases of the disease will be diagnosed this year and that some 102 women will die from it.

*These figures could be dramatically reduced if **every** woman would have a smear test as part of her annual health check up (NZWW, 1968:1-5).*

Women were informed about the cervical smear in a way which normalised it as an essential medical experience:

One of the most important parts of the gynaecological examination is the simple, painless but vital smear test. This test can detect the earliest stage of uterine cancer with almost complete accuracy. Most gynaecologists use a cotton swab, wooden applicator or syringe which is simply touched to the cervix to obtain a small amount of surface material (ibid).

The New Zealand popular media followed a tradition already established in the United States where women's magazines were used as a means to public health

education. In 1942, the American magazines, *Woman's Home Companion* and the *Ladies' Home Journal* published articles on cancer and its detection. The jingle 'never fear have a smear, once a year' was used to convince women of the need to seek medical expertise in the interests of cancer prevention (Read, 1965:86). The aim of this form of education was to normalise the experience of the 'intimate examination', socialising women into accepting that cervical smears and other gynaecological examinations were part of every woman's experience and part of creating a self that was knowledgeable, rational and independent.

An ever widening array of personal issues began to be constructed as medical problems during the 1960s and 70s and this was reflected in the popular media. Articles appeared advising women who woke feeling fatigued to either adjust their daily routine or to have a medical check up (NZWW, 1957:9). Women were also increasingly encouraged to view youth, beauty, body weight and health as inseparable.

As well as being provided with information on a wide range of illnesses which could affect them and their families, women were encouraged to monitor their bodies for signs of 'defects'. These 'defects' were frequently linked with conceptions of beauty and acceptability to men. Solutions were frequently linked with body management techniques:

We women certainly have our problems-we diet and exercise to reduce our weight and then we come face to face with the fact that our shoulders and upper chest are too thin. To correct this appalling condition.....corrective exercises daily and massage are required (NZWW, 1959:72).

These discourses served to remind women to manage their troublesome bodies in order to achieve an idealised self.

v. Managing bodies, managing relationships.

As women became more strongly located in the home in the postwar era and increasingly dependent on men for financial and emotional support, anxieties were expressed in the popular media about the possibility of women losing their husbands. Medical advice became incorporated in general advice to women during the 1950s and 60s about how to maintain their husband's affection. Women who neglected their appearance began to be regarded as unhealthy:

It is every woman's duty to be just as attractive in appearance and manner and thought as time and budget will permit. If she falls down on that task she is either disappointed, discouraged, or not well. And if she is either of those three she should begin at once to get to the root of the problem!.....When a woman is normally vain about her beauty, she is healthy (NZWW, 1958:25).

In continuing to be encouraged to view their bodies as well and their emotional presentation as the currency by which they could attract and hold a husband, women were reminded of ways to remain attractive to the opposite sex. Women who did not manage their bodies appropriately and failed to perform the expected functions of femininity were unlikely to hold the affections of men:

Don't you know the women who rarely-bothers about her appearance unless visitors are expected. Who serves her family with dull, unappetising food to which she has given no thought at all. Who wears the same old dress, day after day. Who is always too busy to go out with her husband. A women is foolish to take her husband's love for granted to such an extent (NZWW, 1960a:92).

Similarly women were reminded by Mary Miller that there was 'always a cause' for husbands humiliating women in public by being flirtatious with other women. She identified the cause of this kind of problem as women not fulfilling their feminine role as fully as they should. The advice she gave was typical of the advice frequently offered which suggested that it was women who were responsible for the success or failure of relationships with others. The ways in which they managed their emotions and bodies were central to this success. In their monitoring of the needs of men, women were encouraged to monitor in detail their responses to their

husbands:

What the wife must do is to understand the cause then ignore the silliness.....After that she must build up her husband's confidence. Let her be attractive and amusing so that he is proud of her. Let her encourage him and take an interest in everything he does. She must be more than delighted with all his successes (Miller, 1960:30-31).

The *New Zealand Woman's Weekly* began to tentatively reflect the changing expectations of women in the 1960s and 70s by featuring a number of articles which explored women's roles outside the home. These were featured within a context of awareness of what May (1992) argues were the simmering challenges to gender relations which began to occur in the 1960s. Women were for example, reminded that they needed to consider how their work roles impacted on others, especially the wellbeing of husbands whose self esteem could be adversely affected by their wives's successful careers. Using irony, Butler advises wives to manage their husband's self esteem with care:

Insist that your job comes first. Talk about it 99 per cent of the time. Make it sound so glamorous and exciting he's ashamed to mention he works too (Butler, 1970:14).

Women were also encouraged to gain insight into the 'type' of women they were and to make social comparisons with others represented in the popular media. This encouragement to compare the 'self' with the idealised feminine self had traditionally occurred within a context of physical attractiveness but during the 1950s and 60s as women's opportunities and roles expanded it began to include a wider range of women's behaviours. An article in the *New Zealand Woman's Weekly* illustrated with a photo of a young woman sitting at a desk featured the caption 'the academic pose-sometimes it doesn't come off'. The article which followed indicated to women the 'types' of femininity which were unattractive to men and those which were not:

The girl who is intelligent, kind and nice looking.....but earnest...

The girl who doesn't want any man to think he knows more than she does...

The girl who if it comes to a choice of having a game of tennis or having her hair done before a date with a new young man, would have a game of tennis...

The article went on to evaluate the above 'types' and concluded that men did not want serious relationships with women who did not conform with male expectations of femininity:

There is nothing wrong with a girl's belonging to any of these types - except one thing, the most attractive men aren't likely to have more than "yes she's a nice girl alright" to say about her (NZWW, 1960b:53).

Increasingly however these gender typifications began to give way to the construction of an increasing range of acceptable 'selves' for women.

vi. Managing bodies and challenging men.

The 1960s and 70s marked a transition period in which the established gender order was substantially challenged. This challenge arose according to Matthews (1984) from a variety of factors which included an expansion of work and consumerism which redefined the roles of both men and women. Women increasingly began to work outside the home, purchase consumer items and to drive cars. At the same time they were developing a sense of competence in a broader range of areas and were becoming more aware of gender inequalities (May, 1992). The rapid expansion of education in the postwar period resulted by the 1960s in an increased number of new professionals many of whom focused their attentions on the control of women and children:

Their task was the management of economy and ideology so, inevitably, they were drawn into the management of women. They supervised and regulated the new complexity of femininity. They did not resolve its contradictions; rather they added to them (Matthews, 1984:199).

The popular media began to represent new constructions of idealised femininity. In

doing so, the reflexive nature of the media is revealed. Whilst women's magazines can be viewed as contributing to conservative views of women's roles in society, they can also be viewed as challenging these views in response to the needs, desires and actions of consumers. As Abercrombie (1990) suggests, media representations are not necessarily homogeneous, nor are consumers passive. From this perspective, the *New Zealand Woman's Weekly* can be viewed as a site for the negotiation of the changing gender order from the 1960s on, in its reflection of the contradictions, uncertainties and anxieties which accompanied changes in constructions of femininity.

Many women were caught during this period between social prescriptions which advocated a maternal role as an appropriate role for women and those which labelled such a role as limiting and perfunctory. In the latter years of the 1960s and 70s as choices for women increased so too did the conflicting advice of 'experts' who were quick to point out the pitfalls of these expanded choices. The *New Zealand Woman's Weekly* featured the often moralising voice of these 'experts':

The woman who settles down to being nothing but her husband's wife is a hitch hiker, hitching a ride through life on her husband's brains, personality and success.....She thinks she is being completely feminine and exactly the kind of woman her husband wants, when all she is really doing is taking the easy, lazy way through life.

That isn't to say that a woman shouldn't put her marriage and family first in her life. She must do that. But she must also grow as a person just as her husband must grow if he is not to stand still in his profession (NZWW, 1960c:60).

Earlier suggestions that women should pander to their men began to be challenged by 'family life consultants' who advised women to stop 'coddling husbands' and feeling that they had to 'ooze flattery at their mates' (David, 1964:13). Whilst some of the advice of professional experts began to construct a more independent woman during this era, the authority of science continued to emphasise the need for body monitoring. One article entitled 'Just What Makes A Pretty Girl Pretty' attempted to 'put beauty on a scientific basis' as part of this monitoring process (NZWW,

1960d:25).

Medical experts began to construct women's experiences of the changes which were occurring during the 1960s and 70s in medical terms. The authority of science was used sometimes paradoxically to situate women within a social context which at times conformed to the existing gendered order and at other times challenged it. The contradictions between the idealisation of marriage and family life and the reality of the isolation and powerlessness many women felt began to be publicly acknowledged in the 1970s. Dr Fraser McDonald, a psychiatrist, invoked scientific medicine to construct women's experiences in terms of 'suburban neurosis' (May, 1992). The 'illness' of suburban neurosis was frequently defined in the medical media as having medical rather than social solutions:

"Suburban Neurosis" is seen by many professional people as a "disease-entity", to be diagnosed and treated by conventional conservative methods, i.e. with medical care given by general practitioners or by specialists (Wassner, 1975:14).

Whilst there was some discussion of women's traditional roles contributing to their distress, other reasons to do with women's changing roles and biological make up were identified as causing fatigue and stress:

Frustration, loneliness and the multiplicity of roles a woman must play in our society wife, mother, playmate, intellectual companion, assistant breadwinner or career woman all contribute to tiredness. But the biological nature of women is also a factor (NZWW, 1962a:90).

Women were also cautioned that they were increasingly prone to heart attacks because they were accepting 'more of life's pressures' (Meridith, 1976a:54).

During the 1980s women were being increasingly encouraged to scrutinise their emotions for signs of psychological ill health or for signs of an inadequate sense of self. Articles in the *New Zealand Woman's Weekly* gave women advice on how to avoid a 'nervous breakdown' (Wade, 1972; Brew, 1980) and how to cope with the emotional effects of pregnancy (Holmes, 1972). Women were also informed that

stress could damage their bodies and be a killer (Smith, 1984; Wheeler, 1982a). Getting rid of guilt was also featured as a worthy activity for women (Stoppard, 1982).

The challenges to women's traditional roles in the child-centred family which occurred in the 1960s and beyond were met in the popular media with what was at times a reaffirmation of the centrality of women's maternal role to their happiness and wellbeing:

Can anyone really appreciate the mental anguish experienced by the woman who longs to become a mother yet believes herself to be sterile? I doubt it, for her emotions are under a strain which never ceases. Her whole life is a series of hopes and disappointments. She feels "different", almost a freak (NZWW, 1962b:118).

The frequently ambivalent support of the media for new definitions of femininity included constructions of a subjectivity which included an 'independent self'. This construction had important implications for the medicalisation of women. In the 1970s and 80s women were encouraged to view the 'self' as having inalienable rights, many of which centred around the management of bodily experiences and access to health care. Independence was constructed as women's willingness and ability to pursue these rights. The body was portrayed as central to the new autonomous self but at the same time women were still expected to conform to long established codes of sexual conduct. Those who did not appropriately use their sexuality were viewed as either deviant or as coming from dysfunctional family backgrounds:

One survey of 100 (unmarried mothers), found that 43 were from broken homes, 36 from homes in which the mother was overly dominating, 15 from where the father's personality was harmfully dominating and the remaining 6 from homes in which there were other unhealthful conditions (Popenoe, 1960:39).

Unmarried mothers were defined as 'nice' if they unexpectedly got pregnant whereas 'hard' types were those women who had sexual intercourse but had avoided

pregnancy by planning ahead and using contraception (Owen, 1970:17). Women were told that they had an obligation to take responsibility for understanding and controlling the outcomes of their sexuality. They were urged to give up their ignorance, become knowledgeable about 'intimacy' and sexuality and as a result create happy homes. The 1960s heralded slowly changing attitudes towards sexuality, birth control, pregnancy outside marriage and divorce. The advent of the contraceptive pill had considerable impact on women's lives but women still remained trapped between the technology which enabled them to control their fertility and moral prescriptions which continued to sanction sex only within marriage. Many women managed the ambivalence of this situation by keeping their sexual relationships hidden:

'Having a reputation' or being seen as 'too readily available' was seen by most as being detrimental to marriage prospects, and there was often a sense of relief when marriage allowed the subterfuge of clandestine sex to end (May, 1992:193).

Women were responsible for maintaining the boundaries of sexual behaviour with men and for taking responsibility for contraception. Despite the increasing medicalisation of many areas of women's lives however, many doctors remained unwilling to prescribe the contraceptive pill to unmarried women.

During the 1960s and 70s women looked to medical science to create the self that was increasingly being constructed as an appropriate form of femininity. Infertility, unattractiveness, nervousness and many other 'disorders' which prevented New Zealand women achieving an idealised self were constructed as problems which had medical solutions. Hormone therapy was suggested for instance as a remedy for women turning into 'old hags' after the age of forty:

In some woman hormone therapy is absolutely essential to prevent destructive premature aging. When hormone production ceases after the menopause, the bodies of these women undergo radical changes-wasting of muscles, a serious loss of calcium in the bones-which can turn them into hags at 45 (NZWW, 1962c:15).

Doctors opinions came to be valued in relation to an ever increasing range of bodily functions. Medical endorsement of products in the popular media played an important part in confirming that medical opinion played an essential part in the maintenance of health and wellbeing. This is indicated in an advertisement for tampons in which a young woman feels confident in her choice after receiving medical advice:

My mother asked the doctor. The doctor approved. Now I'm a Tampax user too (NZWW, 1964b:113).

Women had increasingly become the agents of medical profession in the home in relation to their husbands and children in the postwar period. They were also encouraged to develop a concept of self which necessitated extensive monitoring of their own bodies in the interests of preserving not only their own health but the stability of their relationships with men. The activity of monitoring and complying with medical advice was constructed in the media as the behaviour of the rational, independent and informed woman. However the challenges to male authority which began to emerge in the 1960s, as May (1992) suggests, resulted in women increasingly demanding a greater level of autonomy and freedom both inside and outside the confines of marriage and family. In this climate, challenges to the authority of the medical profession also began to emerge. The popular media began to reflect these changes.

vii. Monitoring bodies and challenging doctors

In the 1970s and 80s women were encouraged to recognise the rights they had in relation to their own bodies. The construction of the 'self' meant that women were also encouraged to desire independence and personal freedom which was translated into a new level of body consciousness. In reflecting the voice of the feminist movement the popular media began to emphasise the importance of a woman 'getting to know her own body'. To 'know' the body came to be synonymous with the knowing of 'self'. This knowing was increasingly identified not only as a right but a duty. Women were advised in the popular media to give up prudish ignorance in the service of this 'knowing' and to challenge the medical profession to do the same:

We have to reject the idea that it is "not nice" to know more about our own body - traditionally women weren't allowed to know - we have the right to ask questions and to have them answered. A right to understand what happens to our bodies and the right to have control over them (Raymond, 1974a:33).

The burgeoning challenges to medical authority and to male authority in general by women in the 1970s were part of a broader social movement of protest which problematised a range of existing values and norms. There was an acknowledgement that many of the postwar aspirations of calm, peace and the 'good life' had not been achieved. Concerns began to be increasingly expressed about the stifling nature of the nuclear family and other social institutions whose rigid moral sanctions began to be perceived as harmful (May, 1992).

The articles which began to appear in the popular media reflecting women's struggles for independence paradoxically challenged medical authority but at the same time encouraged medicalisation by advocating that women take a more active role in monitoring and seeking medical care for their bodies. Cherry Raymond in her 'Speaking Frankly' columns in the *New Zealand Woman's Weekly* was an important platform for reaching women who were not necessarily part of organised feminism. In doing so the popular media brought a feminist 'body consciousness' into the home. Raymond raised a number of issues in relation to women's access to health services and highlighted the political nature of health care within a context of women's right to know and control their bodies. In one article she identified the unequal access women had to abortion and the 'morning after' pill (Raymond, 1972a:11) and in another lamented the 'brutal arrogance' of men who felt they had a right to make women bear children (Raymond, 1972b:12). Raymond's articles frequently aimed to provide women with detailed health information so that they could make informed choices in relation to contraception and pregnancy and other general medical issues. One such article, with a question and answer format, was as a forum for Professor Bonham from National Woman's Hospital to respond to women's questions on how to fight phobias about hospitals, tubal ligation and other health issues (Raymond, 1974b). Bonham was later implicated in the Cervical Cancer Inquiry. In retrospect this kind of advice to women is revealed as ironical and paternalistic in the extreme when Bonham's own hospital was patently not safe for

women.

Women were increasingly confronted with a range of health concerns that they should pay attention to. These included osteoporosis for which they were advised to take calcium or hormone replacement therapy (Wheeler, 1982b; NZWW, 1986a) and herpes which was identified in one article as nature's way of curbing promiscuity (McKenzie, 1982). Breast cancer was also highlighted in the 1970s as a serious health concern for women and a breast self examination technique was illustrated with the suggestion that women should 'act now for safety' (NZWW, 1978:86). Women were also advised on what they could and couldn't do after hysterectomy (Rayner, 1978:82).

The popular media also began to reflect changing views of women's sexuality in the 1970s. In contrast to articles of the 1940s to 1960s, the *New Zealand Woman's Weekly* began to encourage women to view their sexuality in relation to their overall wellbeing and health. Women were encouraged to consider a 'healthy' sex life as not only a right but a moral duty in the interests of good health. Constructing sexual 'problems' as health problems further encouraged women to consider 'intimate' areas of their lives as appropriately accessible to the medical profession:

There is no doubt that sexual problems such as frigidity and impotence, lack of orgasm and so on cause stress within the family unit. In the past many men and women put up with these problems not realising how the stress could damage their physical health after the age of 40 (Meridith, 1976:55).

Marriage, previously portrayed in the *New Zealand Woman's Weekly* as the primary goal of women's lives, began to be constructed in an ambivalent manner. One article suggested that women respond in a facetious manner to the question of 'why isn't a nice girl like you married'? Suggested responses to this question included, 'couldn't we talk about something important', and 'marriage is an institution and I refuse to be committed' (NZWW, 1972:26-27). Another article suggested that some women don't need men and may even have an 'intensely real life' without them (Brothers, 1970:37). Articles also began to appear in which women were encouraged to have a career, with marriage being perceived as no longer

guaranteeing them a lifetime of security (Raymond, 1974c). There were very clear signs in the popular media that constructions of femininity had broadened beyond those of the 1950s and 60s. Women were invited in the 1980s to determine whether they were an 'Amazon', strong and full of earthy wisdom, a 'Madonna', nurturing caring and protective, or a 'Courtesan' who was very adept at projecting her sexuality (NZWW, 1988a:43-45). All three of these roles were portrayed as desirable and socially acceptable.

Despite challenges to institutions which were perceived as limiting women, the popular media began with increasing fervour to encourage women to maintain a strict surveillance over their bodies for signs of weight gain. Women were told that poor women tended to gain weight and rich women tended to be thinner (Lloyd, 1974). The 'bizarre' affliction of *anorexia nervosa* was noted in another article as finding 'victims' in New Zealand (Miller, 1974) and in the 1980s *bulimia* and *anorexia nervosa* continued to feature as diseases of women which were increasing in incidence (Collins, 1986; Ray, 1986). Another article noted that many women's careers depended on them being 'excessively thin' (Cooper, 1976:108).

The popular media began in the 1980s to reflect a growing ambivalence towards the medical profession, especially in relation to the prescribing of tranquillisers, of which women were the primary consumers. Women were told that health was not something that ought to come out of a bottle and that the country was spending millions of dollars a year on tranquillisers (Forde, 1982:26). Despite this the *New Zealand Woman's Weekly* frequently acknowledged that anxiety was a normal response to modern living which women especially experienced. Having defined women's emotions as having the potential to make them ill, the popular media turned its attention particularly to the non-human environment and its potential to cause illness.

Women were encouraged to focus outwards as well as inwards for signs of ill health which may be apparent in their families and themselves. Lead in petrol was raised as a concern, particularly in terms of the 'poisoning' of children (Lamb, 1982a), and alcohol was identified as a 'horrificing threat to the unborn' in an article which suggested that pregnant women should not consume alcohol (O'Neill, 1982:12-13).

'Going overboard with vitamins' reflected further concerns about what was being put into bodies (Wheeler, 1982c:54-55) and Cross (1982:56) suggested that we probably 'eat too much salt for our own good'. In similar vein Crawford (1984) suggested that moodiness and anxiety in women may be caused by the food they ate and that they should analyse their diets.

The medicalisation of what were previously constructed as moral issues in the form of personal failure were also increasingly identified in the popular media as health issues in need of medical attention. Examples of this were articles featuring the treatment of gambling as an addiction (Scott-Vincent, 1986) and 'have you got hurry sickness?' (Woodnam, 1986) in which 'time addiction' was explored. Women who identified themselves as shopping too much were asked 'are you a shopaholic?' (Stephens, 1988:36).

Increasingly the popular media reflected a view of men as being damaging to women's health and wellbeing. Concerns were expressed about men's harmful attitudes and behaviours towards women. Women were encouraged to monitor their relationships with men to ensure that these were not unhealthy and damaging to their sense of self. Frequently relationship difficulties between men and women were identified as problems which should appropriately be brought to the attention of the medical profession. Domestic violence was an issue which received attention (Price, 1982a:36) as did rape (NZWW, 1982a:12). Rape in marriage was canvassed in an article titled, 'Does the law have a place in the marriage bed?' (McNicholas, 1984:4), and 'Women Tackle Violence With Violence' (Wheeler, 1984:4) looked at women's involvement in self defence training. 'The Trouble With Men', an article featured in 1986, identified men as a social problem with society being unable to cope with the victims of male behaviour (NZWW, 1986b). Rural women's concerns at being treated like 'slave labour' by men were also highlighted (Lamb, 1982b:4). Increasingly concerns about the dangers men posed to women's wellbeing became focused on the medical profession.

viii. Dangerous doctors and the medicalisation of bodies.

The popular media had historically encouraged women not to trust their bodies, and had expanded this message in later years to identify their own emotions, men and

the environment as damaging to their health. Increasingly women during the 1980s were encouraged not to trust the medical profession. Anxieties were expressed in the *New Zealand Woman's Weekly* about a wide range of medical attitudes and practices. Questions began to be raised as to the safety of hospitals (McLachlan, 1982) and women were encouraged to rely more on self-help methods rather than doctors to relieve such symptoms as premenstrual tension. They were also increasingly encouraged to use support systems which had been set up largely outside the confines of medicine. These included groups to support 'victims' of pelvic pain for women with endometriosis (Gannaway, 1982:30). Women were also encouraged to challenge what was increasingly being reflected in the media as the medical profession's monopoly on information, with suggestions that 'women should know what was going on inside them' (Price, 1982b:49). A reader's story about having a positive smear test and not being told about it (NZWW, 1988b) was followed by an article featuring Bunkle and Coney's account of the abuse of women's right to know during the National Women's Hospital cervical cancer medical research (Roberts, 1988). The lack of information given to women by the medical profession became a major concern after the National Women's Hospital incident in which women were unaware of their cervical abnormalities. Women expressed their anxieties in the popular media:

Imagine my surprise 10 days later when the gynaecologist phoned to say that the results of my cone biopsy showed that the invading cells were deep in the cervix! (NZWW, 1988b:34).

Similarly in the 1990s women were encouraged to be distrustful of medical screening procedures and of medical authority:

It's important that women get their smears, but it's also important that women don't just accept that everything must be OK because their smear tests are clear. You've got to keep going back and make a nuisance of yourself if necessary if you have other symptoms (Matthews, 1993:40).

Despite the scepticism directed towards the medical profession the medicalisation of women's bodies continued to intensify into the 1980s and 1990s. This trend was

reflected in the popular media. Women continued to be alerted in increasing detail to the latest scientific findings which indicated a need for further surveillance and management of their bodies. Responsibility for preventing disease became an increasingly popular theme. The personal narrative form was frequently used as a means by which 'real' women revealed their experiences in such a way to encourage women to avoid the pitfalls that they themselves had encountered at the hands of an incompetent or uncaring medical profession. The theme of many of these personal stories revolved around the construction of the medical profession as damaging to women's health but at the same time urged an intensification of medical care:

Elizabeth was 42. She'd always examined her own breasts. Two doctors examined her and pronounced her clear only weeks before her condition was discovered. She now says all women should have regular mammograms (breast x-rays) from the age of 40.....(Vincent, 1988:38).

'Ellen' too was portrayed as a woman who had unwisely believed a doctor who had wrongly diagnosed her condition:

Although every so often Ellen Barrett checked for lumps, she never seriously considered that she could have breast cancer. After all, she was fit as a fiddle and only 29. So when a breast lump was said to be cystic hyperplasia, or thickening of cell tissue, she did not doubt the diagnosis (NZWW, 1986c:71).

Another woman told her story of becoming vulnerable to breast cancer because screening was not available (Vincent, 1988). As well as being encouraged to lobby for and seek out medical screening women were also encouraged to become questioning rather than accepting medical consumers. One article suggested that patient's may have been conned into believing that medical screening was 'value for money' and that some screening tests such as those for osteoporosis were unnecessary (NZWW, 1992:36).

In the 1990s the popular media has continued to focus extensively on women's health and illness. In doing so, the media has been accused of actively identifying bodily experiences such as menopause as illness and providing the means for

'medical advisers' to promote pharmaceutical solutions such as hormone replacement therapy to women (Coney, 1992). The media has continued to be influential in the 90s in encouraging women to internalise norms and values on body health and management. It has continued to encourage women to be anxious about illness, especially cancer, and to regard their ageing bodies as increasingly prone to disease. Women have also been encouraged to recognise the diminishing social value of their bodies as they age. Whilst at times critical of the medical profession, the media has increasingly represented a biomedical view of women's bodies which has represented prevention of illness as being dependent upon a partnership between women and the medical profession which women because of their natural, biological make-up are obliged to enter into.

The New Zealand Woman's Weekly has remained popular with readers since the Second World War by accommodating the changes in attitudes which have occurred during this time without representing the extremes of opinion (May, 1992). It has for instance continued to urge women to seek the security offered by a well managed and monitored body and to involve the medical profession in this process whilst at the same time encouraging a sceptical approach to allopathic medicine.

In summary, the management of the body has been represented by the popular media during the twentieth century as a duty and a pleasure. The pleasure of a surveyed and well managed body for women lay in its ability to attract and hold the affections of others, especially men. More latterly as a site for consumption, the well managed body has become a symbol of autonomy in which the accessing of health products and services has become symbolic of a rational approach to body care and the attainment of an idealised self. Management of the body and the consumption of health and beauty products and services have become increasingly inseparable since the 1950s and the popular media has been a major vehicle in encouraging this consumption. *The New Zealand Woman's Weekly* and other women's magazines have continued in the latter years of the twentieth century to focus their attention on the management of women's bodies. Women's bodies have continued to be constructed as both representing the reality of their dependence in being prone to disease as well as representing women's autonomy and independence as they make choices over its management and control. It is within this paradoxical context that

cervical cancer has been constructed in the popular media as a disease which involves women in both pleasure and duty.

It is argued that an historical analysis of the popular media as exemplified by the *New Zealand Women's Weekly*, is instructive of the ways in which the media constructs and reconstructs femininity as a site for the political struggles of a gendered society. Most importantly, it is argued here that the popular media has contributed to the medicalisation of women's bodies by normalising medical experiences within a pleasurable context of femininity. It has also contributed to the construction of *loco medicus* in which women have been constructed as the vigilant eye of the medical profession within the home and the community. The popular media has constructed women as the lay monitors of bodies and in doing so has assisted in creating a gendered society in which women accept as relatively unproblematic that they should be subjected to increasingly pervasive and intensive forms of medical screening.

5. Self-Help, the Media and Cervical Cancer

From the 1970s on women have had access to a broad range of popular literature aimed at self-help and self-improvement. Much of this literature has focused on weight loss, beauty regimes and ways to cope with illness. The increase in the quantity and range of this type of popular literature has paralleled the growth of self-help groups which have increased in numbers since the 1970s. These groups have had either an outer focus with a major agenda of social and political action or an inner focus where members could achieve social and emotional support from others (Kelleher, 1994). The mostly inner focused self-help literature, has aimed to challenge the dominance of medicine in defining and determining the experience of illness, provide alternatives to orthodox medicine and importantly, redefine illness as a subjective experience. Self-help books written by health professionals, have tended to focus on making medical experiences understandable and normative. Titles such as 'My Body, My Health: The Concerned Woman's Guide to Gynecology' (Stewart et al, 1979) and 'Your Smear Test. A Guide to Screening, Colposcopy and the Prevention of Cervical Cancer' (Barker, 1987), reinforce women's ownership of and responsibility for their bodies and provide often detailed information about diagnostic and treatment procedures for cervical cancer and other disorders. Other

self-help books focusing on cervical cancer have attempted to counter the prejudice which has surrounded the disease by encouraging women to reconstruct their perceptions and having done so to attend for screening:

...taboos and prejudices have encouraged both sexes to regard cervical cancer as a 'dirty' disease, one linked solely to promiscuity. Research has now shown that this is, in fact, not the case and it is hoped that more women will now present themselves for screening...(Chomet and Chomet, 1989:12).

Self-help literature has also aimed at encouraging women to take a rational approach to cervical cancer, to attend for screening and avoid reaping the serious and devastating consequences of not doing so (Dyson, 1986). The 'pleasures' these books prescribe, relate to the adoption of 'right' behaviours in pursuit of a lifestyle which symbolizes rational individualism and control of the body. This content is not therefore substantially different from the content of popular books and magazines which promote dietary and beauty solutions to what are constructed as women's body 'problems'. It can be argued therefore that self-help literature is a vehicle for medical discourses, bringing the clinic into the home and women into the clinic. However, other types of self-help literature have attempted to locate cervical cancer within a broader context of feminine subjectivities. This is evidenced by the construction of medical experiences surrounding cervical cancer as personally transformative, subjective experiences and a means to achieve the idealised self frequently promulgated in women's magazines. In this construction, a positive smear result is interpreted as an urgent personal crisis:

On 19 December 1981, my world fell apart. Sitting on the steps of my flat, I read and reread the slip of paper from my doctor that informed me that I had a 'positive smear', and that I needed to come and see him as a matter of urgency (Quilliam, 1992:1).

Women are told to expect a range of emotional responses to a positive smear, such as disbelief, fear, a sense of vulnerability, exhaustion and anger (Barnett and Fox, 1986:1). The urgent crisis of a positive smear is represented as a stimulus for women to examine a range of life issues:

...how does what is happening affect how you feel about yourself? How does it affect your relationships with other people? How can you take control of what is happening? How can you make decisions about your health and treatment? What skills and strength can you develop as you move through the process? (Quilliam, 1992:5).

In these discourses, a positive smear becomes the basis for women to embark upon an even more wide ranging monitoring of the self, with the implication that a positive smear is indicative of a woman having failed to monitor herself properly. The unexamined life which may have precipitated a positive smear is exchanged for one of intense self examination.

The focus of some of the self-help literature which focuses on cervical cancer suggests that monitoring the body for signs of the disease is a pleasure. This pleasurable, personally transformative construction of a positive smear is one particularly directed at middle class women. This view assumes that women have the time, energy and resources to 'restructure' their lives and to pay attention to their attitudes, emotions and behaviours. Case studies are frequently used to emphasise the subjectivity of the experiences surrounding a positive smear:

Many women I spoke to mentioned stress as a factor. They talked of being overworked or worried. And they told me how one of the first things they did after hearing that they had a positive smear was to try to cut down on work load and worry less. 'I've always been a worrier,' said one woman. 'Now I know I must take things easy-I have no choice' (Quilliam, 1992:152-153).

These prescriptions are, as Crawford (1980) suggests, distinctive symbols of membership of the middle class which has the resources and time to make good health a personal pastime. Based on the lifestyle model of disease this construction of cervical cancer in the self-help literature, whether promulgated by the medical profession or lay writers, does not take into account the unequal abilities of people to transform their life circumstances. The pleasures associated with the status and recognition of conforming to these self-oriented health behaviours are denied to many (Tesh, 1988).

Other pleasures associated with cervical cancer relate to medical diagnosis and treatment. Whilst it is acknowledged that diagnosis and treatment can be uncomfortable, painful and embarrassing it is also acknowledged that the consumption of medicine is a pleasurable experience:

"I got the works-the questions, the menstrual history, even a breast examination. It was great!" (Julie) (Quilliam, 1992:25).

In these accounts, the medical examination becomes reconstructed as an exciting, personal journey in which a 'personal crisis' becomes an opportunity to get to know one's body:

Once in with the doctor, the routine was more or less the same: up on the couch, legs apart, the doctor taking a look. I loved watching the whole thing on a television monitor, though it seemed voyeuristic, somehow, even if it was my own insides! (op. cit:232).

These more recent constructions contrast with those of the 70s, where encounters with the medical profession were constructed as unpleasant and women were advised in the self-help literature to seek a more extreme solution for their 'severe CIN':

If future pregnancy is not a consideration for you, then you may want to consider hysterectomy. Some women find that repeated follow up examinations are a hardship and a major source of anxiety. Hysterectomy allows them to deal with the problem once and for all and then forget about it (Stewart et al, 1979:406).

As well as suggesting that women view a positive smear and cervical cancer as a personally transformative experience, the more recent self-help literature has identified another personal goal that women should develop as a result of the experience. This goal relates to looking after the needs of others. This theme, so prevalent in the popular literature directed at women is repeated in the self-help literature with injunctions suggesting that women have a responsibility not only for their own health but the health of others:

Spread the word to other women. If you think your friends are not aware of the need for regular smears discuss it openly with them (Dyson, 1986:116).

and similarly:

...fight for better working and living conditions-showers at work, bathrooms and washing machines in the home-for yourself, your partner and for other women at risk (Quilliam, 1992:108).

It can be argued that the self-help literature continues to invite women to blame themselves for a positive smear test, whilst at the same time appearing to rehabilitate cervical cancer from its sexualized, medical past and to empower women with a more positive view of the disease. Women are invited for example to examine their sexual lives for signs of promiscuity to ensure that normative prescriptions of safe and healthy sex are not being ignored. Suggestions in relation to sexuality and the prevention of cervical cancer range from monogamy to the use of barrier contraceptives and avoiding penetrative sex (Dyson, 1986; Quilliam, 1992). Taking personal responsibility for avoiding contracting cervical cancer by exposure to the human papillomavirus forms the basis of much of the self-help literature for women:

Prevention of CIN and cervical cancer involves providing information for women-especially teens-about ways to decrease the chance of exposure to HPV and other carcinogens (McGinn and Haylock, 1993:292).

In summary, much of the self-help literature on cervical cancer is based on a biomedical view of the disease. The recent literature departs from medical discourses by constructing a positive smear as a personally transformative experience. In doing so it locates cervical cancer within a context of a subjective holistic self and invites surveillance over the totality of a woman's life. Discovering the meaning of a positive smear for a woman's life has become the major focus of some of this literature. It can be argued that this construction of cervical cancer invites women into an intensification of surveillance of their bodies overlaid with the implication that if they lived a better, more examined, life that they would not

have positive smear tests. The medical encounter is similarly constructed as a transformative yet rational and responsible experience in which the pleasures of consuming medical products and services can be enjoyed. This genre of literature does not seriously challenge medical constructions of cervical cancer nor does it invite an in depth and serious examination of the social factors which may lead to a greater incidence of cervical cancer in some groups of women. Instead, it individualises women's vulnerability to the disease and encourages a personal rather than political response to cervical cancer. The medical profession is constructed as being essential to this form of self-help.

6. Conclusion

This chapter has examined the news media, the popular media and the self-help literature in relation to cervical cancer. It is argued here that the news media has presented a view of cervical cancer which has left largely unchallenged dominant metaphors and discourses of femininity. It has presented a view of cervical cancer as a disease connected with lifestyle and individual responsibility. The news media has tended to represent cervical cancer as a personal and social drama. In doing so it has however provided a platform for both orthodox and dissenting medical discourses. This was particularly so in relation to the events surrounding the Cervical Cancer Inquiry. This is indicative of the reflexive rather than sovereign nature of the media as a site for the contesting of power over a range social issues including gender and medicine.

Popular magazines such as the *New Zealand Woman's Weekly* and the self-help literature have played an important part in providing narrative reconstructions of the relationship between bodies, illness and the world the women live in. The duties and pleasures of body consciousness and monitoring are set in these media within a context which helps women to make sense of their bodies and the medical encounter. It is suggested by Williams and Popay (1994:133) that medical discourses are not sufficiently inclusive of issues which are of significance to the individual. On the other hand, popular and self-help literature have encouraged women to construct a narrative of the meaning of their bodies for their lives. Whilst at times challenging medical authority and assisting women to become empowered in their encounters with the medical profession, it can be argued also that much of

the self-help literature and the content of women's magazines has contributed to the medicalisation of women's bodies. The consumption of medical care by women in the interests of the idealised self, promulgated in the popular literature, has contributed to medical constructions of women's bodies and behaviours having achieved a sovereign authority. Constructing body monitoring as rational and at the same time pleasurable has also contributed to medicalisation. It is within an historical context of a body-focused popular media that the intensification of cervical screening programmes have occurred. The unprecedented monitoring of the cervixes of New Zealand women which has occurred in the 1980s and 1990s has assumed a level of body awareness, docility and compliance. Whilst it is important not to over emphasise the existence of these attributes in New Zealand women and to underestimate the resistance to organised screening which exists, the medical profession continues to play an increasingly important part in the management of women's bodies. It is argued here that the popular media has been important in bringing the clinic into the home and bringing women out of the home and into the clinic.

CHAPTER NINE

Cervical Cancer, Medical Technology and the Surveillance of Women's Bodies.

1. Introduction

This chapter discusses the ways in which the use of medical technology in the diagnosis and treatment of cervical cancer can be analysed as essentially a political process. It is argued here that technological determinism, that is the treatment of technology as a factor external to social relations but impinging on them is an inadequate explanation for the development of medical technology in general and in relation to cervical cancer. The argument which is developed here, follows that of Daly and Willis (1987) who have argued that social relationships and technological innovation and application are inextricably linked. From this perspective technological innovation is a political process intimately connected with social control and the distribution of power. This critique challenges the traditional view of technology as arising out of rational, asocial and apolitical processes and being therefore outside the domain of sociological inquiry. It also questions the view that knowledge which arises out of and informs scientific and technological inquiry, is epistemologically privileged and instead locates this knowledge within the context of one of a range of possible knowledge cultures (Pinch and Bijker, 1984). This accounts for the fact that many technological innovations are frequently contested and even rejected because they do not conform to existing epistemological frameworks. As a result, technological innovations may have their acceptance delayed until a knowledge culture changes to a point where it can accommodate what was earlier considered dissonant (Stern, 1927).

Philosophers have been criticised for perpetuating an over-idealised relationship between science and technology by suggesting that science discovers truth and technology is the means by which this truth is applied. From a philosophical perspective, technological innovations are frequently discussed as the outcome of an orderly apolitical and linear progression of discovery which proceeds from basic to applied research and finally to production and usage. As a result descriptive historiographies have treated technological artifacts as successes or failures within a context of progressive discovery. These accounts not infrequently attach precise dates and names to inventions, with the implication that new technologies arise out

of the inspirational genius of individuals who are deemed to be heroic inventors. Such accounts ignore the social context of technological development and the social negotiation which contributes to the adoption or rejection of a particular artefact (Pinch and Bijker, 1984). Social scientists have themselves been criticised for their tendency to focus on the impact of technology rather than attempting to uncover the social factors which have shaped technological changes (MacKenzie and Wajcman, 1985). This represents a tendency, to use Strauss's (1957) concept, towards a sociology *in* technology as opposed to a sociology *of* technology. The former has focused on solving the problems of the application of technology, accepting technology as a given, and the latter on applying a critical approach to technology and questioning its basic tenets.

In recent years medical technology has increasingly come under scrutiny from different quarters. The social relations of medical technology have been highlighted by a number of writers who have identified the social, moral and political bases for much of the decision making which occurs in relation to technological application (Bates and Lapsley, 1985; Rowland, 1992). Feminist writers in particular have emphasised the political nature of medical technology. They suggest that Western science and technology have embodied the stereotypically male values of control, power, objectivity and domination, inviting medically invasive solutions to body 'problems'. Such solutions, they argue, have frequently been viewed as prestigious to the professional groups linked with them, and have often been associated with constructions of medicine as dramatic and heroic (Ratcliff et al, 1989). The use of technology in the control of women's reproductive capacity has been identified as giving others, including the medical profession the capacity to control women's fertility and therefore their lives (Doyal, 1979). Feminist standpoint theorists suggest that medical technology supports and arises out of the ideologies of the patriarchy in which women are constructed as naturally nurturing, as well as dangerous, irrational and defective. In this context, procreation and birth are viewed as a resource which men wish to appropriate from women, with medical technology being the means by which men attempt to gain power over a coveted resource (Rowland, 1992:13). Feminists have also suggested that economic interests contribute to the development and use of medical technologies such as pharmaceutical products, and that women have frequently been the targets of such initiatives (Coney, 1991; Whatley and

Worcester, 1989). Medical technology in the form of pregnancy monitoring devices has also been considered by Arney (1982:100) as having a significance beyond that promulgated by the medical profession. Such devices are identified by the profession as detecting potential problems in pregnancy at an early stage and thereby ensuring a more normal and natural childbirth. Arney suggests that these technologies are inherently political in that they represent a 'monitoring concept' and a change in the deployment of obstetrical power. He relates these changes to a new mode of social control over childbirth and suggests that the use of monitoring technologies has enabled the medical profession to extend the practice of obstetrics out from the clinic and into the community to monitor ever widening aspects of women's experience. Under these circumstances every birth and every woman becomes subject to the medical gaze.

Marxist writers have also examined the development of medical technology and suggest the existence of a complex network of groups and organisations which promote and proliferate technology. From a Marxist perspective, medical technology is viewed as largely the outcome of the pursuit of profit by corporations who are frequently assisted by state patronage which supports private enterprise and legitimates the capitalist political-economic system. Academics and clinicians, it is argued, assist in fostering new technology through professional publications and thereby assist corporations to cultivate markets in health institutions (Waitzkin, 1990:227). The pharmaceutical industry has been identified as being especially vociferous in ensuring that technological innovations such as drugs are intensively marketed to the medical profession (Kawachi and Lexchin, 1992).

Other writers have noted the central role medical technology has played in the dominant position held by medicine in the medical market place thereby maintaining professional dominance. The retention of absolute control of a range of technical procedures by doctors has been identified by Zola (1977) as one of the means by which the profession has gained jurisdiction over an increasing range of human experiences. He suggests in particular that the right to prescribe drugs and to perform surgery has contributed to an expansion of definitions of illness by doctors. These definitions encompass an ever widening array of human experiences with technological interventions being viewed increasingly as an appropriate response to

what is termed 'illness' or 'dysfunction'. The control of medical technology has also been identified as enabling the medical profession to limit the practice of other professionals and thereby safeguard their access to medical work (Faulkner, 1985; Willis, 1983). It has been argued by Mein Smith (1986) that the use of pituitary extracts to induce labour is historically significant in allowing the New Zealand medical profession to gain control of childbirth from midwives in the 1920s and 30s.

Part Two sets the scene for this chapter by exploring the role of medical technology in body surveillance and discipline. **Part Three** begins to apply the theoretical concepts already developed to trace the use of the speculum in medicine. **Part Four** traces the development of the Pap smear and the responses of the medical profession to this technology. **Part Five** locates colposcopy within a context of contested technology and suggests that social relations played an important part in the eventual adoption of this tool for examining the cervix. **Part Six** concludes the chapter by restating the major theme of this chapter which is, that technologies which have been developed in relation to cervical cancer owe their existence to social as well as scientific factors. This problematises other accounts of these technologies which locate them within a socially neutral, scientific discourse.

2. Medical Technology and Body Surveillance.

The role of medical technology in the surveillance of bodies has received the attention of sociologists and social philosophers in recent years. Foucault (1973) argued, for example, that a change in medical perception or gaze occurred at the end of the eighteenth century. This change represented a shift in the medical gaze from the two dimensional phenomena of body tissue, symptoms and patient reports of illness to the three dimensional body which had illness contained within the boundaries of the body, the disease and the medical interpretation. The 'truth' of illness became 'known' through the clinical examination which searched for signs in a body which sometimes remained symptomless:

The clinician had to map the volume of the body by use of ear, touch and sight so as to localise and identify the pathological lesion which was inserted therein (Armstrong, 1984:738).

The 'truth' of illness under these circumstances, no longer depended on the patient's account of their experience of their body as had previously been the case, but on what the doctor saw. For Jewson (1976:232) this change represented a shift from a person-oriented to an object-oriented medical cosmology and resulted in the subordination of the patient to the doctor. During the early decades of the nineteenth century, medical knowledge therefore began to be located with the doctor and not with the patient. This led to a new mode of production of medical knowledge based not on diffuse speculations to which the patient substantially contributed, but on an increasing consensus of theories of illness based on ideas of localised pathology. The former 'bedside medicine' was replaced by the practice of 'hospital medicine', which resulted in a new configuration of the body. The patient's knowledge of their body was eclipsed by the medical profession's knowledge of all bodies. For Foucault the increasing power exercised by the medical profession was a product of a changing political context. No longer was political power centralised in the sovereign but rather diffused throughout society. With this decentralisation of political power went a new knowledge of the citizenry and a new form of 'disciplinary' power. As with the prisoner in the *panopticon*, the clinical method, in its search for signs of pathology increasingly began to be the means by which all bodies were monitored. Medical technologies began to play an important part in assisting the medical gaze in locating pathology and in assisting the medical profession to gain increasing access to bodies as well as protecting and legitimating this access.

As Jewson (1976:229) suggests, structural nosology, localized pathology, physical examination and statistical analysis began to form the basis of medical practice. Technology increasingly came to be viewed by physicians as the means by which the body would reveal the secrets of its structure, function and pathologies. Visual technologies such as the ophthalmoscope which gained popularity in the nineteenth century epitomised the way in which the mode of production of medical knowledge had shifted from the patient to the doctor:

The doubts physicians harboured about their ability to judge the character of structural changes in the eye just from the patient's verbal account of the symptoms were replaced by the certainties of direct sensory perception: physicians could evaluate the pathology firsthand (Reiser, 1978:47).

The stethoscope had preceded the use of visual technologies in allowing the medical profession to explore the interiors of living bodies. Both forms of technology however sustained the the role of the doctor as a 'medical investigator' whose role it was to make apparent what Reiser (1978:55) terms the 'discrete, picturable lesions' which represented disturbances in a part of the body rather than in patients themselves.

For Armstrong (1987) the advent of visual and auditory technologies in medicine resulted in a situation where the patient was in a situation of being aware of being monitored but remained unaware of what had been seen or heard. He identifies the stethoscope as an important instrument of power:

Who can challenge the 'value free' nature of the whispering breath sounds it reports? Yet at each and every application it establishes, confirms, and reproduces the passivity, solidity, and the individuality of the silent body it surveys. Why else would the stethoscope have become such a potent symbol of modern medicine, a self-conscious emblem to mark out the figure of the doctor (Armstrong, 1987:70).

Armstrong argues that medical sociology has failed to identify the significance of the clinical method and the use of technologies such as the stethoscope in a system of disciplinary power with the body as its object.

Whilst medical technologies have been significant in the disciplining of bodies, the history of the advent of the techniques of bodily surveillance is punctuated by discontinuities and disputes. Recognising this, Nettleton (1995:27) suggests, that the success of medicine is not determined by technological advances but is the outcome of socio-political struggles surrounding technology and its application. This is illustrated in relation to the diagnosis, treatment and construction of cervical cancer.

3. The Socio-historical Development of the Speculum.

The cervix and the uterus have been identified by the medical profession as a part of women's bodies which are uniquely accessible for both cell and tissue study as well being accessible for direct physical examination (Gusberg and Frick, 1970:145). A number of technologies have been developed which have allowed the medical

profession to take advantage of this 'unique accessibility'. One of these technologies is the speculum. The speculum is an instrument which has been designed to facilitate medical access to the vagina, cervix and uterus. Its primary purpose is to separate the walls of the vagina in such a way that the cervix and vagina may be viewed by the naked eye. It also allows the unimpeded use of further technologies to take cell and tissue samples or to gain a magnified view of the surface of the cervix. Such is the fundamental importance of this instrument to gynaecology, that the speculum is to the cervix what the stethoscope is to the heart. Just as the stethoscope represents the medical profession's sovereignty over the total body, the speculum can be said to similarly represent the profession's sovereignty over women's reproductive organs. This fact was not lost on the feminist health movement.¹²

The speculum has had a long history of use in the examination of women's bodies. Historical accounts of its development point to its ancient Greek origins. More recent accounts suggest that the use of the speculum and its further development as an item of medical technology followed on 'naturally' from the use of the ophthalmoscope and laryngoscope to explore the body through the use of natural, anatomical channels. These accounts also point to an emergence of an enlightened approach to the use of the speculum in the first half of the nineteenth century after a period in which reluctance to use the instrument was based on medical concerns of offending feminine delicacy and modesty (Reiser, 1978:55). Historical explanations such as these, fail to take into account the social location of technology. Socio-political issues frequently provide a basis for groups who seek to contest the adoption of technologies and this was so in relation to the use of the speculum. Medical opposition to the use of this instrument in the nineteenth century was based on professional concerns about access to middle class patients within a context of control of women's sexuality. The 'speculumizing' physician risked alienating the husbands and fathers of women who were concerned that the instrument may lessen the sexual inhibitions of wives and daughters and as a result threaten paternal control

¹² Refer to Chapter Seven for a more detailed discussion of the significance of the speculum for the feminist health movement.

(Moscucci, 1990).¹³

By the early years of the twentieth century, the speculum had become an accepted and established part of medical practice, being described in the medical literature as a 'necessary tool to ascertain the condition of the vaginal and cervical mucous membrane' (Jellett, 1908:13). Gynaecological texts gave precise information on how the speculum should be used as well as the attributes of the different speculum designs which were available. Such descriptions included the appropriate positioning of the patient and suggestions on how the instrument should be introduced into the vagina. These descriptions were often accompanied by illustrations indicating the appropriate use of the speculum (Eden and Lockyer 1935; Jellett 1908; McLaren 1963). What is significant about these descriptions, is the passivity of the patient whose docility and compliance is considered essential to the use of the instrument in the diagnostic process. This docility has been further compounded by the fact that the cervix is visible to the physician but remains invisible to the woman being examined. Like the stethoscope, the speculum establishes and confirms the passivity of the body which is being monitored.

In recent years however, women have attempted to claim the speculum as an instrument of feminist power. The instrument became a metaphor for women's right to see and understand their bodies and to reclaim knowledge of their bodies back from the appropriating medical profession. It can be argued that the pervasive use of the speculum by the medical profession and the championing of the speculum as a liberating technology by feminism has lead to the normalising of its use as a means to view the cervix. The self-literature not infrequently constructs this technology as an unproblematic part of women's relationship with their doctors:¹⁴

When you are settled, the doctor will place a metal or plastic instrument called a speculum in your vagina. You will almost certainly have had one used in your smear test. The speculum looks rather like two shoe horns joined together and as

¹³ See Moscucci (1990) for a socio-historical account of the use of the speculum in medicine. This account clearly shows the social location of opposition to the use of this instrument.

¹⁴ See Chapter Eight, Part Five, for a discussion of the self-help literature and constructions of cervical screening and cervical cancer.

it is eased apart, it opens your vagina so that the doctor can see down to your cervix (Quilliam, 1992:37).

The use of the speculum in the context of a medically performed gynaecological examination has in recent years been presented in the self-help literature as an empowering experience for women. This contrasts with feminist constructions of gynaecological examinations in which empowerment centred around women having the ability to use the instrument in undertaking a vaginal examination to view their own cervixes. The self-help literature normalises the vaginal examination and reconstructs the passivity of the examination (in which women are often supine, with legs apart and feet positioned in stirrups), as an experience in which women are exercising personal choice and feeling powerful:

This position can be off-putting; it may also make you feel vulnerable. But one woman's realization could help: 'Remembering that I was in charge helped a lot. I kept telling myself that I had chosen to be there because I wanted to be healthy - and that meant I was in control' (Quilliam, 1992:36).

In recent years, the medical profession has constructed the gynaecological examination and the use of the speculum in a way which emphasises the subjectivity of the patient. Acknowledging patient's individual responses to the use of the instrument has enabled the profession to consider ways in which women's co-operation in the medical encounter can be more actively pursued. McLaren (1963:19) has suggested for example, that English women are more 'difficult to handle' and are more likely to make 'more of a fuss' in relation to the gynaecological examination than German women who are less reserved and shy. He identifies the importance of the doctor going through a specific ordering of the examination to ensure women's co-operation:

In clinical practice the four examinations, breast, abdominal, vaginal and speculum examinations are carried out 'seriatim'; this order is reassuring to the patient and helps her to relax at the most uncomfortable part of the examination, viz. bimanual and speculum examinations (McLaren, 1963:20).

Showing women the speculum before examination, warming the instrument and allowing a woman to see her cervix during the clinical examination have also been identified as appropriate ways to respond to the needs of the subjective patient (Broadmore, et al 1986). This has allowed a greater level of disciplining of women's bodies as their individuality becomes constructed and monitored.

The speculum has been used in conjunction with other forms of technology which has led to an increasingly intensified monitoring of the cervix. The instrument has been used since the early 1900s to allow application of the x-ray tube for radiation therapy and to facilitate biopsy, cytological smear taking and colposcopy (Fluhmann, 1961). By the mid-twentieth century the speculum examination had become a 'routine' examination in 95% of gynaecological examinations (McLaren, 1963:21, 23). In the 1990s the speculum is widely conceived of as a morally neutral, medical instrument which is an expected part of the medical encounter for women presenting for a gynaecological examination.

Whilst this instrument is no longer a contested form of medical technology, its use remains largely in the hands of the medical profession. Attempts to have women involved in the taking of their own cervical smears or examining their own cervixes through the use of the speculum has received little support from the medical profession (Given and Jones, 1992). By maintaining control of the use of the speculum, the medical profession has maintained control of medical access to the vagina and cervix.

The debates around the use of the speculum provide an excellent example of the social location of technology. The history of the speculum is significant in its illumination of the gendered basis of the relationship between medicine and the laity. The speculum has been significant in assisting the medical profession to retain control of gynaecological work and maintain the right to monitor women's bodies. Far from representing the neutral and asocial application of scientific medicine, the history of this medical instrument is one of boundary maintenance and the use of professionalising strategies. Whilst the speculum does not adorn the bodies of doctors as does the stethoscope, its political and symbolic significance goes beyond its ability to part the walls of the vagina. This instrument has allowed the unfettered

examination of the cervix and has therefore provided the means for the medical construction of the cervix. This in turn has resulted in the intense medical monitoring of the cervix. Both feminist and self-help constructions of the speculum and its use have contributed to women's acceptance of this form of medical monitoring as a normative bodily experience.

4. Medical Technology and the 'Architecture' of Cells.

In 1928 George Papanicolaou proposed a cytological method for the early detection of cervical cancer. His proposal was based on the idea that cellular changes in the cervix could be detected before cancer of the cervix occurred. This, he hoped, would be a reliable means for preventing the disease. Papanicolaou's theories however, were for some years ignored by the medical profession (Chang, 1988). Such was Papanicolaou's enthusiasm for the vaginal smear technique, that he described himself as being 'enslaved by it' (Papanicolaou, 1946:316).

The diagnosis of disease in the laboratory had its origins in the sixteenth century when urine was analysed for its colour and distilled properties. At this time, physicians increasingly urged others to look beyond the superficial properties of blood and urine to find the hidden properties of these fluids which they believed would reveal pathological changes. By the late eighteenth century, British medical scientists had investigated the properties of blood and were making suggestions on how illnesses could be diagnosed and treated. The diagnostic significance of changes in the composition of body fluids for conditions such as dropsy, rheumatism, gout, jaundice and scurvy was identified (Reiser, 1978:127). However the majority of European physicians disregarded the new knowledge associated with the chemical evaluation of disease. The reasons for this were cited at the time as the unpleasantness of experiments with biological matter, the lack of methods to synthesize or separate biological products and the lack of interest on behalf of chemists in analysing biological products (Johnson, 1803:2-3 cited by Reiser, 1978:127).

In 1827 Bright, an English physician demonstrated that a common illness 'dropsy' which caused fluid retention in the body was often accompanied by a shrunkened kidney and a large amount of albumin in the urine. Bright concluded that there was

a link between the clinical picture of illness, chemical analysis and pathology (Peitzman, 1989). The significance of Bright's findings however went beyond their application in treating a widespread and unpleasant illness:

Bright had nevertheless discovered and publicized a significant chemical sign of a major disease. His work built an alliance between bedside observation, anatomical dissection, and chemistry. His strong advocacy of chemistry to serve clinical practice, rather than to clarify physiology (the task given chemistry by most of his predecessors), and the simplicity of the chemical test he developed, combined to make the albumin test the harbinger of further applications of chemistry to medical diagnosis (Reiser, 1978:128).

For Peitzman (1989) the renaming of 'dropsy' as 'Bright's' disease as a consequence of Bright's analysis, was significant because it represented a change in the way disease was conceptualized and defined. 'Dropsy' came to be associated with albuminuria and signs of pathology in the kidney. These were signs of illness which could not be detected by the patient but could be identified by the physician. He concluded that from this point on, that patients lost their 'sovereignty' over their own illness. Many of Bright's findings were contested in the nineteenth century and his contribution to medicine can be viewed as significant in that it represented a change in the mode of production of medical knowledge which had implications not only for patients as Peitzman suggests but also for the status and autonomy of physicians themselves.

Laboratory medicine was given impetus by the development of knowledge about physiology and histology in which cell theory formed the basis for the identification and explanation of the properties of tissues (Jewson, 1976). Laboratory medicine like hospital medicine relied on visual inspection to establish pathology. However visual inspection in the laboratory developed to include the examination of tissues and cells on a microscopic scale. The microscopic diagnosis of disease was however contested as a useful medical intervention by many physicians. It was thought that this form of analysis diverted physicians away from the useful task of observing the patient and encouraged them instead to speculate on the cause of disease. The technology of the microscope itself was also contested by eighteenth century

physicians who complained that the instrument produced distorted images and therefore observations through the devices could not be trusted. By the 1840s, the microscope had gained a more confident following amongst the medical profession and professorships in medical schools in Germany, France and England began to be filled by anatomists who supported this form of technology. In the mid 1850s the German pathologist Virchow suggested that cellular disruption was the basis of disease and that the cell itself was the basic structure of living organisms (Reiser, 1978).

Cellular theory which was translated into the 'germ theory' of disease brought about a substantial change in the practice of clinical medicine, the mode of production of medical knowledge and the ways in which the body was conceptualised. These factors had considerable impact on the patient-physician relationship and on the increasing professionalising aspirations of the medical profession. For Jewson (1976), cellular theory and its concomitant, laboratory medicine, represented a shift away from the person as the centre of medical cosmology to the 'objects' which had become identifiable in the laboratory. The subjective experiences of the sick person as a physical and psychological individual which characterised 'bedside medicine' lost their potency as the central point of medical knowledge. Whilst hospital medicine had centred illness in the patient's body and its discrete anatomical structures, laboratory medicine according to Jewson, distanced medical attention even further from the sick individual and focused it instead on minute particles of organic matter. This change in medical investigation had significant social consequences:

The increase in social distance was accompanied by the erection of strong boundaries between the sick and medical investigators. Indeed the character of social relationships in the era of Laboratory Medicine gave the community of medical investigators the appearance of an insulated intellectual cocoon.....Significant communication about the causes and cures of illness was confined to the members of the group, legitimate publication outlets being reduced to a closely guarded few. The use of technical jargon and concepts served as a ritual mode of differentiation between the established and the outsiders (Jewson, 1976:238).

Reiser (1978:89) argues that these events led to a growing tendency for many doctors to regard laboratory methodologies as representing the pinnacle of diagnostic medicine. The traditional methods of gaining evidence about tuberculosis for example, which were auscultation and medical history taking began to appear inferior to the knowledge which could be gained through bacteriology. Interest in locating disease in the laboratory before it manifested in the body also began to gain attention as a result of these changes.

The location of disease in microorganisms identified disease as a technical problem as opposed to a social problem and set the scene for a mechanistic and reductionist approach to the practice of medicine. By the end of the nineteenth century laboratories were viewed as an essential part of medicine and began to be widely established in England and Europe. In the late nineteenth century, interest in laboratory medicine was also growing in New Zealand and in 1877, a microscope was purchased for Christchurch hospital. Originally, clinical pathology was practised as clinical microscopy without the specialist functions which later developed and included the cytologist, haematologist, histologist and bacteriologist. The earliest clinical pathologists in New Zealand and elsewhere were bacteriologists. Whilst cytological diagnosis of disease had received some interest in the nineteenth century especially in attempts to identify malignant growths, by the end of the century interest had waned because of the complexity of the techniques involved.

Germ theory however, provided a major impetus for the search for a microorganism which could cause cancer and between 1911 and 1940 researchers published some fifty papers on cancer viruses (Tesh, 1988:36). Finding the cancer 'germ' took precedence over other forms of laboratory analysis such as cytology which promised less dramatic findings and less dramatic medical solutions such as the application of antibiotics and vaccines. Some researchers were however interested in studying the histology of cervical cancer in an attempt to discover the effects of what was believed to be an infective agent (Bailey, 1930). In the 1930s however, cytology was reintroduced as Dudgeon publicised his research on sputum cytology and Papanicolaou generated some limited interest in 1928 when he advocated different staining methods for the cytological detection of cervical cancer.

In 1943 Papanicolaou and Traut published a monograph which outlined their methods for identifying cancerous cells taken from the cervixes of apparently healthy women. They hoped that early recognition of abnormal cells would lead to the early diagnosis and effective treatment of cervical cancer. In their monograph Papanicolaou and Traut took Virchow's cellular definition of disease as an historical precedent for their own conception of early cellular changes in the cervix. They pointed to the limitations of the existing and commonly used methods employed in the diagnosis of the disease:

The biopsy method which is the mainstay of the present routine for demonstration of the disease is, after all, an operative procedure, requiring proper facilities and technique which are somewhat time consuming and expensive, and hence it cannot be applied upon the scale necessary to reveal the early lesions in women of the cancer-bearing age (Papanicolaou and Traut, 1943:1).

Papanicolaou and Traut hoped that their techniques would reveal the 'life history' of cervical cancer through the use of a laboratory test known as a 'vaginal smear'. They proposed that the smear test should only be used as a preliminary test with diagnosis being confirmed by biopsy and tissue diagnosis. Papanicolaou and Traut considered women were capable of taking their own cervical smears:

This method of preparation of vaginal smears is very simple. It was so designed in order to permit repeated sampling without any discomfort to the patient. No instruments except the pipette are necessary. An intelligent woman can easily be taught to prepare her own smears when a larger number of them is required for study. Women are supplied with the necessary slides, with bottles containing equal parts of alcohol and ether, and with a sterilized pipette (Papanicolaou and Traut, 1943:4).

The medical profession were ambivalent towards Papanicolaou's renewed attempts to arouse interest in his cytological methods. Grudging support for these methods was frequently tempered in the 1940s and 50s with suggestions that the cytological techniques were 'arduous', 'time consuming' and unreliable with malignant cells being obscured by other 'cellular debris' (Ayre, 1947:609). Some doctors viewed the

method as 'ancillary', in that it required specialised experience which when combined with the need for biopsy would prove too costly for the general laboratory. Cytological diagnosis was not considered to give any more diagnostic evidence than that provided by the more commonly used biopsy method (Gates et al, 1947). The *Lancet* summed up the basis for resistance to the new methods:

Much has been written in the past ten years about this method of detecting early carcinoma in the female genital tract, and many gynaecologists have welcomed the method with enthusiasm and advised its routine use. On the other hand, some doubt the accuracy and others the practicability of the procedure as a routine. The shortcomings of the method lie in its expense and in the tremendous time it takes - "some 500 hours of work necessary to reveal one carcinoma"-as well as in the difficulty of securing staff who have sufficient experience of its use (Lancet, 1953:779).

Notwithstanding medical accounts of resistance to cytological methods, some members of the profession's opposition stemmed from the fact that the new cytological methods presented a challenge to the traditional methods of cancer detection, particularly biopsy, which had been the mainstay of diagnosis for some years. Biopsy of the cervix (introduced in 1938) and other diagnostic methods were medically interventionist techniques. These methods involved the destruction of localised areas of tissue from the cervix, removal of a cone shaped segment of the cervix and in some cases total hysterectomy. By the 1950s many members of the medical profession were willing to concede that the speculum in conjunction with the naked eye were insufficient in making a diagnosis of cervical cancer but many were unwilling to concede that cytology alone was an appropriate method of diagnosis:

The diagnosis can only be made by microscopic examination of cervical tissue; biopsy is essential in every case where signs or symptoms raise the slightest suspicion, and this irrespective of whether cervical smears do or do not contain malignant cells (Jeffcoate, 1967:516).

Such opposition illustrates what Willis (1983) has argued is the social location of science and technology. He suggests that reluctance to accept new medical

technologies is not infrequently based on concerns that to do so would demonstrate the relative ineffectiveness of existing medical practice. In some instances also, accepting new medical techniques, undermines vested interests. Acknowledging the value of cytological methods meant that the medical profession had to concede that their diagnostic acumen could be surpassed by the skills of the cytologist.

There is evidence of at least some level of enthusiasm for cytological methods amongst members of the New Zealand medical profession in the 1950s. This was especially so in relation to detecting signs of pre-invasive *carcinoma in situ*. Professor Carey from National Woman's Hospital was a keen exponent of cervical cytology and as part of his role was responsible for the treatment of cervical cancer patients (Bunkle, 1988). Carey and cytologist Herbert Williams began to carry out research and concluded that cervical cytology was an effective means of diagnosing cervical changes which could lead to cervical cancer (Carey and Williams, 1958:235). A full-time cytologist was appointed to National Women's Hospital to set up a laboratory and to train staff. He was also sent to the United States to get first hand experience of cytological methods and on returning to New Zealand introduced the grading system for cervical smears formulated by Papanicolaou.

By 1958 Carey and Williams could claim that cytological processing and reporting

to be incorporated into existing medical interventions such as biopsy and colposcopy. The techniques associated with the roles of the pathologist and cytologist increasingly placed them in the position of confirming or overturning the diagnosis of cervical cancer which had been made through clinical examination. For some gynaecologists such as Green, the use of these technologies represented a challenge to the traditional power of the gynaecologist in maintaining control over diagnosis:

...he did not believe that pathology was an accurate science. He placed primary value on what the gynaecologist could see with his naked eye during an examination and on his questioning of the women. He thought an abnormality should be defined by what it did over time, rather than what it looked like under the microscope (Bunkle, 1988:165).

Whilst there was much debate on how extensively cervical smears ought to be applied to healthy women, there was little opposition to cytological methods as such. However, under the influence of Green many general practitioners continued to doubt the worth of taking smears from healthy women (Bunkle, 1988).

Cervical cytology has been significant in the construction of cervical cancer and in the determination of the normative cervix. As result of cytological techniques, the cervix has been categorised and graded in terms of its 'normality' and 'abnormality'. The cervix has become imbued with biomedical meaning, which establishes its statistical and prognostic status. Whilst the speculum allowed the cervix to be visually accessible to the medical profession but not to women, cytological techniques have provided a narrative of the cervix which is even more inaccessible to women. If a woman wishes to 'know' her cervix, she must rely on her medical practitioner to translate the language of the laboratory into a lay narrative. Ironically however, the medical practitioner has to rely on the cytologist to construct this narrative in the first place.

Cytology threatened the professional autonomy of some gynaecologists because the knowledge claims of its proponents challenged the established knowledge claims of those who had been using other techniques. Some gynaecologists viewed cytology as representing a scientific advance which when combined with existing technologies

could not only legitimate them but enhance their effectiveness. The acceptance of cervical cytology has reached a level in the late twentieth century where cytological techniques are routinely applied to the asymptomatic bodies of New Zealand women.

5. Colposcopy as Contested Technology.

The colposcope was designed by Hinselmann in 1925 as an instrument which used sharply focused light with binocular magnification to examine the cervix. Hinselmann believed that cancer of the cervix first manifested as minute ulcers on the external surface of the cervix which with magnification and illumination would reveal themselves as tumours (Kolstad and Stafl, 1977:15). The original purpose of the colposcope was therefore to screen asymptomatic women for early signs of cervical cancer. Prior to the use of the colposcope, the speculum was the instrument commonly employed to visually examine the cervix.

The visual examination of the internal features of women's bodies through the use of the speculum has had a long history as previously outlined. Towards the end of the nineteenth century a greater range of visual technologies began to more intensively monitor women's anatomy and included the exposure of the unborn foetus through the use of x-rays. Increasingly, the social power women derived from the knowledge and understanding they had of their bodies began to be eroded. This was particularly so in relation to pregnancy:

Step by step, the physician's finger, then his stethoscope, later X-rays, tests, and sonar have invaded women's gendered interior and opened it to nongendered public gaze. Pregnancy has become operationally verifiable. Women of my generation look at their insides with medical optics that create scientific facts. Now, quickening is at best a feeble reminder of what a woman already "knows". This characteristic experience, which leaves neither bloody nor slimy traces, has lost its former social relevance (Duden, 1993:81).

Visual technologies such as the colposcope contributed to what Cartwright (1995:14) describes as a tendency of twentieth century medicine to do away with distinctions of interior/exterior or object/ground. In this sense, the viewing and mapping of the cervix through the use of the colposcope has constituted the cervix as a public space

to be defined, monitored and treated by professionals. As a result the cervix has been intensely photographed and mapped. Initially this took place on specimens removed from the body through hysterectomy or postmortem examinations. After the development of colposcopy the cervixes of living women also began to be surveyed in this manner.

Colposcopy was not widely accepted by the medical community during the early years of its introduction as a diagnostic technology. Prior to the 1970s for example, colposcopy had not received widespread acceptance in either Great Britain or the United States of America. The technology appears to have been contested in these countries because it did not conform with the prevailing medical culture and was not therefore constructed as a medical advance. Hinselmann who developed the instrument was a German. He and his pupils published much of their work in German and developed terminologies related to the use of the colposcope which were not easily translated into other languages. This meant that it was difficult for English speaking doctors to relate their knowledge of the cervix to the new concepts being proposed by Hinselmann (Fluhmann, 1961). Hinselmann was also criticised for his knowledge claim that leukoplakias (specific vascular patterns in the cervix observable through the colposcope) were precursors of cervical cancer. Martzloff (1955:887) expressed his reluctance to accept Hinselmann's hypothesis regarding leukoplakias and criticised the methods used in promoting the colposcopy:

Further when attempting to assess the early literature, mostly German, on the subject it is often difficult to know what histologic criteria are utilized by some authors to define cancer. As a consequence the diagnosis of cancer made by one author had been seriously questioned or completely denied by other qualified workers. One therefore unfortunately gains the impression of lack of objectivity, lack of critique and a highly promotional effort on the part of the proponents of the colposcope.

Other members of the profession were reluctant to concede that the colposcope had any advantages over the naked eye as a diagnostic method:

Examination of the magnified cervix by means of the colposcope, as advocated by

Hinselmann, may be of some value in the hands of an expert but practically we believe it to be of little advantage. Extremely early lesions of pinhead size may be discovered by the naked eye and if these are recognised and properly treated they are curable (Linde, 1946:362-263).

It was also argued that the use of the instrument was time consuming for the busy gynaecologist. It was a diagnostic technology which would 'steal much time and return little value' (Curtis, 1946:285). Learning the technical jargon of the colposcopy was likened by some doctors to the difficulties of learning the jargon of psychiatry (Novak, 1955:888). The colposcope was also viewed as being in direct competition with cytological methods of diagnosis in which there was increasing interest in the 1950s and 60s. The taking of cervical smears appeared to many doctors to be an easier diagnostic method which did not require the time-consuming training required in the use of the colposcope. As previously noted such arguments formed the basis of early resistance to cytological smear testing. This fact was not lost on Scott et al (1969:925) who suggested that objections to colposcopy by physicians in North America were exactly the same as those expressed by physicians in Europe for not performing routine cytology. As laboratory medicine and in particular cytological methods became increasingly important to clinical medicine the colposcope was viewed as an inadequate technology in that it only gave visual information of the gross changes of the cervix and not the microscopic changes which could be provided by cytological investigation. It was also viewed as being limited in its application because it would not change the commonly used surgical treatment of cone biopsy (MacGregor, 1984). There was also the suggestion however that incompatible clinical views held by medical practitioners accounted for the lack of widespread acceptance of colposcopy:

The opinion has been expressed recently (through personal communication with Wespi, 1952), that colposcopy has been largely avoided by "Anglo Saxon" countries because "histologists" either did not recognise or refused to recognise "preinvasive cancer", thereby leaving the clinical colposcopist in the dilemma of having his clinical impression of early cancer refuted by the laboratory (Martzloff, 1955:887).

The decreased flow of medical literature between North America and Germany preceding and during the Second World War was also postulated as a basis for the disinterest in colposcopy (Scheffey et al, 1955:877). There also appeared to be some disquiet amongst North American physicians that the colposcope was being too vehemently promoted abroad and that this had reached absurd proportions in Germany. In the post-war environment the regimented approach to its use in Germany is likely to have formed the basis of some resistance:

...it has been seriously proposed in the German literature that legislation be enacted compelling physicians who examined women under the German insurance plan to use the colposcope in all vaginal examinations (Martzloff, 1955:887).

It was not until the reconstruction of colposcopy as an 'adjunctive' technology that it became more widely accepted (Kolstad and Stafl, 1977). In this reconstruction, colposcopy became the means by which other diagnostic techniques could become more effective and more widely used. Biopsy for instance had for some years been an established diagnostic and treatment method for conditions of the cervix. The colposcope came to be viewed as the means by which biopsy could be more accurately directed. It was also acknowledged however that the use of the colposcopy could in some cases prevent the need for biopsy altogether (ibid). By the 1950s colposcopy was also being constructed as a diagnostic method complementary to, rather than in competition with, cytology (Scheffey et al, 1955; Navratil et al, 1958). For those doctors convinced of the usefulness of the colposcope this new technology clearly outstripped in efficacy the speculum and the naked eye. One physician described the colposcope as revealing what the naked eye failed to see, and the cervix under magnification becoming, 'another world'. The new technology constructed in this way was identified as an essential tool for the 'cancer-conscious' clinician (McLaren, 1963:23).

The technology of the colposcope was introduced to New Zealand at National Women's Hospital in the mid 1960s. Dr Bill McIndoe who was based at the hospital, was for ten years the only colposcopist in New Zealand. He was responsible for setting up a colposcopy clinic and for training others in the use of the technology

(Bunkle, 1988). By the 1980s, the colposcope was so widely in use that a New Zealand Society for Colposcopy and Cervical Pathology was established (NZMJ, 1980). The establishment of this Society illustrates the point that technologies are not only used by specialists but also create specialisation (Wertz and Fletcher, 1989:223). The creation of specialisation has in some instances led to a fragmentation of medical work. It has also led to a fragmentation of the medical focus on increasingly atomised portions of patient's bodies. Specialisation has also lead to intraprofessional rivalry and disputes. Recognising this, the Cervical Cancer Inquiry identified the importance of co-operation amongst the different medical specialties:

During the 1960s Dr McLean, as pathologist in charge, Dr McIndoe, as gynaecological colposcopist, and Dr Green as gynaecologist, all had specialist training and skills. Each would have knowledge and understanding of each other's work, but none could reliably undertake the highly specialised work of any other member of the team. This dependence of the clinician on information from other specialists highlights the dangers for patients if there is mistrust or lack of cooperation (The Committee of Inquiry, 1988:32).

Whilst colposcopy gained many exponents, there were practitioners who were against its widespread use. During the 1980s for example, colposcopy (and cytology) were described by Green as having the qualities of an 'empire'. Green argued against the mass screening of women for cervical cancer which was being proposed in the 1980s, expressing concerns that women would be unnecessarily exposed to the physical and emotional discomforts of both smear testing and colposcopy technology which had proliferated in relation to the disease (Green, 1985:968). Green's comments regarding cytology and colposcopy 'empires' are a reflection of the growing trend in medicine for specialist medical practice to arise out of the development of new technologies. During the twentieth century, members of the medical profession increasingly had to rely on others to provide diagnostic information such as laboratory tests or to provide specialist treatments. The advent and increasing acceptance of colposcopy spawned a medical speciality in New Zealand and elsewhere which had not existed before. The incidents which resulted in the Cervical Cancer Inquiry are indicative of the ways in which medical specialisation contributes to the development

of social distance amongst physicians. This is exemplified by the knowledge claims (which arose out of the colposcopic examinations of women involved in the National Women's Hospital research) which were discounted by Green who claimed that his clinical knowledge was superior.

By the 1980s, colposcopy was being credited by many members of the medical profession as a technology which played a 'pivotal role' in the diagnosis of cervical cancer. It was considered not only advantageous for women in that it prevented the need for cone biopsy but also that it saved 'money and resources' (Chang, 1989:6). By the 1970s and 80s, colposcopy examination had come to be redefined as complimenting cytological methods of diagnosis and as a means by which positive cervical smears could be followed up by visual examination and biopsy. It had also gained wide acceptance amongst the medical profession as a 'precision tool' for the diagnosis of cervical and vaginal lesions (Stafl et al, 1977). During the 1970s ablative therapy began to be used as a method for the treatment of conditions of the cervix. Ablative methods are based on the local destruction of tissue and include cryocautery, diathermy, cold coagulation and laser treatment. Increasingly these methods have come to be used in conjunction with colposcopy with patients being treated on an outpatient basis (MacGregor, 1984:1024). By the 1980s colposcopy had been reconstructed by the majority of the medical profession in New Zealand and overseas as a technology essential for the diagnosis and treatment of diseases of the cervix. In 1982, a study group of the Royal College of Obstetricians and Gynaecologists concluded that, 'ideally no patient with cervical intraepithelial neoplasia should be treated unless there has been prior colposcopic assessment' (ibid:1024). Colposcopy was also identified in the *British Medical Journal* in 1994 as being necessary in further investigating abnormal smear tests and assessing the 'clinically suspicious cervix' more thoroughly, even when cytological results were normal (Austoker, 1994:246). By the late 1980s colposcopy and cytology were being described by the New Zealand medical profession as 'complimentary' technologies (Chang, 1989: 1). The Committee of Inquiry (1988:205) also affirmed colposcopy as an essential medical tool and recommended that colposcopy services be expanded. The Inquiry also recommended that an increasing number of gynaecologists receive training in the application of colposcopy.

As the colposcope gained increasing acceptance by the medical profession, attention has been focused on the subjectivities of women patients exposed to colposcopic examination. Putting patient's at ease and explaining colposcopic procedures have been described as important in assisting women to be less tense and to reduce the potential for cramp in the 'colposcopy position'. Relaxation in women has become a means for allowing the colposcopist to effectively carry out the examination (Harding, 1979:40). Having women develop a personal relationship with staff carrying out colposcopy has also become important within the context of this medical procedure:

A woman attending Hospital A would return for her treatment to the same room in the outpatient department. Not only the room but very often the faces too would be familiar, as there was a good chance that she would see the same colposcopist and nurse on each of her visits to the clinic. This allowed a personal relationship between the patient and the medical personnel to develop (Posner and Vessey, 1988:21).

Women's experiences of the colposcopy examination also began to be documented in the 1970s and 1980s, particularly in the self-help literature. This included women's emotional responses to the examination as well as their physical discomforts and attitudes towards the medical staff carrying out the procedures (Posner and Vessey, 1988; Quilliam, 1992). Women were constructed as needing to know what to expect in the use of the colposcope so that they were not frightened or disturbed (Harding, 1979:40).

The articulation of the medical examination from the real or imagined perspective of the patient, represents for Armstrong (1984:739), not enlightened humanism but the trend of medicine beginning in the 1950s to 'illuminate the dark spaces of the mind and social relationships'. By understanding the thoughts and feelings of the idiosyncratic patient undergoing colposcopy, women's responses could be managed in the interests of medical monitoring. Colposcopy, a physically and emotionally uncomfortable experience for many women, could then be reconstructed as a sensitively performed medical procedure which met women's needs.

In summary, the contesting of colposcopy as a worthwhile medical technology reflects

the ways in which social relations impact on technical innovations. Colposcopy was originally rejected not because it wasn't a useful medical tool but because its German cultural origins made communication about the instrument more equivocal and problematic. Concerns that the technology was being promoted inappropriately in a sensitive post-war environment may also have inhibited acceptance of it in the United Kingdom and North America. Colposcopy did not initially fit into the prevailing medical knowledge culture and was perceived as a technology which was in competition with other methods which had already gained medical allegiance such as biopsy and cytological diagnosis. It was only after colposcopy had been reconstructed as an 'adjunctive' technology which could be used to compliment these existing methods that it was more widely accepted. In New Zealand intraprofessional rivalries centred around National Women's Hospital led to competing knowledge claims about the appropriateness of the use of the colposcope. The Committee of Inquiry (1988) provided further legitimization for the instrument by constructing it as an essential technology in the maintenance of the health of New Zealand women.

6. Conclusion

A sociological analysis of the development of technologies in relation to cervical cancer points to a history of discontinuity and contestation rather than orderly progression and discovery. These technologies were contested on the basis of socially located arguments rather than on objective scientific evidence. Central to these arguments in many instances was the wish of the medical profession to protect existing practices against the encroachment of new knowledge claims. This legitimated existing medical techniques especially interventionist methods which had historically provided the basis for medical prestige. The spawning of medical specialities on the basis of new technologies provided the basis for intraprofessional disputes particularly where clinical acumen and the 'art' of the diagnostic method was threatened by the 'science' of the laboratory. This was a significant aspect of the disputes which occurred in relation to the use of cytology in New Zealand between 1960 and 1980.

Whilst women's bodies formed the background of the development of technology in relation to cervical cancer, their voices are seldom heard in any direct sense in the medical literature. When women do appear, they do so as 'subjective women' whose

needs must be taken into account in relation to the medical technologies being used. By paying attention to the sensibilities of women, the medical profession has been able to construct the use of technologies such as the speculum and colposcope as normal and benign experiences essential to the health of women. The self-help literature has added to this by constructing these medical encounters as personally transformative and empowering. Feminism has also contributed to the creation of 'subjective women' in identifying the use of the speculum by women as a liberatory experience in pursuit of every woman's right to know her body. Women's bodies have as a consequence become more governable within the context of a caring and sensitive medical environment which takes into account their gendered sensibilities. Women have not been coerced into these medical encounters but have been persuaded to co-operate with what have been normalised as rational and caring medical experiences. From this perspective, the 'warmed speculum' can be regarded as a metaphor for a form of power which regulates bodies through sensitively understanding their individuality. Ironically whilst the medical profession may claim to better understand the bodies and psyches of women, women themselves could claim that such technologies have distanced them from their bodies and increasingly disenfranchised them from knowledge of their embodiment.

CHAPTER TEN

The Cervical Cancer Inquiry.

1. Introduction

In 1987 an Inquiry into allegations concerning treatment of cervical cancer at National Women's Hospital and other related matters was begun. This Inquiry had wide reaching and important implications for the practice of medicine in New Zealand. It brought to public attention issues of power and gender in medicine. Whilst these issues had been extensively aired in the feminist literature they had not had wide public exposure. Significantly, the Inquiry opened up to public scrutiny the relatively private world of medical practice and education. Many members of the public were exposed to a medical reality which they had not personally encountered as patients. This reality also differed from the medicine portrayed in the popular media which was frequently dramatised as dramatic, heroic and benign (Lupton, 1992). Whilst there had been a greater level of questioning of the benefits of scientific medicine since the 1970s (Brandt, 1991), the abuse of medical privilege which Coney and Bunkle exposed and which was later examined by the Committee of Inquiry, shocked many observers.

The Committee of Inquiry also exposed the political nature of the professional relationship between the nursing and medical professions. The professional privilege of doctors and the subordinate position of nurses were seen by the Inquiry as contributing to the abuse of the rights of patients. This outcome was perceived by the nursing profession as providing a platform for their professionalising aspirations. The Inquiry and its findings prompted much protest on behalf of many members of the medical profession who resented the intrusion of lay scrutiny of medical matters. In contrast to the nursing profession, doctors viewed the Inquiry as potentially obstructing their professionalising strategies. Attempts were made by the medical profession to discredit the findings of the Inquiry and to limit its impact by constructing doctors as having been victimised, misunderstood and unjustly criticised.

This chapter sets out the circumstances which led to the Inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital and examines the background events which led to the cervix becoming the catalyst for

widespread disquiet over the practice of medicine in New Zealand. **Part Two** identifies the events at National Women's Hospital which led to the Inquiry and the role of Coney and Bunkle in bringing these events to public attention. **Part Three** outlines the scope of the Cervical Cancer Inquiry and explores its outcomes. **Part Four** analyses the responses of the medical profession to the Inquiry and its outcomes. **Part Five** documents the responses of the nursing profession to the Inquiry and contrasts these with the responses of the medical profession. It is argued that whilst the medical profession viewed the Inquiry as eroding professional power, the nursing profession saw in the outcomes of the Inquiry, opportunities to claim occupational territory from the medical profession. **Part Six** analyses the responses of feminists to the Inquiry and argues that they viewed the Inquiry and its outcomes as a victory in which the gendered practice of medicine was exposed in a way which confirmed the feminist platform which constructed the medical profession as sexist and patriarchal. **Part Seven** concludes the chapter by suggesting that whilst the Cervical Cancer Inquiry may appear to have been a major setback to the power and status of the medical profession that in reality it confirmed the profession in its role as the guardians of women's bodies by advocating the establishment of a national cervical screening programme.

2. Exposing the 'Unfortunate Experiment'.

The Cervical Cancer Inquiry arose directly out of the actions of two feminists, Sandra Coney and Phillida Bunkle. As activists in the women's health movement, Coney and Bunkle were members of the group *Fertility Action*, a women's health consumer interest group. It was within this context that a colleague drew their attention to a paper published in 1984 in the *Journal of the American College of Obstetricians and Gynecologists*. The paper originated from the National Women's Hospital and the Department of Community Health, University of Auckland and documented the results of a study into cervical cancer which had been in progress at National Women's Hospital since 1955. Coney and Bunkle experienced difficulties in decoding the medical language used in the article and obtained assistance in understanding its contents, from a range of individuals including members of the medical profession (Bunkle, 1988). In the paper, McIndoe et al (1984:451) reported on the results of a study undertaken by George Green on women, which aimed to observe the progress of *carcinoma in situ*. The authors reported that the senior medical staff of National

Women's Hospital had sanctioned a study beginning in 1966 which had the objective of examining the invasive potential of *carcinoma in situ*. In the paper, McIndoe et al (1984:451) identified the major parameters of the study:

No further treatment was to be offered to a group of patients who had no clinical, cytologic, or colposcopic evidence of invasive carcinoma, and in whom the histologic diagnosis of CIS of the cervix had been established by a limited biopsy of the most significant area.

The authors stressed that only a proportion of patients were managed in a conservative way. The paper concluded that of the 817 patients who had their *carcinoma in situ* followed up by normal cytological procedures 1.5% developed invasive carcinoma. In the group of 131 patients treated conservatively, 22% developed invasive carcinoma. This led McIndoe et al (1984:458) to conclude that 'the present study clearly demonstrates that CIS of the cervix had a significant invasive potential'.

The paper presented by McIndoe et al contrasted dramatically with a report of this research and the events surrounding it in the popular media by Coney and Bunkle (1987). The medical paper represented the authoritative and rational face of scientific medicine and followed the format of countless scientific papers before it. The authors outlined their methodology and analysis in an objective, factual and detached manner. The style of the paper conformed to what Gilbert and Mulkay (1984:56), term an 'empiricist repertoire' which is characterised by an impersonal style with few overt references to the authors' actions and judgements. McIndoe et al alluded in the paper to 'differences of opinion' within the hospital on the invasive potential of *carcinoma in situ* but did not express their personal feelings on the intense disputes and intraprofessional rivalries which had accompanied the research undertaken by Green.¹⁶ The cervixes of the women involved in the study were reported as disembodied objects of cytological interest which were codified and quantified in the interests of medical research. The women involved in the study remained nameless and faceless, their experiences and perceptions were not deemed to be scientifically

¹⁶ See Chapter Six for a discussion of these disputes.

relevant to the largely medical readers to whom the paper was directed. Whilst McIndoe et al presented the research at National Women's Hospital as a morally neutral, technical process, Coney and Bunkle (1987) presented an analysis of the research in their article in *Metro* magazine as morally and ethically problematic. When McIndoe and the three other authors of the paper were asked by *Fertility Action* to describe the management of the study in terms of ethical issues such as informed consent, McIndoe responded that the paper had dealt with a retrospective study and that management of patients and issues of consent were not relevant to its content (Bunkle, 1988). The paper by McIndoe et al had received a muted response from the New Zealand medical profession. Its ethical implications received barely a passing comment in the medical literature.

The cervical cancer research at National Women's Hospital took place according to McIndoe et al within a context of differences of opinion as to the invasive potential of cervical cancer. Professor Green was central to this division of medical opinion. Green, as a member of the gynaecological medical team, was accorded considerable power and status within medicine in New Zealand in that he held a highly visible and prestigious position in obstetrics and gynaecology. The status accorded to Green rested on status signifiers which had a long established history within medicine. He had specialist expertise in a highly valued branch of medicine, international recognition through published papers and conference presentations and an involvement in medical education. The institutional recognition of this status lay in Green's professorial title and in his high degree of occupational and personal autonomy. Green's institutional and personal power was also complimented by his gender. He was a male specialist working within a branch of medicine which focused solely on conditions affecting women. It was a medical speciality which had a long history of regarding its role in terms of the guardianship of women's bodies (Moscucci, 1990). Green was also a member of a profession which had a history of subordinating other professions, particularly nursing which was largely made up of women practitioners. Green's position in the medical hierarchy was also one which allowed him (and those of similar status) to professionally subordinate other members of his own profession. This was particularly so in the case of those who attempted to challenge his power by questioning his clinical knowledge or expertise.

The fact that Professor Green was able to conduct research which exposed women unknowingly to the risk of invasive carcinoma and possible death was indicative of his powerful position in the medical hierarchy. Geiringer (1988:19), pointed to the difficulties encountered in challenging the power of individuals in a hierarchical medical system:

Public hospitals are made up of power pyramids. If the (research) proposal had come from a registrar the HMC (Hospital Medical Committee) would have had little difficulty blowing it out of the water, but hierarchy makes it difficult to challenge from the inside, top people and their protégés.

At the time of Green's research, National Women's Hospital had become a central site for the training of the majority of specialists and general practitioners in obstetrics and gynaecology. The hierarchical nature of the medical division of labour within the hospital was a central factor in the events surrounding the cervical cancer study conducted by Green. The medical superintendent of the hospital appeared to be subordinated to the 'academic chief' with post-graduate staff enjoying the status of an elite class within the hospital. Their university status was more highly valued than that of clinicians and this was augmented by the fact that they held full-time positions and had academic titles. Clinicians who were involved with the hospital were mostly in private practice and worked part-time (Coney, 1988a:20). However status differences were also apparent amongst clinicians and other medical workers. Green, who eventually gained considerable influence in legitimating what he considered appropriate theory and practice in relation to cervical cancer, regarded the judgement of clinicians as superior to that of other medical workers. His scepticism, for example, of the usefulness of cytology and pathology in relation to cervical cancer provided the basis for subordinating medical practitioners in these specialities and limiting their influence over the diagnosis and treatment of cervical cancer. Undermining the 'cytology and colposcopy empire' was for Green a desirable outcome of the promotion of his ideas and practices (Green, 1985). The subordination and exclusion of competing clinical perspectives resulted in Green gaining considerable power and clinical freedom (Davis, 1988). His position of power at National Women's was such that he was able to withstand criticism of his dissenting views on cervical cancer and to gain sufficient support to experimentally

test these views. Commonly such dissent in medicine is met with denigration and attack to the extent that those who challenge the orthodoxy may be subjected to exclusionary or limiting strategies (Bosk, 1979). During a period when there was still a degree of uncertainty amongst the medical profession as to the prognosis of *carcinoma in situ*, Green's views were tolerated.

The basis of Green's research into the progression of cervical cancer was his high degree of clinical certainty that *carcinoma in situ* could be treated conservatively. As Fox (1975) suggests, doctors are frequently confronted with uncertainty and must learn to acknowledge the limitations of their clinical knowledge and skills. Green's trial appears to have been designed more to confirm his clinical certainty rather than to test it. Green also had other certainties which were morally and ethically based. These were significant in guiding his clinical practice in relation to cervical cancer and included the belief that it was wrong to subject women to unnecessary tests for cervical cancer (Green, 1985). He also believed that it was wrong to destroy what he regarded as women's most highly prized attribute, their fertility, through unnecessary surgery which he believed was frequently a consequence of medical misjudgment in relation to cervical cancer (Bunkle, 1988). Green's apparent paternalism evident in his view of himself as the guardian of women's fertility was in keeping with the premise on which National Women's Hospital was established as a hospital 'devoted to the needs of women' (NZMJ, 1964:241). Not all doctors shared these conservative views however.

Whilst National Women's Hospital was established to provide obstetric services and to treat gynaecological conditions it had two other important functions. These were teaching and research. Research into women's health problems which are not connected to reproduction have historically been given low priority by the medical profession (Doyal, 1994). However, cancer of the cervix was regarded by Green and others as a condition which ought to receive high priority in terms of research because of its link with women's fertility. It was regarded as a condition which had the potential to cause death in women in their childbearing years and on occasions to lead to hysterectomy.

In the early 1960s Green began to test his views on cervical cancer by conservatively

managing women with positive smear tests. His management of these women relied on further cytological smears and his own clinical judgement to determine the severity of the women's condition. As Green's certainty about the benign nature of *carcinoma in situ* grew, so too did his conviction that offering conservative treatments was the appropriate course of action (Coney, 1988a). Green's construction of *carcinoma in situ* was one which accorded him a high degree of clinical autonomy as he largely relied on his own judgement to determine future medical intervention. Green's research into *carcinoma in situ* appears to have had two major aims. One was to gather data to support his hypothesis about the invasive potential of *carcinoma in situ* and the other was to confirm his eminent reputation in the medical community. Green had been subjected to considerable criticism for his controversial views by members of the medical profession much of which had appeared in the medical literature. He had over a period of time vehemently defended these views (Green, 1969; 1972; 1974; 1979; 1985). His aim was not to join the prevailing thought collective which had accepted the generally internationally held views about cervical cancer but to change these views. In 1966 Green formalised research which had already begun by gaining permission from the National Women's Hospital Medical Committee to conduct a study which aimed to establish that *carcinoma in situ* was not a pre-malignant disease. The Committee represented senior medical staff at National Women's Hospital including the superintendent, and approved research on both technical and ethical grounds. The 'in-house' process of approval for Green's research illustrates the ways in which the medical profession is able to exercise considerable autonomy over what it considers to be medical matters.

The term 'professional autonomy' refers to the legitimated control that an occupation is able to exercise over the organization and terms of its work (Elston, 1991:61). Professional autonomy has been keenly negotiated throughout the history of New Zealand medicine as both the state and more latterly consumer groups have challenged the lack of external constraints or scrutiny of the practice of medicine. Medical autonomy has been exercised for example in economic matters with doctors attempting to maintain the right to determine their level of remuneration for their services. The profession has also claimed political autonomy in making policy decisions on matters which it considers to be the legitimate preserve of medicine. Claims to clinical or technical autonomy have also allowed the profession the right to

determine its own standards and to control the clinical performance of its members. The latter has traditionally been exercised through clinical freedom in doctors' consultations with patients, control over recruitment and professional training as well as collegial control over professional breeches involving discipline and malpractice (ibid). The clinical autonomy exercised by Green and his peers at National Women's Hospital in approving and carrying out research which did not have adequate safeguards for patients, can be contrasted with the lack of autonomy of the patients themselves. Whilst the medical profession claimed the right to make decisions to conduct the trials, the subjects (as patients) were not accorded the right to exercise autonomy over their bodies. This placed them in an extremely powerless position:

...the fundamental powerlessness of patients is revealed, repeatedly and poignantly, throughout this affair. The group of patients at issue were especially vulnerable. They were, in the main, working class women attending the public outpatient clinics and wards of NWH (private patients seemed to have remained in orthodox treatment with their consultants). They understood little of their condition, even less of the trial (Davis, 1988).

There were a number of features related to the subjects involved in the research carried out by Green which are likely to have an impact on their involvement in the study. Gray (1975:138) suggests from his investigations, that the more dissimilar the subject is from the physician carrying out the research, the more likely it is they will remain unaware that the research is taking place. The women in Green's study, differed from him in terms of both gender and class. Green's educational level and status as a medical practitioner were likely to be a major factor in the social distance between he and his patients. Gray concludes from his research that, even under conditions in which informed consent is gained from research subjects, the social distance between researcher and subject is such that subjects may still remain unaware of the nature of research being carried out on them. In the case of Green's research however, no attempt was made to gain informed consent from the women involved. Barber et al (1973:173) have argued that medical schools in particular have tended to lag behind other types of biomedical research institutions in the effective use of controls on research, particularly in relation to the use of peer review. In keeping with the medical profession's tendency to resist any challenges to autonomy,

medical schools have historically resisted the imposition of formal methods of control of research:

...it is a strongly held value in the medical profession that, as far as possible, controls should be informal colleague controls. Such controls are much preferred to either local-institution or professional formal controls. Formal controls are seen as unnecessarily restrictive and involving bureaucratic red tape and distant authorities who are not as competent to judge an individual professional's work as are his local peers. Attempts at control by agencies outside of the profession are seen as worst of all; hence the great resistance to suggested control by local communities, social service agencies, or state or federal governments (Barber et al, 1973:173-174).

Barber et al suggest that research in medical schools is a particularly highly valued enterprise and that formal controls have typically been perceived as infringing upon the interests of the medical school and research community. They conclude that given these interests, medical schools are more likely to resist formal peer group review (op. cit:174).

Whilst Green's research appears to have been scrutinised by a formal peer review structure within National Women's Hospital, this structure seems to have lacked sufficient objectivity and detachment to challenge and resist the zeal, authority and status of Green.

There was however resistance from some members of the medical staff at National Women's Hospital to Green's research. When the original research proposal was put forward by Green in 1966, it was opposed by McIndoe a colposcopist. He expressed concern about the conservative nature of treatment of the research subjects and suggested that in cases of positive smears, tissue should be removed from the cervix. For McIndoe the management of *carcinoma in situ* being suggested by Green, was inadequate in terms of both diagnosis and treatment (Bunkle, 1988:156). McIndoe continued throughout the years to oppose Green's management of cervical cancer and was later joined by a pathologist, McLean, who identified cytologically that tumours were occurring in some of the women who were part of the study. McLean

and McIndoe challenged the hierarchy at National Women's Hospital by formally writing to the medical superintendent and asking for a reappraisal of the policy on the management of patients with abnormal cytological or colposcopic findings. McIndoe attempted to stimulate more informal peer review and was convenor of a tumour panel in 1971 which discussed individual cases of gynaecological cancer. He followed this up with more formal action in 1973 by writing to the medical superintendent of the hospital and requesting a reappraisal of the policy on cancer patients (Bunkle, 1988:159; Coney, 1988a:62). The superintendent of National Women's Hospital attempted to have these concerns dealt with by the medical superintendent-in-chief of the hospital board but it was referred back to the hospital to be dealt with internally. The concerns raised by McLean and McIndoe, were eventually reviewed by an internal committee of inquiry. The committee made up of hospital doctors concluded that in all but one of the limited number of patient's files reviewed, hospital policy was being adhered to. The terms of reference of the committee were sufficiently limited to exclude judgement on the outcome of the study being conducted by Green. The committee concluded that staff involved in the trial, except for a junior pathologist, were conducting themselves with personal and professional integrity (Coney, 1988a:65). McLean's and McIndoe's concerns regarding Green's research were constructed by the medical hierarchy as personal differences which were only of concern in that they were potentially disruptive to scientific inquiry (ibid). Increasingly both McLean and McIndoe were subjected to collegial limitation, exclusion and subordination. Their clinical specialities were regarded by Green as largely irrelevant to his research:

Green was sceptical, bordering on contemptuous, of the usefulness of the pathologist and cytologist. For him the clinician's judgement was supreme. Such an ethic sustained an extreme interpretation of clinical freedom; it also inspired a dismissive attitude towards alternative scientific and epidemiological evidence (Davis, 1988:249).

Neither McLean nor McIndoe had the power to control the way in which medicine was practised within the hospital and their views were subordinated to those who did. During the Cervical Cancer Inquiry, McIndoe's attempts to express concerns at National Women's Hospital were equated with 'an office boy trying to tell the

Managing Director how to run the firm' (Committee of Inquiry, 1988:72). McLean and McIndoe's attempts to gain collegial support for opposing the study by publishing a paper in the Journal of American College of Obstetrics and Gynaecology resulted in little overt interest or action by other members of the medical profession.

3. The Cervical Cancer Inquiry

Whilst the paper by McIndoe et al received little attention, the publication of the article by Coney and Bunkle (1987) outlining the research at National Women's Hospital prompted widespread concern and debate. Shortly after the publication of the article, the then Minister of Health, Michael Bassett announced that there would be an Inquiry into the events exposed by Coney and Bunkle. One of the primary and initial aims of the Inquiry identified by Bassett and the Auckland Hospital Board appeared to be to restore confidence in the health professions and the institutions of medicine. Silvia Cartwright, a district court judge, was appointed to head the ministerial inquiry into the events at National Women's Hospital. In appointing Cartwright, Bassett stipulated that the Inquiry was aiming to be 'short and sharp'. He also confirmed that it was to be neither a 'witchhunt' nor a 'circus' (Coney 1988a:74-76). The Inquiry had a total of nine matters to examine. Amongst these was the issue of whether there had been a failure to adequately treat *carcinoma in situ* at National Women's Hospital and if this failure existed, to identify the reasons which contributed to it. The Inquiry was also charged with determining whether the research which was carried out on women at the hospital was approved; whether informed consent had taken place and whether the women involved were properly examined and treated during the course of the research. Also at issue was whether the hospital had properly investigated the research in response to expressions of concern by staff members and whether the on-going surveillance of research was adequate. The Inquiry was also to focus on patients' access to information and their rights in relation to treatment procedures and research. The Inquiry was also concerned to investigate the level of education being offered to medical students and practitioners in the diagnosis and treatment of pre-cancerous and cancerous conditions of the genital tract. The need to investigate the relationship between the academic and clinical units of National Women's Hospital was also identified as a focus for the Inquiry as was the need to contact women who had been referred or treated at National Women's for *carcinoma in situ* and to offer them further treatment or advice (Committee of Inquiry 1988:4-5). The Inquiry heard

from members of the medical profession from New Zealand and overseas, from patients and their relatives and from members of the nursing profession amongst others. Over a thousand patient files were also reviewed (op.cit:228-237).

The report of the Inquiry confirmed that women at National Women's Hospital had been involved in research without their knowledge or consent, that progressive disease was ignored and that inadequate treatment had been given. The Inquiry concluded that women had been subjected to persistent disease and some had died as a result of the research. The Inquiry concluded also, that the medical profession had failed patients by not confronting the issues which had been brought to its attention during the duration of the trial (op.cit: 70). The Inquiry made a number of recommendations which included ensuring that the women involved in the study were recalled and received advice and treatment. Guidelines for the treatment of gynaecological diseases were to be developed and maintained and these were to become the basis of information to patients. Patient rights were the focus of the majority of the recommendations of the Inquiry and included the establishment of a health commissioner, a statement of patient rights and the appointment of patient advocates. The provision of full information in a patient's first language and the right to participate in decision making regarding all medical interventions whether related to treatment or medical education also formed part of the recommendations. It was also recommended that a national population-based cervical screening programme be implemented urgently in consultation with consumer groups and health professionals. The Inquiry also recommended that teaching on patient rights and *carcinoma in situ* be improved in medical schools and that a specialist oncology unit be developed at National Women's Hospital for the treatment of invasive cancer of the genital tract (op. cit:210-218).

The examination of medical practices in relation to cervical cancer had significant implications for the medical profession. Clearly exposed were the ways in which the profession had attempted to control its own members and to preserve its occupational position against intrusions from other professions as well as the laity. Johnson (1972:45) argues that a profession is a means of controlling an occupation and Turner (1987:135) identifies a profession as being the basis for structuring the relationships between, experts, patrons and clients. Central to the maintenance of

professional power and status is the collegial control of members. This is achieved in a number of ways but these largely parallel the means by which professions ensure that they maintain their position in relation to other occupational groups. The fact that the Inquiry occurred at all is indicative of the failure of the medical profession to manage its own members and to adequately structure the relationship between the profession and the laity. As a result, collegial control and medical autonomy had been eroded. Whilst McLean and McIndoe were excluded and limited in the extent to which they could become involved in the clinical decision making which impacted on patients involved in the research, they were able to express their concerns through the medical media. It appears that they had hoped that rational, medical evidence would persuade the profession to act, but there is little evidence to suggest that this occurred. What finally eroded the professional strategies of the medical profession was the translation of McLean and McIndoe's scientific paper into a readable and emotive 'story' which informed the 'laity' about covert medical practices. The article by Coney and Bunkle was significant in its undermining of the profession's ability to limit the intrusion of the laity, and maintain a public, collegial silence over medical disputes. Once the story broke, the profession had only two strategies left to exercise. These were, to concur with the content of the article and denounce the actions of the offending members of the profession or to counter the accusations by defending medical practice and denying the veracity of claims of medical abuse. Both strategies were employed by the profession during and after the Inquiry.

To some social commentators the persistence of Green's flawed programme and the findings of the Inquiry, signified a remarkable and enduring failure of medicine to mobilise institutional safeguards:

But what happened to the normal institutional constraints? Where were the processes of informal control and peer review that are supposedly the hallmark of the medical profession, where was the scrutiny of the research community that should have operated in an academic unit, and where was the active concern for patient care that might have been shown by a medical administration answerable to an elected lay board of control and ultimately to the public (Davis, 1988:248).

The expectations of the medical profession which Davis documents, represent the

implicit norms of the social contract between the medical profession and the public. These norms form the basis of public confidence in a relationship in which the public as consumers of health care are, as Johnson (1972:51) suggests, largely, 'unorganised, dependent and exploitable'. As a consequence of the Cervical Cancer Inquiry, the public was, according to Coney (1989:24), appalled at what the medical profession considered to be 'normal' medical practice. Many members of the profession were likewise appalled that the public did not concur with their view of what constituted 'normal' medical autonomy. What further alarmed some commentators was that the presentation of evidence at the Inquiry itself replicated to some extent the events which had occurred at National Women's Hospital. Davis (1988:250) showed how the hearings at the Inquiry were dominated by legal and institutional protection of reputation with little regard for the women involved. Supportive of the patients at the centre of the Inquiry however, were the authors of the *Metro* article, the Ministry of Women's Affairs, the Auckland Cancer Society, and the authors of the 1984 medical paper which outlined the results of the research under investigation. Lack of specific institutional support for the women patients was according to Davis very much in evidence:

But specific institutional representation and protection of the interests of the patient, there was none. The public interest almost failed for want of an advocate (Davis, 1988:250).

The Inquiry not only exposed the events at National Women's hospital but also exposed the professional strategies commonly used by the medical profession to protect its reputation and status in the medical 'market place'. What became evident during and after the Inquiry was that many members of the profession were unwilling to concede that the rights and interests of the public should override medical preference and practice.

4. The Report of the Committee of Inquiry: The Responses of the Medical Profession

The Inquiry made some recommendations which challenged the autonomy and authority of medicine. It also made recommendations which affirmed and entrenched medical dominance. At the time of the Inquiry the medical profession

was already increasingly experiencing challenges associated with a pervasive questioning of the authority of professions in general and the questioning of medical ideals in particular (Brandt, 1991; Kelleher, et al 1994). The profession was also experiencing a restructuring of health care in which an increasingly powerful managerial class began to target the health system for economic reform. The medical profession was also increasingly facing challenges posed by practitioners offering alternatives to allopathic medicine (Easthope, 1993), as well as epistemological challenges to medical knowledge which had arisen out of feminism and the rise of self-help groups (Kelleher, 1994).

On the 24 August 1988, the *New Zealand Medical Journal* in its 'News' column reported the outcome of the Committee of Inquiry. The report presented the circumstances which led up to the Inquiry and its outcomes in a pragmatic and factual manner (NZMJ, 1988a). The *New Zealand Medical Association* in its Annual Report of 1988 briefly summarised the findings of the Cartwright Inquiry:

The report was very critical of the medical profession in places and has been seen as a landmark by some women's groups for knocking doctors off their pedestals (NZMA Annual Report, 1988a: 1-2).

The initial responses of the medical profession reported in the medical literature, read like a technical report of a medical event. Little of the sometimes emotive and dramatic nature of the events appeared in these reports. The profession appeared to distance itself from the outcomes of the Inquiry and attempted to limit the extent of its culpability. The *New Zealand Medical Journal* (1988a) for example prefaced its report by stating that the Inquiry had faulted National Women's Hospital, by implication limited the extent of the 'fault'. The New Zealand Medical Association in its response suggested that the Inquiry had been very critical of the profession 'in places'. A further report in the *New Zealand Medical Association Newsletter* did however acknowledge the gravity of the Inquiry and the need for the profession to improve its services. This was prefaced, however, by an attempt to discredit the Inquiry by suggesting that it was limited by the adversarial context within which it occurred, the historical nature of the issues being examined and the presence of the news media. The profession was alert, however, to the political advantages of being

seen to acknowledge collective responsibility for the events examined by the Inquiry:

Although the Enquiry may have been about an event in the past in one part of the country, collective responsibility is an aspect of professional that we cannot shirk, particularly if we wish to retain some control over discipline and peer review (Baird, 1988:1).

The content of these reports was indicative of the medical profession's initial attempts to respond to the outcomes of the Inquiry as if it had erred in a limited and technical manner. The fact that the Inquiry had shown the profession to be responsible for gross moral-ethical error was not easily accepted by many of its members.

Resistance to the outcomes of the Inquiry by the medical profession appeared in a variety of forms. Some doctors refused to accept its findings on the grounds that the Inquiry itself arose out of the initiatives of two lay individuals. This was the position of Cairney (1989:261) who suggested that the medical conclusions of the Inquiry would not endure because they were drawn from the 'intellectualisations of two polarised journalists'. Concerns about the intrusion of lay individuals into medical matters were intensified for some members of the profession because of the gendered political stance taken by Coney and Bunkle. They were identified as 'feminists' who had initiated a political 'witchhunt' against doctors (McArthur, 1992; Mackay, 1991; Purdie, 1990). Similarly, 'militant' feminists were identified as the source of an 'antidoctor' theme which had pervaded the Inquiry (Faris, 1990:354; Harison, 1991:235; Pryor, 1990: 355). Some members of the profession were alarmed at the power being welded by these two feminists and a female judge in challenging the authority of a largely male dominated profession:

How the strident claims from a couple of feminists, and the findings of a woman judge, can warrant the replies we have seen in the press and on television, I do not know. Who is going to have the decency to defend those under attack, or at least to point out that most of us were not only uninvolved in the events at National Women's, but didn't even know that they were happening (NZMA Newsletter, 1988b:11).

Other doctors aired their concerns about the Inquiry in the popular media. Geiringer (1988) attempted to discredit the impartiality and rationality of Coney and Bunkle in the popular magazine *NZ Listener* by drawing attention to their feminist politics and what he believed to be their feminist bias on medical issues:

Indeed had his (Green's) first name been Hermione he would at this point have been a shoo-in for the pantheon of fearless feminist fighters against male medical mutilators. Her opposition to wholesale womb snatching, her questioning of the medical establishment's determination to "upend all women" for an annual smear, would have earned her a rave in Broadsheet (Geiringer, 1988:19).

For Geiringer, the Inquiry was set within a context of 'negative attitudes' against medicine which had been generated by feminists. He suggested that medicine had never discriminated against women. The power of Geiringer's position arose from his status as a prominent medical practitioner and liberal intellectual. He was known as a critic of medical conservatism, campaigning for abortion law reform, population control, cervical screening and measles vaccination (Burgess, 1995:C5). Coney (1990) suggests that, from the responses to Geiringer's comments it appeared that he had articulated the feelings of many New Zealand doctors.

The responses of members of the medical profession were set within a background of what Coney (1990a:214) suggests was a lack of acknowledgement of culpability on behalf of the profession as a whole. This lack of admission of guilt was justified by the profession on the grounds that legal action was pending. Coney considered that this excuse overlooked the fact that the institutions responsible for the 'experiment' were defending themselves against the action rather than paying compensation to the women who were harmed by it. Coney (1990b:355) pointed to the invisibility of the women involved in Green's research in the responses of the medical profession to the Inquiry:

Of course, the people who have become invisible in this "debate" are the women and families of women who died. The current attempts (by the medical profession) to justify what happened at NWH deny what for them was very tragic reality.

A statement did however appear in the *NZMA Newsletter*, which summarised the findings of the NZMA Working Party which had been established to study the recommendations of the report from the Committee of Inquiry. The statement acknowledged the profession's anger that the 1966 research had been allowed to occur and noted that the trial had 'deteriorated scientifically and ethically'. The statement also suggested that it was 'inexcusable and deplorable that all patients involved did not know they were part of a trial' and that it took a magazine article to initiate an investigation (*NZMA Newsletter*, 1989:6.) In the next issue of the *NZMA Newsletter* however, the item was retracted:

It (the Cartwright report item in the January newsletter) was part of a draft paper to the Working Party on the implementation of the recommendations in the Report. The statement does not represent NZMA policy and its inclusion in the Newsletter is regretted (Baird, 1989:8)

Those members of the medical profession who did appear to accept the findings of the Inquiry sometimes did so in an ambivalent manner with their acceptance being tempered with expressions of concern that the medical profession had not been properly understood. Hopkins (1989:71) for example, suggested that the Inquiry was a catalyst for 'taking stock' and acknowledged that the profession had been remiss in not responding to patient concerns of consent and communication. He suggested also however, that medicine 'had failed to explain its own case' and that doctors needed to 'explain how we practice good scientific medicine for the patient's benefit' even though this did not 'always agree with the patient's notions'. For others, the failings of the medical profession were, at least in part, indicative of 'society getting what it deserved' within a context of medicine being given a 'low political priority' (Campbell, 1991:36).

There were members of the medical profession who unequivocally accepted the findings of the Inquiry. This acceptance often occurred within a context of chastisement of colleagues who appeared less inclined to acknowledge the profession's errors (Peacock, 1990). Gray (1990a:378) for instance in chastising a fellow practitioner urged his colleagues to focus on the conclusions of the Inquiry:

He (Dr Bruce Faris), attacks the report obliquely at what he perceives as its weakest link, that a "militant" feminist (Sandra Coney) dared to raise such an issue.

Dr Faris might be more credible, if he concentrated on the judicial findings of the report itself.

Other members agreed with the findings of the report and acknowledged the accuracy of the basic premises behind it:

I have just finished reading the Report of the Cervical Cancer Inquiry, 1988 and I don't see anything wrong with it. It is a damning indictment of a paternalistic system of medicine which rode roughshod over patient's rights (Welch, 1989:326).

Paul (1988:538) acknowledged the failure of doctors at National Women's Hospital to protect patient's safety but considered that the reasons for this failure had to be sought in the 'attitudes of doctors to science, to accountability' and more equivocally, 'perhaps to women'. For McPherson, trust between the medical profession and patients was at the core of the Inquiry. He saw restoration of this trust as essential and expressed concern that there had been little sign of an admission of abuse of trust by the profession nor had there been any disciplinary action:

One cannot help gaining the impression that the medical establishment are resisting a straightforward and public admission that there was any abuse of trust (McPherson, 1989:169).

Those doctors who were perceived to be responding favourably to the findings of the Inquiry were castigated by colleagues for acknowledging the culpability of the profession.¹⁷

In its responses to the Inquiry, the Medical Council acknowledged the seriousness of the outcomes and stated that the Inquiry would have an impact beyond the hospital

¹⁷ See Pryor (1990) and Purdie (1992) for examples of the type of criticism levelled at members of the profession who were in agreement with the outcomes of the Inquiry.

and medical speciality concerned. The Council also acknowledged that 'clinical freedom was never a valid reason to pursue a course of action contrary to standard treatment methods' (NZMJ, 1988b:618). The NZMA Council also stated that the modes of treatment at National Women's Hospital were 'patently unethical' (NZMA Council Minutes, 1988: cited by McPherson, 1988:169). McPherson predicted that the lack of a public statement of these sentiments by the profession would have serious consequences for doctors by giving credence to those who argued for a curbing of medical power and authority. Despite this and other acknowledgements of culpability, the responses of the medical profession in general to the outcomes of the Inquiry were indicative of a defensive and patriarchal profession (White, 1994).

The Inquiry caused some members of the profession to examine issues of professional solidarity in the face of what were perceived to be unprecedented intrusions and attacks by the media, feminists and the public (Cairney, 1991). Concern was expressed that the profession was not supportive of members subjected to attack during the Inquiry. This prompted Varlow (1990:192) to ask whether there was an organisation which defended doctors. These concerns were especially apparent after the President of the New Zealand Medical Association took a complaint against doctors involved in the National Women's Hospital research to the Medical Council after the release of the report from the Inquiry. Whilst the Medical Council was viewed as existing to protect the public, the New Zealand Medical Association was expected to protect the interest of members of the medical profession. The motives of the NZMA were therefore called into question by some doctors:

I am left uneasy by the NZMA complaint against some of the National Women's doctors criticised by the Cartwright Report. Where was the NZMA at the time these things were happening? For the NZMA to show concern after the Cartwright Report and some 20 years after the events seems blatantly political to me (McArthur, 1990:108).

The complaint to the Medical Council, set in motion charges of disgraceful misconduct against Green and Bonham and charges of professional misconduct against Seddon and Faris, members of the Hospital Medical Committee who

examined Green's research (NZMJ, 1990a). In response to the Medical Council's findings of 'disgraceful conduct' against Bonham (NZMJ, 1990b), and the charges against Green, who was later found to be unfit to defend the charges, (NZMJ, 1990c) members of the profession rallied to support both doctors and lauded their contribution to medicine (Adams, 1992; McCowan et al, 1990; Malloch, 1990). Gwynne (1990:378) suggested that Professor Green 'deserved a medal' for his contribution to the conservative management of self-limiting cervical disorders. Other medical commentators expressed the hope that the Medical Council's finding against Bonham would result in the silencing of medical critics of the report of the Inquiry (Paul and Holloway, 1990).

By the 1990s the medical profession recognised the Inquiry as a serious event likely to impact on it for years to come. This recognition was not however always indicative of an acceptance of the need for substantial change in the way in which the profession responded to the public:

The fallout from Cartwright will take years to recover from, medical research has been set back by decades, screening programmes costing millions and of doubtful value have been embarked upon, unworkable consent forms have been produced and majority lay committees can decide on treatment protocols. (Take medical decisions away from doctors!) (Pryor, 1990:355).

Many members of the profession continued to resent what was perceived to be an

which had published the original article in 1987 on the events at National Women's Hospital. This article provided a forum for the deconstruction of the knowledge claims of the authors of the original article and of the subsequent Inquiry:

It is now possible to say that the Inquiry was launched on evidence which was misinterpreted and reached conclusions which were not justified by the evidence. It is possible to say too that Professor Green has been a victim of a well-orchestrated smear campaign, and of an inquiry which didn't give sufficient credence to his side (Corbett, 1990:55).

Professor Green was portrayed in the article as having been wronged by the actions of two feminists. Coney and Bunkle were described as approaching their story with a heavy load of 'psychological baggage' because of their past dealings with the medical profession. Corbett also suggested that Coney and Bunkle's feminist politics had contributed to a lack of objectivity in their interpretation of events at National Women's Hospital. As well as suggesting that the case against Green had been morally wrong, Corbett suggested also that it had been technically flawed and that it over estimated the harm that had been done to women patients. Evidence from a semi-retired gynaecologist was presented which disputed Coney and Bunkle's interpretation of the statistical evidence of the cervical cancer trials conducted by Green. Corbett called into question the basis of the findings of the Inquiry. The claim by Corbett that the evidence presented to the Inquiry was flawed was later disputed by Paul and Holloway (1990:583) writing in the *New Zealand Medical Journal* who argued that the evidence presented did in fact point to the experiment by Green as having serious detrimental medical consequences:

The results of the management of cervical carcinoma-in-situ at NWH for the years 1955 to 1976, however the patients are grouped, have almost certainly been the worst that have been documented in the world.

As well as receiving this support from the medical profession, the Inquiry also received endorsement from the Public Issues Committee of the Auckland District Law Society (1990:17) who supported both the way in which the Inquiry was conducted and its findings.

In summary, the events surrounding the Inquiry represented an unprecedented intrusion of the public in medical matters. These events were indicative of a failure of the professionalising strategy of 'social closure' in which medical disputes and uncertainty remain largely hidden from the public. Many members of the profession responded to these events by attempting to reestablish medical prestige and dominance by discrediting the knowledge claims which emerged from the Inquiry and by calling into question the motives and credentials of those who provided evidence. In contrast, the nursing profession's response to the Inquiry involved quite different professional strategies.

5. The Responses of the Nursing Profession to the Cervical Cancer Inquiry

The Cervical Cancer Inquiry served to highlight the political nature of the relationship between nurses, the medical profession and patients at National Women's Hospital. The Committee of Inquiry (1988:172) made this explicit by noting the political dimensions of professional relations at National Women's Hospital:

Nurses who most appropriately should be the advocates for the patient, feel sufficiently intimidated by the medical staff (who do not hire or fire them) that even today they fail or refuse to confront openly the issues rising from the 1966 trial.

As a paramedical profession, nursing has had a long history of exposure to the occupational strategies employed by the medical profession in its attempts at boundary maintenance (Turner, 1987; Willis, 1983; Witz, 1992). These strategies have ensured that nursing has remained a subordinated profession, limited in the medical work that it has been able to carry out and excluded from the high degree of autonomy and status claimed by the medical profession. Central to the position of nursing in the professional hierarchy has been its female character. The historical development of nursing was based on Florence Nightingale's ideas that the occupation required a training which harnessed womanly virtues. Eschewing the germ theory, Nightingale was willing to leave curing to the medical profession and claim for nurses what she considered to be the more important work of caring for patients (Reverby, 1989). As a result, nursing became associated with the more menial tasks of caring for the sick. Nightingale was keen to see that the initial hard

won acceptance of nurses in the military setting was not compromised by their encroaching on the army doctor's areas of responsibility. Dixon (1990:5) suggests that these historical antecedents have continued to impact on nursing:

Nurses are still subject to doctors' control, helping them to carry out their work quickly and with as little effort as possible - by filling in forms, taking specimens for them and smoothing their paths in patient encounters.

By the late 1980s and at the time of the Cervical Cancer Inquiry, the New Zealand nursing profession was becoming increasingly explicit and vociferous in its claims for a greater share of medical work. Nurses pointed to the transfer of nursing training to technical institutes in New Zealand as a significant professional milestone. They claimed that this change legitimated calls for an expanded role for nurses. Discourses on nursing began to reconstruct the nature of the profession from a narrowly focused caring role to a broader all encompassing role within the health system (Shaw, 1988:322). Shaw suggested that nurses and nursing organisations needed to develop a greater level of political activity by becoming involved in health policy and planning at regional and national levels. As part of their claim to a greater share of medical work, nurses began in the 1980s to emphasise that they had unique professional qualities. 'Doctoring' was constructed as treating patients in a mechanistic fashion whilst nursing was constructed as an holistic approach based upon individualised, patient management systems and a problem oriented, nursing process. Witz (1994:38) argues that discursive reconstructions of nurses as professionals rather than as subordinate handmaidens are part of a professionalising strategy aimed at legitimating claims to a greater level of autonomy in medical decision making. The adoption of the 'nursing process' therefore, represented a redefinition of the core tasks and responsibilities of nurses. Nursing goals, defined within the context of the 'nursing process', rather than being subsumed to medical goals became redefined as being of equal value to the goals of clinical medicine.

By the 1980s nurses were also calling for a collegial rather than a hierarchical relationship with doctors on a basis of negotiated areas of responsibility (Mathias, 1987:69). Members of the New Zealand medical profession responded to these calls with a degree of hostility. Referring to a paper in which Mathias stated the need for

collegial co-operation between doctors and the nursing profession, Mackay (1987:189) questioned the motives of nurses:

This piece of fiction is a feeble attempt to ape aspects of medical practice thought to give power and prestige. And it is power and prestige that your leading article aspires to, not the proffered 'pursuit of excellence in patient care'.

Other doctors congratulated Mackay on his courage in raising the concerns of the medical profession and in doing so, risking what was perceived to be the 'ire of the nursing profession' (Frengley, 1987). Their 'delusions of grandeur' and preoccupation with professionalisation were identified by Greer (1987:256) as a 'sickness' in the nursing profession which was not only a threat to other health professionals but also to patients.

It was within this historical context that the Cervical Cancer Inquiry implicated the nursing profession at National Women's Hospital by suggesting that all who knew of Green's trial and its consequences and allowed it to continue were responsible for its grave outcomes (Committee of Inquiry, 1988). The Inquiry heard evidence from the Nurses' Union who suggested that the political structure at National Women's Hospital was the basis for nurses' inaction on behalf of their patients. Breen, speaking on behalf of the Nurses' Union, described the culture within the hospital as male dominated and hierarchical with nurses being subordinated to the authority of doctors. When, according to Breen, nurses had attempted to take action on issues related to the welfare of patients, they were met by resistance by those in authority. The Nurses' Association noted that even senior medical staff had experienced difficulty in thwarting more senior medical staff in relation to the cervical cancer trial and pointed out the even greater level of powerlessness experienced by nurses (Coney, 1988a). The political position of nurses at National Women's Hospital at the time of Green's study was considered to have made it difficult for nurses to act ethically:

The nurses at National Women's Hospital knew the institutional constraints made it very difficult for them to act ethically. Those who protested were ignored or chastised and they were unclear about the ethical requirements of nursing (Dixon, 1990:7).

The fact that many of the nurses were students working in short rotations was another factor which it was suggested compounded their powerlessness in the bureaucratic structure of National Women's Hospital (NZNJ, 1988). The medical profession was described as overruling any authority the nurses had by overturning decisions made by senior nursing staff on the placement of nursing staff (Coney, 1988a). Keith (1988:14) suggested that the nursing staff at the hospital was under 'moral stress', in being aware of what they ought to do on behalf of patients but finding that the institutional constraints made it almost impossible to act.

The Inquiry raised the issue of the obvious and deeply entrenched subordination of nurses by the medical profession. It also highlighted the ways in which the practice of nurses was limited, especially in relation to the transmission of information to patients. Nurses demonstrated that their attempts to advocate for patients, resulted in doctors sometimes aggressively asserting their authority to the patient's detriment:

...one nurse reported that sometimes, if she suggested to a male doctor that he could be carrying out procedures on women in a more gentle way, the response would be to treat the patient more roughly (Bickley, 1993:131).

Nurses were also considered to have become enculturated to their powerlessness and had accepted that many practices were an immutable part of the medical system. The Cervical Cancer Inquiry brought to public attention the longstanding political dimensions of the division of labour in health work. What had become the norms of the professional relationship between nurses and the medical profession were exposed as being seriously detrimental to the wellbeing of patients. Whilst nurses were considered to be relatively powerless within the medical hierarchy of National Women's Hospital, patients were identified as being even more powerless.

The nursing profession responded to the criticisms and recommendations of the Cervical Cancer Inquiry in a less resistant and defensive manner than the medical profession. This can be attributed to the fact that the outcomes of the Inquiry were perceived by nurses as being ultimately enhancing of their position in the medical hierarchy. In contrast, the medical profession perceived the outcomes as challenging the profession's privileged and autonomous status. In the light of this, the

recommendations of the Inquiry were quickly endorsed by the Nurses' Association and nurses 'welcomed' the findings of the report of the Inquiry. The report was described by the Association as a carefully researched document. Whilst the profession felt that the report could have promoted the role of nurses more extensively in its recommendations, it responded with what Bickley (1993:127) describes as a 'flurry of activity at national and local level'. Unlike many doctors who viewed the Inquiry team as feminist adversaries, the nursing profession expressed its gratitude to Cartwright, Coney, Bunkle and others and solicited advice on how to best implement the report (ibid). In particular, nurses began to examine the ways in which their understanding of ethics had become confused with professional etiquette:

This leads to nurses being reluctant to suggest that patients question a recommended medical treatment, or request a second medical opinion, in the mistaken belief that it would constitute a breach of ethics (Dixon, 1990:7).

The Cervical Cancer Inquiry provided a legitimate basis for the nursing profession to challenge occupational strategies which had subordinated them to medicine. The reconstruction of ethics as a moral basis for nurses to protect patient interests as opposed to protecting the interests of the medical profession indicates an attempt to restructure the political relationship between doctors and themselves. Professional etiquette which had previously structured the deferential nature of the relationship between nurses and doctors, was redefined as a means by which the medical profession had been able to practice unethical medicine in an environment in which nurses felt unable to challenge their actions.

The two recommendations which arose out of the Inquiry which received most support from nurses related to the development of a Health Commissioner Bill and the initiation of a national cervical screening programme. The latter recommendation had political significance for the profession as it saw nurses as potential providers of smear taking services which would challenge the medical monopoly in this area. Nurses, in conjunction with consumer groups, were active in lobbying for a national screening programme. In an effort to secure the new occupational opportunities which smear taking promised, some nurses began to employ protective strategies to avoid this activity falling into the hands of other groups. Some nurses opposed lay

individuals being involved in this work and in doing so emphasised the skills of nurses as essential to this role:

Not all nurses believed that the use of lay smear-takers was a good idea. Their argument was that practice nurses could provide a professional standard and carry out a more comprehensive health check than a lay health worker could at the same time as the smear was taken (Bickley, 1993:130).

Whilst nurses attempted to claim medical territory from doctors and prevent encroachment from lay health workers, medical orthodoxy continued to remain in ascendancy. The Wellington Area Health Board for instance ignored nurse or lay smear takers, and recommended that women contact their general practitioner or family planning clinic for smear testing. Whilst the number of nurse smear-takers has grown, Bickley (1993:131) suggests that practice nurses have encountered difficulties in being recognised as independent practitioners rather than as ancillary smear-takers under the supervision of a general practitioner.

In summary, the Cervical Cancer Inquiry was an event which provoked quite different responses from the two major professional groups involved in health care in New Zealand. The basis for this difference lies in the historically based dominance of the medical profession in medical work and the subordination of the nursing profession. The historically gendered structure of both professional groups added another powerful dimension to their differing responses to the outcomes of the Inquiry. For the medical profession the Cervical Cancer Inquiry represented a major challenge to professional dominance. Professional 'privacy' was intruded upon to a degree that medical knowledge, practice and protocol were held up for the most public of scrutiny. National Women's Hospital, a symbol of the medical profession's dedication to the scientific care of women's bodies, was reconstructed as an institution in which uncaring and unscientific doctors harmed and even caused the death of women. The suspicion which arose as a result of this was that all medicine was capable of doing the same. The medical profession had been shown to be lacking in collegial surveillance and control. Doctors were exposed to the public as having overridden patient safety in the interests of 'professional etiquette and decorum' (Davis, 1988:249). Whilst the nursing profession recognised the Inquiry as a means by which

they could renegotiate the occupational boundaries they shared with doctors, the medical profession quickly identified the Inquiry as seriously encroaching on their professional boundaries. The nursing profession were quick to endorse the outcomes of the Inquiry and acknowledge their professional shortcomings. In doing so they indicated their willingness to implement the recommendations that pertained to them and positioned themselves to take advantage of the potentially altered professional relationship between nursing and medicine. The medical profession in many instances attempted to discount the findings of the Inquiry by constructing them as evidence of ignorance of the laity or the political manoeuvrings of malicious feminists. The views and motives of the latter were not only constructed as unscientific but also as irrationally based on distortions of the relationship between men and women as well as between doctors and their women patients. The nature of these strategies expose the gendered structure of the practice of medicine.

The nursing profession welcomed the public exposure of the hierarchical nature of health care in New Zealand because it pointed to the difficulties experienced by them in their subordination to doctors. This occurred within the compelling context of the outcomes of this political discrepancy for the well-being of patients. Highlighted were the most dangerous effects of medical dominance. The medical profession in many instances was quick to defend its members who were criticised by the Inquiry and reconstruct them as misunderstood medical heroes. This response followed an historical tendency of medicine to present its successes in terms of the great deeds of great men and to maintain a relative silence about its failures. Typical of the medical profession's response also was the tendency to construct the events at National Women's Hospital as technical failures which could be remedied with proper technical procedures. This was so in relation to the ethical as well as the scientific issues raised. Improved medical systems were viewed as the means to providing a better service to the newly consciousness-raised woman, as health care consumer. The fundamental issue of the medical profession's attitudes to women as a morally problematic area of medical practice received little attention from the profession itself. The nursing profession on the other hand were quick to use the term 'sexist' in its descriptions of doctors as part of its post-Inquiry discursive discourse. As part of its gendered strategy, the nursing profession was also able to align itself with the female patients who had experienced the effects of medical dominance at National Women's

Hospital. In doing so it added to discourses which constructed doctors as belonging to a profession which was patriarchal and insensitive and which needed to make major changes.

6. The Responses of Feminists to the Cervical Cancer Inquiry.

The Cervical Cancer Inquiry and the publicity which preceded it succeeded in making what were previously largely feminist issues into public issues. It also provided a focus for those who may not have previously identified with the feminist cause to have their concerns about the abuse of professional power and the excesses of medicine confirmed and validated. The Inquiry united a wide range of individuals, some of whom viewed the issues as being indicative of gender abuse and oppression and others who saw the issues as indicative of the abuse of professional power and privilege. Concerns about what were regarded as the alarming excesses of scientific medicine at National Women's Hospital reflected general anxieties about the potential for malevolence in science. The widespread public exposure to the events at the hospital served to highlight the legitimacy of feminist claims by making them highly visible and placing them within a context of extreme and proven medical negligence.

Women had been complaining for some years about the treatment they had received at National Women's Hospital but these concerns had remained largely a marginalised, feminist issue. The response of the hospital to these concerns was, according to feminists, to improve its public relations in an effort to reduce expressions of criticism rather than address the basis of women's concerns. There was also an attempt by hospital staff to suggest that these complaints arose out of women's inability to grasp that their treatment was normal and beneficial. The Inquiry was able to do what individual women had been unable to do, and that was to expose to public view the norms of the medical culture at National Women's Hospital:

At the Cartwright Inquiry we discovered that an Auckland health group, Maternity Action, had written to Dr Gabrielle Collison, medical superintendent of National Women's Hospital (NWH) in 1985 about the use of non-consenting anaesthetized women to teach students vaginal examinations, to no effect. It was considered normal (Coney, 1989:24).

For feminists, the Inquiry was conducted against an historical background of unacknowledged and unaddressed abuse of medical power to which women patients had been exposed.

The feminist health movement played an active part in the Inquiry itself. Coney, under the auspices of 'Fertility Action' presented cases on behalf of the women involved in the research at the hospital. The feminist movement was also active in maintaining a commentary on the Inquiry as it progressed. Feminist constructions of these events focused particularly on the political implications of the evidence being heard. Commentators identified the abuse of institutional power and highlighted the gendered nature of events at National Women's Hospital. Rosier (1987b:5) commented on the evidence given by doctors at the Inquiry by noting the way in which one doctor indicated that women were 'naïve' if they did not realise that National Women's Hospital was a teaching hospital where consent was implied. Another doctor suggested that giving women information about procedures only made them anxious. Rosier suggested that these kinds of responses were indicative of the patriarchal nature of medicine:

I find these assumptions, that women have to be protected from knowledge about 'their' conditions and treatment and they won't understand, all the more frightening because the doctors don't see anything wrong with them (ibid).

Feminist commentators monitored the media reaction to the Inquiry. They observed that the media was increasingly echoing feminist outrage at the ways in which women had been treated at National Women's Hospital. When Professor Bonham revealed that vaginal examinations were occurring without consent from women because obtaining consent would take ten minutes, (which he considered to be an unacceptable length of time), the media was reported by one feminist as being in 'uproar' (Rosier, 1987a:5). Also noted by feminists with concern, was a constant theme of the Inquiry which was that doctors defended clinical freedom with the refrain that, 'you can't have doctors looking over other doctors' shoulders' (Rosier, 1987b:6).

The conclusions of the Cervical Cancer Inquiry, were represented by feminist

commentators as a 'feminist victory'. Not only was the report from the Inquiry viewed as legitimating the claims of Coney and Bunkle but it was also viewed as having broader implications for the restructuring of the relationship between women and the medical profession at a fundamental level:

It (the Cartwright Report), establishes the right of women patients to expect to be treated as fully human and the responsibility of medical professionals to treat us as such (Rosier, 1988a:7).

The Inquiry and the writings of Coney and Bunkle were viewed as exposing the ways in which medicine in New Zealand had developed primarily around the needs of the medical profession rather than the needs of patients. The report was described in the feminist literature as 'authoritative', largely because the evidence of women had been supported by evidence from overseas medical experts. The report was viewed also as a powerful tool for feminists:

There has never been a better time for us all to claim that right (to be treated by the medical profession as fully human) as forcefully as we are able and consolidate the gains that this report represents. We can all monitor progress on implementing the recommendations: they have been endorsed at top level, let's keep a watchful eye on progress (op. cit:7).

The Inquiry was also seen in the feminist media as being cathartic in providing those women who presented submissions, the opportunity to express years of frustration and anger about the treatment of women at National Women's Hospital (Rosier, 1988b). The Women's Health Caucus (Wellington Branch) of the Public Health Association (1988:12) also praised the report of the Inquiry for its thoroughness, accessible language, and its consumer orientation. They identified the report as validating women's experience beyond the issues examined by the Inquiry and also validating the 'years of work by the women's health movement in New Zealand'.

The Inquiry was viewed by feminists as a watershed for their aspirations in the health arena but they recognised the need to continue to monitor the medical profession. Feminists anticipated that the medical hierarchy would 'regroup' and resist changing

its practices and procedures. Coney (1988b:25) suggested that doctors would find it difficult to give up playing 'Dr God' and that unless women and community groups inserted themselves into the process of reform 'rather forcibly' similar events to those identified by the Inquiry were likely to reoccur. Feminists also continued to monitor the responses of the medical profession to the Cervical Cancer Inquiry. In doing so feminist discourses provided a political analysis largely absent from other sources in the post-Inquiry period. This analysis has provided a basis for understanding the interrelated political issues which led to the implementation or rejection of the recommendations of the Inquiry. The medical profession has for instance been criticised for not realising that the issues raised by the Inquiry were symptomatic of systemic problems rather than of an isolated and historical, clinical incident. The medical profession had, according to Bunkle (1992:68), accepted the events at National Women's Hospital as 'bad science', but doctors had not realised that there needed to be fundamental change.

For feminists, the Cervical Cancer Inquiry represented a vindication of their efforts to have the medical profession recognised as sexist, patriarchal and at times dangerous to women. The often marginalised constructions of the medical profession which feminists had attempted to promulgate since the 1970s reappeared in the formal proceedings of the Inquiry as factual evidence. The 'victory' in the Inquiry for feminists, was that their vigilant surveillance of doctors had led to the exposure of the shortcomings of the profession and eventually to the Inquiry being initiated. The political dimensions of gender and status which feminists had long identified as subjugating women were publicly aired and validated. For feminists, the Cervical Cancer Inquiry was not only about the structural inadequacies of health care delivery, but about gender and power. It was for this reason that many feminists remained sceptical that the outcomes of the Inquiry would bring about substantial changes in the relationship between a male dominated medical profession and their women patients.

7. Conclusion

This chapter has juxtapositioned the responses of the medical profession, the nursing profession and feminists to the Cervical Cancer Inquiry. The responses of the medical profession are seen through this analysis to be indicative of a

professional group which had difficulty in acknowledging that the events at National Women's Hospital were any more than technical failure and poor scientific judgement. Staffen (1994:756) suggests that whilst doctors tend not to deny that there is an ineradicable moral element to the practice of medicine, they reserve the right to determine which element is clearly moral and which is technical. Zussman, (1992) argues that by constructing issues as technical rather than moral, the medical profession maintains its authority and autonomy in decision making. The Inquiry clearly determined that what doctors may have seen as technical issues at National Women's Hospital, were in fact moral issues. It can be argued that this confusion on behalf of the profession was responsible for the lack of acknowledgement of Green's research as being morally flawed.

For many doctors, the Cervical Cancer Inquiry primarily represented a contesting of professional boundaries. A state sponsored Inquiry, presided over by a member of the legal profession and initiated by members of the feminist laity, represented a challenge to the knowledge claims of medicine and its authority to control medical matters. The professionalising strategies employed by doctors, in response to these events, are indicative of a profession in the midst of boundary protection. The discrediting of the evidence against the profession and those from whom it emanated were not dissimilar to strategies employed by doctors to marginalise members from within the profession who seek to challenge medical consensus. What was different in this instance was the sometimes gendered nature of the professionalising strategies, particularly in attempts to discredit feminists who brought the issues into the public arena.

The Cervical Cancer Inquiry brought to a close the longstanding dispute regarding the appropriate treatment for *carcinoma in situ*. Whilst some doctors are likely to have welcomed a definitive decision which finally discredited the 'truth' of Green's knowledge claims they lamented the cost of this outcome in terms of the erosion of medical power and status. It is argued here however, that whilst the Cervical Cancer Inquiry resulted in a greater level of monitoring of medical work, it has at the same time led to a greater level of surveillance of women's bodies. The national cervical screening programme which arose out of the recommendations of the Inquiry has resulted in an unprecedented level of monitoring of the asymptomatic bodies of New

Zealand women. As a result, the medical profession, who remain the major smear takers for the programme, have enhanced their role as guardians of women's bodies. Added to this, Coney (1993:38) suggests that doctors have continued a campaign of resistance to many of the recommendations of the Inquiry.

The nursing profession has been active in supporting the outcomes of the Inquiry. In contrast with doctors, nurses appear to have had little difficulty in constructing the events at National Women's Hospital as moral error. They were willing also to concede that nurses were morally and ethically at fault in their passivity in the face of abuses of patient rights. They did so within a gendered context of constructions of a subordinated and limited profession which (like the patients at the centre of the Inquiry) was powerless to challenge medical authority. They saw in the Inquiry the opportunity to challenge prevailing constructions of nursing and in doing so to extend their occupational boundaries. The Inquiry provided the nursing profession with, not only the moral right to do so, but with the political opportunity also. The nursing profession responded to the professionalising opportunities which arose out of the Inquiry and quickly acknowledged the profession's culpability and support for the recommendations of the Inquiry.

Feminists came to the Inquiry with a long history of resisting medical power and authority. The Inquiry served as a public 'court' at which gendered disputes between feminists and the medical profession could be heard and adjudicated on. Feminists continued to be active in the process of the Inquiry through direct involvement, and through a political commentary which highlighted the patriarchal nature of medical discourses in the evidence given. Feminists heralded the outcomes of the Inquiry as a victory not only because its recommendations were viewed as advantageous to women, but because the Inquiry had legitimated an historical feminist platform. Feminists recognised however that the medical profession was not likely to capitulate and they anticipated that the gendered disputes between the profession and women would continue to occur unless women and community groups were active in an ongoing process of reforming the medical profession (Coney, 1988b:25).

CHAPTER ELEVEN

The Establishment of the National Cervical Screening Programme.

1. Introduction

One of the major recommendations to emerge from the Cervical Cancer Inquiry was that a population-based cervical screening programme be established for New Zealand women (Committee of Inquiry, 1988:209). This chapter examines the events which led to this recommendation and the political debates which emerged during the implementation of the programme. Central to, but often invisible in these debates, were the gendered bodies of women which became the sites for competing discourses within a context of a public health imperative. The discourses of the medical profession, the Minister of Health, the Department of Health, and feminists are examined in the light of competing constructions of the meaning of the national screening programme. These constructions are set within a background of the failure of doctors to employ occupational strategies to protect their authority and autonomy in the post-Inquiry environment. These competing discourses are also set within a context of the once marginalised feminist agenda being legitimated and gaining sufficient social power to have considerable input into the establishment of the screening programme. What is also highlighted are the unintended consequences and paradoxes which arose during this implementation phase. This chapter challenges the view of the national cervical screening programme as a rational, political act aimed at meeting the indisputable medical needs of New Zealand women. It argues instead that the programme can be regarded as an unprecedented act of state surveillance and regulation of women's bodies and as an exemplar of the extension of medicine into ever increasing areas of social life. It also argues that whilst the screening programme appears to have challenged the authority and autonomy of the medical profession, what has actually occurred is that medical power has become further legitimated and entrenched.

In **Part Two** of this chapter the concept of public health is subjected to a sociological analysis which identifies the body as a site for the mobilisation of power. This sets the scene for further analysis of public health discourses which locate risk in relation to cervical cancer within the bodies of all New Zealand women. The national screening programme is itself located within a broader enterprise of biopower and the

regulation of women's bodies. **Part Three** sets out the historical context of cervical screening in New Zealand identifying discontinuities which occurred in the establishment of a population-based screening programme for cervical cancer. These discontinuities are set within a context of competing intraprofessional priorities and strategies. The increasing social power of epidemiological discourses in defining a need for routine cervical cancer screening is examined. **Part Four** examines the bureaucratisation of cervical cancer within a context of the contested space of women's bodies. This section draws out the political discourses and strategies which emerged around issues of who should control and manage the surveillance of the cervix. Competing constructions of the meaning of the national screening programme are examined as are the paradoxes which emerged as the implementation process continued. These events are situated within a context of the restructuring of the health care sector in New Zealand during the 1980s and 90s. **Part Five** examines the oppositions mobilised by medical practitioners in relation to cervical cancer screening. It is argued that these oppositions were mobilised largely around professional boundary maintenance and around the contested territory of women's bodies. **Part Six** concludes by drawing out the paradoxes which emerged in the establishment of the national screening programme and the ways in which discursive strategies constructed the screening programme.

In summary, this chapter challenges the assumption that the implementation of the national cervical screening programme has been a progressive political act of unalloyed good which has addressed a neglected medical need. This view links the screening programme with the erosion of professional autonomy in the medical profession and with the advancement of the feminist platform. An alternative view locates the cervical screening programme within a context of actions of a bureaucratic state in pursuit of the further rationalisation of the lives of individuals in areas which had previously escaped its monitoring and codifying gaze. A sociological perspective alerts us to the unintended consequences of what appears to be the application of rational and progressive ideals which instead have been reactionary in their consequences. As a consequence of the screening programme, medicine has been able to extend its boundaries in its surveillance and regulation of women. Paradoxically, feminists have found themselves in support of such measures. Whilst earlier opposition to cervical screening voiced by Green was originally identified as

being motivated largely by the ideals of conservative patriarchal medicine, opposition to a national screening programme may also be construed as an attempt to resist the hegemonic encroachment of scientific medicine.

2. Public Health through Private Actions: The Surveillance and Regulation of Bodies.

The recommendation of the Cervical Cancer Inquiry for a population-based screening programme, occurred at a time of increasing interest in preventive health care and biological testing. A national approach to cervical screening represents one of the more intensive and ambitious approaches to preventive health care which has occurred in New Zealand. As a public health measure, the cervical screening programme aimed to direct medical attention towards the aggregated as opposed to the individual bodies of women which had characterised earlier attempts at screening. Whilst the recommendation of the Inquiry appears to be a rational public health solution to a health 'problem' sociological analysis alerts us to the fact that public health initiatives are embedded in the social. Public health discourses and practices are not, as is often assumed value-free but are, as Lupton (1995:2), suggests highly political, socially located and changing in time and space. Public health philosophies and practices are often founded on the concept of risk and as a result are cloaked in utilitarian and humanitarian discourses which emphasize public good and wellbeing. Cervical screening has often been represented as a medical triumph of unquestionable benefit. Its value-free nature is commonly perceived to lie in its ability to assist all women to achieve a cancer-free cervix irrespective of age or socio-economic status. It is a public health measure which attempts to inculcate in women a 'smear career' in which screening becomes an expected and taken for granted, annual or triennial experience in women's lives.

Public health measures such as cervical cancer screening aim to identify bodies at risk. In risk discourses, bodies have a degree of uncertainty which must be located, managed and contained. For Armstrong (1995), the intensification of medical attention on the potentially ill is indicative of a new form of medicine which arose in the early years of the twentieth century which he terms 'surveillance medicine'. Surveillance medicine deconstructs the binary relationship of healthy and ill and reconstructs all bodies as potentially ill. All bodies are of medical interest as the

normal is problematised and the medical gaze extends beyond the hospital into the community. Surveillance medicine relies on risk factors as a basis for identifying the potentially ill who need medical intervention. In the past it was signs and symptoms which in hospital medicine positioned individuals in a medical space which legitimated hospitalisation and treatment. Risk measurement has become one of the major functions of medicine in the late twentieth century. This has been assisted by computer technology which allows for sophisticated statistical analysis of data from large populations of the potentially ill (Skolbekken, 1995). This has meant that risky populations can be extracted from large pools of epidemiological data which enables public health strategies to be directed with relative ease towards specific populations within the community. Underpinning risk measurement however is a secular philosophy which defines bodily events as predictable and potentially manageable. Risk discourses emphasise the 'laws' of risk which can be responded to in a rational way (Lupton, 1995). In public health, risk is synonymous with danger and has been linked historically with external events which impinge on bodies over which individuals have little control. In more recent times, public health discourses construct risk in terms of the vagaries of personal choice implicit in the concept of 'lifestyle'. The 'styling' of one's life in a rational, self-controlled manner is associated with risk reduction. Public health discourses therefore construct risk as a statistical, moral and technical entity.

The pervasive nature of risk according to Beck (1992), leads to a form of 'immiseration' or victimisation in which individuals are dependent on experts to identify the dangers that threaten them. Sovereignty over the ability to assess the dangers of risk as individuals is replaced by what Beck terms the 'scientization' and 'commercialisation' of risk. Nelkin and Tancredi (1989:9), have noted a growing preoccupation with biological testing in medicine and suggest that this links with a developing actuarial tendency to identify potential risks and construct these in biological or medical terms:

The individual must therefore be understood actuarially, that is, with reference to a statistical aggregate. In this context the information derived from tests becomes a valuable economic and political resource.

The concept of 'risk' is therefore not only a source of alienation for individuals as they are persistently reminded of the precarious position of their bodies in the world but it also results in the construction of political imperatives. Risk discourse, biological testing and surveillance, in concert with social anxieties around gender, class and race have lead to forms of social control through the knowing of bodies. Concerns with risk also reflect a commercial consciousness which attempts to generate profit through the proliferation of technologies for testing healthy bodies or to contain costs by locating and managing bodies which would otherwise prove costly to the workplace, hospital or clinic.

Beck focuses on risks external to the individual but in doing so identifies the link between knowledge about risk and the determination of identity. Public health and health promotion rely on a repositioning of identity in those who are targeted for preventive health measures such as cervical screening.¹⁸ Individuals who perceive themselves to be healthy because they do not experience symptoms and have no discernible signs of illness are unlikely to respond to calls for medical surveillance. The 'unsettling' of identity is essential to mobilise bodies for surveillance. The construction of the 'risky self' through public health discourses places what were once considered to be symptom-free, 'normal' bodies in an uncertain space between health and illness. The 'risky self', represents a new configuration of the individual as an active, intentional agent who has control over the self (Ogden, 1995). This theme is further explored by Armstrong (1993;1995) who suggests that the 'risky self' is both subject and object of surveillance medicine. The 'thoughtful actor' and the 'cautious self-regulator' have emerged from the discourses of surveillance and risk.

The diagnostic or screening test has emerged in the twentieth century as a means to locate invisible disease or disease potential in the body. The screening test is an exemplar of biomedicine in that it is located within an ideology of rationality whose object is to know the 'truth' of the body and to manage the consequences of this knowing. Critiques of preventive medicine however call into question assumptions that diagnostic techniques are technically rational, asocial and unquestionably

¹⁸ See Chapter Twelve for a discussion of health promotion strategies in relation to the national cervical screening programme and in particular the construction of subjectivities.

beneficial in their application. Diagnostic procedures are identified by Daly (1989:100) as essentially social processes with the results of diagnostic testing not being necessarily beneficial to patients. As social processes, diagnostic tests are situated within a context of a network of power relations with patients largely ignorant of diagnostic procedures and their meaning. Medical professionals on the other hand have the ability to create a 'narrative' of what the results of diagnostic screening means. Such tests are often promoted as having the ability to end uncertainty and to make a capricious body manageable. This is certainly the case with cervical cancer and yet as Lupton (1995:93) points out, the possibility for error in the execution and interpretation of tests may in some instances be quite high. When the potential for error in diagnostic tests is revealed, many members of the public respond with anger and cynicism. This revelation challenges the implicit contract between the public and the medical profession, that adopting specific technologies of the self, will promote a healthy, 'normal' body.

In medicine, epidemiological discourses have quantified risk and provided the basis for health promotion activities which target specific populations. In recent years, epidemiological discourses have increasingly linked morbidity and mortality patterns with individual lifestyles and behaviours. Epidemiology attempts to bring about an understanding of the occurrence of disease among specific groups of people within a specific territory and, as a result of this understanding, to eliminate disease. Whilst traditionally, epidemiology has concentrated on identifying the physical conditions which contribute to disease, commentators such as Arnoux and Grace (1994:273) have called on epidemiology to move beyond its positivist tradition and take into account the subjectivities of the individuals being studied as well as the social conditions from which they emerge. It could be argued however that this new approach represents a further extension of biopower. It would place epidemiology in a position of not only locating physical points of intervention to prevent disease, but also to more specifically focus technologies of the self and thereby intensify surveillance.

Cervical cancer has been mobilised as a risk to all heterosexually active women. Risk discourses have constructed cervical cancer as potentially reaching 'epidemic' proportions with cervical screening being advocated as the rational, preventive

measure by which this particular risk can be contained (Skegg et al, 1985). Increasingly however whilst the rhetoric of risk has associated cervical cancer with heterosexual activity, lesbian women have recently been constructed as being vulnerable to contracting the disease (*Broadsheet*, 1995). This represents the extension of the medical gaze to incorporate groups who have not been included in this form of medical surveillance. Armstrong (1995:403) describes this phenomenon as indicative of the monitoring gaze sweeping across innovative spaces of illness potential. Under this gaze increasing numbers of individuals have become constructed as 'risky', including heterosexual women of all ages and more recently lesbian women also. All women are now mobilised as having a risky cervix.

The practice of surveillance medicine relies heavily on having a population which is well informed about their 'risk status'. Health promotion activities have attempted to ensure that women recognise the cervix as an organ which needs regular monitoring. Women have also been encouraged to recognise that they can influence the level of risk of contracting cervical cancer by exerting control over their sexual behaviours and by presenting for regular cervical smear testing. Cervical screening has become a normalising strategy to which all women are expected to subscribe. A national screening programme has been constructed by both feminists and the medical profession as the most rational and humanistic approach to locating risk in women's bodies. The campaign for a national cervical cancer screening programme is however inherently problematic and contradictory. Concerns by the women's movement for the health of women have been located within a rationalising state bureaucracy and scientific medicine. This has resulted in a high level of 'risk consciousness' in New Zealand women and an increasing surveillance and medicalisation of their bodies. Bureaucratic processes have reached a level of sophistication where there is now a national record of the state of women's cervixes.

Technological and organisational innovations have become central to the practice of surveillance medicine (De Swann, 1990). Preventive health campaigns rely on the organisational functions of bureaucracies which determine health policies and procedures for population-based health campaigns. These functions also include the education of populations and the monitoring of results. Essential to this process is the availability of quick and reliable testing techniques and the willingness of health

professionals to perform the techniques. Computer technology which allows for the analysis and recording of tests has also become an important part of the effective functioning of population-based programmes. Most importantly however, surveillance medicine requires a willing population which will present for testing.

In summary the pervasive nature of risk discourse ensures that for many individuals diagnostic screening for conditions such as cervical cancer is the only rational option. Risk discourses in relation to cervical cancer have constructed women as not only having a risky cervix but also as being a risk to themselves through not presenting for screening. Risk discourses appear to be value-free and empowering of the individual. It can be argued however that the public health interventions which are associated with risk are sometimes uncertain in their outcomes and benefits and lead the individual into ever intensifying networks of surveillance and medical intervention.

3. Cervical Cancer Screening Prior to the Inquiry

The history of cervical screening in New Zealand before the Cervical Cancer Inquiry is particularly illustrative of the 'medicine as social process' claims made in sociology. Prior to the Inquiry cervical screening was a contested medical intervention which divided the medical profession into those who supported screening and those who did not. Whilst the medical profession debated the efficacy of screening, feminists increasingly took a stance in support of it (Calvert, 1978). Professor Green from National Women's Hospital who led the campaign against screening, claimed that his 'anti-screening' stance reflected his and others' concerns that women were being unnecessarily subjected to unpleasant and damaging medical examinations and treatments (Bunkle, 1988). Feminist responses to Green's apparent concern for women was to dismiss his views as representative of the conservative and anti-women stance of the medical patriarchy (Coney and Bunkle, 1987). This view of the stance taken by Green and others was later supported and legitimated by the Cervical Cancer Inquiry. What emerged prior to the Inquiry then were two dominant discourses, one which constructed routine cervical screening as a positive medical intervention which was in the interests of women and the other which claimed the opposite. The paradox inherent in these discourses was that feminists were more closely aligned with those views which promoted a 'routine' approach to cervical screening than those which opposed this view and used concerns for women's

welfare in support of it. The history of cervical screening does not therefore reflect technical uncertainty alone, but reflects disputes about constructions of femininity and about the 'truth' of women's bodies.

Prior to the 1960s, cervical screening was carried out in New Zealand on an 'opportunistic' basis, occurring mainly when women were hospitalized for a gynaecological condition. During the 1960s cervical cancer was increasingly constructed as a health concern for all women and attempts were made to organise screening on a planned and rational basis. A population-based screening programme was launched in the Thames area in 1962 with the support of the Auckland Division of the Cancer Society. This programme aimed to determine how often cervical screening should be repeated in the absence of symptoms (McIndoe, 1964;1966). The Auckland Division of the Cancer Society also financially supported the establishment of a national screening register initiated by the Research Council of the Royal College of General Practitioners. This register identified gynaecologists, physicians, surgeons and general practitioners throughout New Zealand who carried out cervical screening and maintained a national record of the results of smear tests. The aim of the register was to promote routine cervical cytology for the early detection of cervical cancer and to study the incidence of the disease. This register recorded cytological results on a scale of one to five, grading cervical smears from 'negative' or 'suspicious' to 'positive'. The register also recorded the parity and menopausal status of the women being screened. The use of hormone therapy by screened women was also noted. Records were also kept of women's status in terms of their race and country of origin (Marshall, 1964:18-21). The register was discontinued in 1965 because of lack of enthusiasm and co-operation by doctors. This lack of interest by doctors was attributed to National Women's Hospital by members of the medical profession giving evidence at the Cervical Cancer Inquiry. The strong 'anti-screening stance' of doctors at this hospital was cited as having had considerable influence on medical training (Committee of Inquiry, 1988:206). Dr Allan Gray medical director of the Cancer Society claimed that National Women's Hospital had resulted in several generations of doctors not carrying out cervical smears because they thought they were useless (Bunkle, 1988:182). These early attempts to set up a national register contrast with similar attempts in the 1990s. Both initiatives represent the rational management of women through the use of bureaucratic

processes. These early attempts did not however have state legitimation nor did they have interest group lobbying and support. Importantly dominant medical discourses of the time were successful in deconstructing cervical screening as a worthwhile medical intervention and managed to reconstruct it as harmful to women. This opposition to the screening of asymptomatic women was later interpreted by those in favour of screening (such as feminists (Bunkle, 1988) and doctors (Gray, 1990a)) as having contributed to a situation where New Zealand was lagging behind other countries in their treatment of cervical cancer.

In 1977 the Department of Health produced brief guidelines for the frequency of cervical smears (Department of Health, 1977 cited by Grew, 1992). During the 1980s a number of medical commentators attempted to counter the anti-screening stance of doctors at National Women's Hospital. In the 1980s epidemiological discourses in particular began to increasingly reframe cervical cancer as a statistically significant health problem which required urgent attention. In 1985 in a report commissioned by the Department of Health and the Cancer Society, a working group of health professionals including an epidemiologist outlined an approach to screening all women who had experienced sexual intercourse. This report was to become an authoritative guide on how cervical cancer should be managed in New Zealand. The report concluded that the incidence of cervical cancer was increasing and that 'most' epidemiologists considered that screening was an effective preventive measure. In the report, Skegg et al (1985:637) stated that approximately 200,000 smears were being taken annually in New Zealand and expressed concern that no records were being kept of women who had been screened. They also expressed concern that pathologists had suggested that many general practitioners were not taking cervical smears and that many of the smears taken were inadequate. They also argued that there was 'compelling evidence' that cytological screening was an effective preventive measure. The reframing of cervical cancer in epidemiological terms was to be a significant factor in the later bureaucratisation of the disease. It authoritatively located the disease within a discourse of risk and began to suggest risk-reducing public health strategies within a context of statistical data which provided a screening profile of New Zealand women. This type of information was increasingly used to emphasise the numbers of non-screened women in New Zealand and singled specific groups out for medical attention. The use of terms such as 'routine' screening (which

had appeared in the medical literature prior to the 1980s) and was used by Skegg et al in their report, was part of a process by which screening for cervical cancer became 'naturalised' as an appropriate form of medical surveillance. Another part of this process was the increasing tendency during the 1980s to construct cervical screening as a technical measure unrelated to women's sexual history. The uncoupling of cervical cancer from its morally reprehensible past in these discourses enabled epidemiologists and others to position all sexually active women within the net of surveillance without having to delineate 'monogamous' from 'promiscuous' women and involve medicine in the contentious area of overtly determining women's moral status.

Whilst the powerful medical elite at National Women's Hospital continued to dispute claims that cervical cancer warranted wide-spread screening initiatives, epidemiologists, gynaecologists and obstetricians at other hospitals and medical schools increasingly countered these claims. These attempts can be viewed as a means of destabilising the social power of the dominant discourses arising from National Women's Hospital. Opposition to the anti-screening stance increasingly constructed cervical screening as a method of risk reduction with the risky bodies of New Zealand women being constructed as a health imperative which warranted action by the medical profession and the state. Feminist health activists increasingly concurred with this view and added the important dimension of positioning cervical screening as a moral imperative once the events at National Women's Hospital had been revealed.

Since the 1970s, feminist health activists had increasingly been promoting cervical smear testing as an important health issue for women (Bickley, 1987; Calvert, 1978). The lack of action on screening in New Zealand was considered by feminists to be a political issue which required action from and on behalf of women. It was suggested by Coney (1987:14), that women would have to 'insist that New Zealand catch up with the rest of the world'. Feminist frustrations at the lack of action on cervical cancer echoed the views expressed by those promoting screening in the medical media. In 1985, the Cancer Society of New Zealand organised a meeting with the Department of Health on cervical cancer. The report of the meeting (Department of Health, 1986 cited by Grew, 1992) generated enough interest for a

working party to be established to look into implementing the recommendations which arose out of the meeting. Members of the working party included representatives of the Department of Health, Cancer Society and Ministry of Women's Affairs. At the instigation of the Ministry of Women's Affairs, pilot schemes were established to determine the best ways to encourage low-income and Maori women to attend for screening (Grew, 1992:42). The composition of this working party is indicative of the emerging dominance of pro-screening discourses. However, support for routine screening by the Department of Health was slow to emerge. Cervical cancer was not viewed in bureaucratic terms as statistically significant and there were political issues which made the Department reluctant to act. In 1986, Sandra Coney, in her role as a women's health activist, attended a symposium organised by the New Zealand Society for Colposcopy and Cervical Pathology as part of a conference organised by the Royal New Zealand College of Obstetrics and Gynaecology. At this symposium, the Department of Health, Coney argued, was continuing to avoid giving a commitment to establishing a nationwide screening programme. She suggested that the lack of action on the part of the Department of Health was a political act which arose out of a desire not to challenge the 'power bloc' at National Women's Hospital which, under the influence of Green and others, did not support widespread screening (Coney, 1993e:166). Gray (1990a:378), medical director of the Cancer Society, suggested that the Department lacked courage prior to the Cervical Cancer Inquiry to set up a screening programme in a climate dominated by Green's single minded and powerful influence. Feminist writers concurred with this view, believing that the Department had been captured by a group of medical professionals who had the power to influence national health policy:

The Health Department is dribbling out bits of money here and there for pilot programmes when what is clearly needed is an organised national screening programme. How often does it have to be said? Is the influence of National Women's Hospital so great that nothing else can penetrate the Health Department? (Rosier, 1987b:7).

In 1987, the Health Economics Study Group in Christchurch, made an assessment of different policy options for a national approach to cervical screening. They concluded that a three yearly screening programme for all 'appropriate women' was

a justifiable use of scarce health resources (Bethwaite, 1987:224). Calls for a national screening programme which was centrally co-ordinated, culturally appropriate and affordable, were also made by the Ministry of Women's Affairs during this period (Keene, 1988; Committee of Inquiry, 1988:201).

Whilst there was growing support from a number of quarters for an organised approach to cervical screening at the time of the Cervical Cancer Inquiry, screening continued to have an ambivalent status in New Zealand with services remaining unco-ordinated and fragmented. Screening continued to be carried out in family planning clinics, by general practitioners and in obstetrical and in gynaecological units in hospitals. There was no centralised or regional register of women's records and general practitioners provided few services to encourage women to have smears (Grew, 1992; Committee of Inquiry, 1988).

The publication of the *Metro* article by Coney and Bunkle (1987) provided a moral imperative to the technical arguments which had been emerging in support of cervical screening in the twenty years prior to the Cervical Cancer Inquiry. Women had been seen to be wronged by professionals who had a mandate to protect them. Implementing a cervical screening programme increasingly came to be viewed as not only a means to redress a medical wrong against women but to redress a moral wrong against them also. This, more than any other event in the history of cervical screening in New Zealand, challenged the dominant discourses which had until this point determined the medical and social meanings of cervical screening. This is an excellent example of medicine as social process. It wasn't the medical efficacy of cervical screening which propelled it into a category of 'public health imperative', but its social and political currency.

The Cervical Cancer Inquiry was therefore conducted not only against the background of the events at National Women's Hospital but also against the historical context of an increasingly unified construction of the disease as a serious health problem. Those who shared this construction were feminists, the Ministry of Women's Affairs and increasingly vocal members of the medical profession (many of whom were attached to influential medical institutions). Against this background, the Cervical Cancer Inquiry accepted the recommendations of the 'Skegg Report' (Skegg

et al, 1985) and concluded that a population-based cervical screening programme should be initiated for New Zealand women. It concluded that further debate on the need for such a programme was unnecessary.

The Inquiry specified a range of objectives as part of its recommendations:

- to screen all sexually active women until age 65;*
- to repeat the first smear to avoid the possibility of a false negative result;*
- to repeat it at least every three years thereafter;*
- to develop follow-up procedures for those women in whom disease is detected;*
- to provide adequate facilities for diagnosis and treatment;*
- to ensure that women are monitored so recurrent or persistent disease can be treated (Committee of Inquiry, 1988:201).*

The recommendations of the Inquiry consolidated a construction of cervical cancer as a disease which all sexually active New Zealand women were at risk of contracting. It also legitimated the establishment of a process which would result in the monitoring and codifying of their bodies. The debates which had pervaded the medical literature on whether cervical screening would reduce mortality from cervical cancer were silenced. Those members of the medical profession who held anti-screening views now, not only had to oppose the views of their peers who were in support of screening but also had to counter the conclusions of a formal Inquiry. Many were reluctant to do so in a climate in which the medical profession had been found wanting as guardians of women's bodies. To be seen to be against screening was to be seen to be on the side of patriarchal medicine.

In summary, during the 1970s and 1980s a unified discourse began to emerge between the Ministry of Women's Affairs, feminist health activists and the medical profession. This discourse constructed cervical cancer as a serious and preventable disease which required a rational, central government initiated response to its eradication. Medical and feminist discourses became united in identifying some members of the medical profession as ignorant and obstructive of what they believed to be an unquestionably beneficial medical intervention. The Ministry of Women's Affairs as a state bureaucracy was active in supporting both the medical profession

and feminists in their criticism of the Department of Health and its reluctance to initiate action on cervical cancer. What informed this unified discourse was a consensus on the risk posed by cervical cancer and the imperative of managing this risk. Cervical cancer increasingly became not only a technical problem to be dealt with but a moral and social issue which reflected a state of medical and bureaucratic neglect. Opposition voiced by doctors or inferred by the inaction of the Department of Health was constructed as reactionary and patriarchal. Cervical cancer screening became a liberal cause *par excellence* in which widespread surveillance of the bodies of New Zealand women was constructed as a progressive response to the neglect of their needs. The Cervical Cancer Inquiry drew the threads of the developing discourse on cervical cancer together and gave it further legitimacy by criticising oppositional discourses and providing the state with an imperative to implement a national screening programme.

4. Competing Discourses and the Development of the National Cervical Screening Programme.

i. The bureaucratisation of the national cervical cancer screening programme.

The publication of the article in *Metro* by Coney and Bunkle (1987) resulted in the transformation of cervical cancer from a medical event to a moral issue, social cause and political imperative. This was so for members of the public, feminists and politicians. Recognising this fact, politicians of the day were quick to endorse the findings of the Cervical Cancer Inquiry and support the implementation of its recommendations. Those who were against a national approach to cervical screening regrouped to redirect their oppositions towards the ways in which the screening programme was to be implemented. This allowed them as stakeholders to retain the moral high ground by, in some cases, seeming to support the concept of the programme whilst at the same time resisting an initiative they fundamentally opposed. This resulted in members of the medical profession and the Department of Health at times obstructing and criticising the implementation of the national screening programme with apparently liberal and progressive motives.

Once the Inquiry had ended, cervical screening went through a process of being transformed from a social cause to a bureaucratic project. This transformation

resulted in screening becoming a contested arena in which feminists, the medical profession and the state sought to control the implementation process. Feminists were keen to maintain the construction of cervical cancer as a gendered social imperative to ensure that women, as an aggrieved group, had a measure of control over the programme. The medical profession, in contrast wanted the programme to be regarded as a technical, medical initiative which could be best managed by the profession itself. This approach would allow the profession to reestablish itself as experts on what was best for women's bodies at a time when claims to this expertise had been seriously undermined. The Department of Health on the other hand wished to view the screening programme as a bureaucratic project which required an instrumental and rational approach to its implementation. This perspective allowed the Department, at a time of fiscal probity and health sector restructuring, to proceed with the implementation of the programme along the lines of corporate managerialism, unfettered by political considerations of meeting professional and interest group demands. The screening programme represented for the Government a political imperative in which public confidence in the institutions of medicine needed to be restored. Most importantly for Government, the programme represented an opportunity to be seen to be responding to public concerns.

The release of the report from the Cervical Cancer Inquiry, was greeted by David Caygill the Minister of Health for the Labour Government with assurances that its recommendations would be implemented. In doing so Caygill reflected what Bunkle (1993:51) describes as a 'tidal-wave of public opinion' which supported the outcomes of the Inquiry. A number of initiatives were quickly begun by the Department of Health in response to the Inquiry's recommendations for the establishment of a code of rights and the appointment of a health commissioner and patient advocates. The Department also responded quickly to the recommendation for a national screening programme with a November 1989 deadline set for its implementation. The Department's response from the outset was, however, in the direction of establishing the surveillance mechanisms of the programme. This included the establishment of pilot register projects in Wanganui and Marlborough. Helen Clark (1993:65) who succeeded David Caygill as Minister of Health expressed her concern that initial Departmental efforts appeared to be primarily focused on establishing the computer-based aspects of the programme. Other aspects such as the management of human

factors involved in boosting screening rates and gaining consensus from women and health professionals about an appropriate approach to the programme, appeared to have been less of a priority. This was the first evidence that the Department regarded the screening programme as a bureaucratic project as opposed to a social cause in line with the feminist view.

By establishing a computer-based system, the Department was implementing one of the recommendations of the Inquiry. The Inquiry had seen the need for cervical screening to be conducted on a rational and organised basis in contrast to the random and relatively disorganised manner of the past. This relied on technology to process the vast amounts of data a national screening programme would generate. The Inquiry identified a computer-based register as being necessary for the establishment of efficient 'recall systems' (Committee of Inquiry, 1988:208). The recall system being proposed was one which would remind women that their next cervical smear test was due. Some doctors had also recognised that computer registers were valuable for the effective management of cervical screening (Moodie, 1989; Skegg et al, 1985; Skegg; 1989). For at least one member of the medical profession 'computerised control' of cytological records smacked of women having their cytologic status recorded alongside their car licence number and record of criminal convictions (Briant, 1985:915). There was however little opposition to an approach which was generally considered to be a rational and acceptable response to the need to screen all adult women. The imperative that national screening had become, had the effect of marginalizing oppositional discourses of the kind expressed by Briant. Opposition to the programme from feminists and others tended to focus on concerns that the screening programme was not being implemented quickly enough, or that the Department of Health was not ordering its priorities appropriately. The lack of opposition or even debate surrounding the fact that the Department of Health was about to implement a public health initiative which had unprecedented surveillance capabilities is significant. This situation attests to the success of risk discourses in creating a high level of acceptance of initiatives which were deemed to lower risk and this was especially so in relation to women's bodies. It also attests to the significance of the programme as a political salve on a moral wound.

In emphasising the 'computerised control' aspects of the programme, the Department

of Health increasingly came under criticism for its ordering of priorities. Managing the technical requirements of the hardware and software required for screening provided what Coney (1993e:65), from a feminist perspective, regarded as a 'refuge' for officials from the Department of Health. Coney argued that the Department failed from the outset to write a policy for the development of screening at national and regional levels. She also criticised the Department for not having clear guidelines on what was to be achieved. The bureaucratic goals of establishing a computer register appeared to her to have taken the place of formulating clear policy, a process which would require consideration of social issues:

...it (the Department of Health) seems to have thrown the scientific aspects of the programme at Azimuth, a computer firm which was to develop the software for the register. Azimuth began to make its own policy, making decisions about matters such as the manner of recall, and the register's interactions with women, which would bind the programme for years to come (Coney, 1993:167).

The Department's approach to the programme according to Coney was of concern to women who had other views on how a national screening initiative should be implemented. Some women argued that money was being expended on computer technology and not more visibly on the needs of women. They also considered, that women were not being sufficiently consulted in the important, initial stages of the programme. The competing perceptions of the Department and of women for whom the screening programme was being developed became an identifiable feature of the implementation process. What was being contested were the actual and symbolic foundations of the programme. For feminists the implementation phase of the programme represented a hard-won opportunity to have and maintain control over a health initiative for women. In a symbolical sense, the screening programme represented a victory over patriarchal medicine. The Department on the other hand appeared to maintain a technically focused approach which paid little attention to the symbolic values of the programme to women or to the subjectivities of those who had a political stake in it. Feminists wanted the Department to acknowledge the affective and human elements and the 'social cause' features of the programme. They also wanted the Department to recognise the moral significance of the 'victory' the Inquiry represented for women by showing a willingness to consult them as equal partners

in the implementation process. From the outset, the Department appears to have fuelled women's concerns that the bureaucratic process was going to politically disempower them. In doing so it could be seen as symbolically reenacting the events at National Women's Hospital in which institutional power had resulted in women being disenfranchised from decisions which effected their bodies.

The issue of the 'laity' being involved in medical as well as bureaucratic matters was central to the events which precipitated the Inquiry and those which followed it. The Inquiry itself legitimated continued involvement of the 'laity' by recommending consultation with women as health consumers, in the establishment of a screening programme. As part of this process it suggested that the Minister of Health should form a group to act in an advisory capacity (Committee of Inquiry, 1988:209). This recommendation has to be set within a context of unprecedented involvement of the 'laity' in medical matters. The Inquiry itself was initiated as an outcome of the actions of two lay individuals. Judge Cartwright who presided over the Inquiry and who was influential in the formulation its recommendations, was a member of the legal rather than the medical profession. The Inquiry accepted the need for the involvement of lay individuals in decisions on cervical cancer as uncontentious and appropriate. This contrasted with the views of many members of the medical profession who were resentful of the involvement of lay individuals in all matters to do with the Inquiry and its aftermath. Similarly it conflicted with the Department's wish to implement the screening programme in a technically rational way without having to consider the subjectivities of women health consumers.

The Department of Health was however charged with establishing processes which would ensure that appropriate consultation on setting up the cervical screening programme occurred. It responded to this task by organising a national cervical screening workshop in Porirua in 1988. The role of the workshop was ostensibly to make recommendations to the Government on how to structure the screening programme. This action by the Department was viewed by some commentators as not fulfilling the Inquiry's recommendation for a 'representative group'. The workshop was seen by feminists and the medical profession instead, as the Department's attempt to plan the screening programme 'in house' (Coney, 1993; Skegg, 1989). Feminists, and those members of the medical profession who supported the national

screening programme, were both increasingly experiencing their marginalisation in the implementation process. The Department was considered to be not adequately consultative. The medical profession expressed concern that its expertise was not being sufficiently utilised, and complained that medical experts from overseas were not being consulted to share their experience of already established cervical screening programmes (Skegg, 1989). Similarly feminists felt that their expertise and knowledge was not being acknowledged and utilised by the Department. The large number of individuals invited to the Porirua workshop was seen as a strategy by the Department to stymie consultation as the numbers were too large to allow effective discussion to take place. Coney (1993e:168) suggests that the Department did not want any recommendations to emerge from the workshop which it would be uncomfortable implementing. However, in what were perceived to be circumstances of inadequate briefing and unrealistic time-frame, recommendations did emerge from the Porirua workshop. Many participants expected these recommendations to be implemented but the Department delayed the release of the report from the meeting. This was also viewed by feminists as a strategy to avoid taking on the views of interest groups and this added to the alienation many women were already beginning to feel in relation to the implementation process. One of the recommendations which did emerge from the workshop was that an executive group with representatives from women's and health professional groups be established. This group was to have the ability to make decisions, be charged with controlling the national screening programme and allocate funding for it to Area Health Boards. It was also recommended that national co-ordinators be appointed who were accountable to the executive group. The workshop also suggested that cervical screening services should be provided free and that the screening programme should be funded separately from the financial allocation which had already been allocated to health (Clark, 1993; Grew, 1992).

The Department's approach to the initial stages of setting up the screening programme was in light of these experiences viewed by both feminists and the medical profession as a means of disempowering interest groups through 'repressive consultation', that is, being seen to consult but not actually doing so in any meaningful way. Delays in establishing the 'executive' or 'expert' group were also viewed as ensuring that women's real involvement in the programme was limited and contained

(Coney, 1993e).

The Department of Health can be regarded as attempting to ensure that wishes of interest groups remained peripheral to the process of establishing the screening programme. The Department appears to have failed to appreciate the significance of the fact that feminists had been highly successful in placing cervical screening on the political agenda. As Grant (1989) suggests, interest groups have no one route by which they exert influence. Feminists were active in using the media, lobbying the Minister and mobilising women in support of a consultative approach to the programme. A change of Minister of Health from David Caygill to Helen Clark in 1988 further delayed any action on setting up an advisory group. The new Minister identified the Department as being highly active in relation to the screening programme but somewhat misdirected in its focus. She suggested that the original ideals of the programme were disappearing down a 'bureaucratic memory hole' as the Department continued in its computer-focused development:

Without further consultation officials continued work on the national programme, but that work seemed increasingly to focus on the design of the register and associated issues. The importance of women actually being screened seemed to diminish in the overall scheme of things. A launch of the programme, alias the register, was planned for later in 1989 (Clark, 1993:68).

Increasingly the screening programme became the focus of intense political activity. The new Minister of Health was in a position of having to mediate the diverse constructions of what the programme represented to stakeholders. Concern was increasingly being expressed about the direction of the programme from advocacy groups, the Ministry of Women's Affairs, health professionals and Area Health Boards. Helen Clark came under growing pressure from these groups to act. In 1989 she asked the Department of Health to establish a review team to monitor and report on its progress to date in establishing the national screening programme (Minister of Health, 1989, cited by Grew, 1992:46). The Minister, dissatisfied with the Department's response to the proposed review, established a Ministerial Review Committee in 1989 to review progress on the screening programme (Grew, 1992). The Ministerial Review Committee had representation from the medical profession,

women's health consumer groups, the Department of Health, the Cancer Society, Ministry of Health and Maori Women's Welfare League amongst others. The Minister accepted the recommendations of the review team which suggested that the focus of the programme needed to ensure that as many women as possible had regular cervical smears, and that only fifteen percent of the programme's budget should be allocated to the register. Other recommendations included the abandonment of a national launch, with each Area Health Board joining the programme when it had sufficient structure and community involvement. Also recommended was that a smear-taking benefit be made available and that a national co-ordinator position be established. The Review also recommended that an Expert Group be established to monitor and advise on the programme (Clark, 1993). The Expert Group was to have representation from health professionals including medical and nursing groups as well as from policy and consumer groups (Ministerial Review Committee on Implementation of a National Cervical Screening Programme, 1989). The Expert Group was to develop policy in a range of areas related to the screening programme. These included, promotion of the cervical screening register, standards of competency for smear takers and the development of a service acceptable to women (Grew, 1992:49).

Control of the national screening programme had been successfully retrieved from the Department of Health. Paradoxically according to Straton (1990:55), a doctor from the University of Western Australia who completed a review of the programme, the atmosphere of secrecy which the Department had been accused of generating was perpetuated by the Expert Group once it was established. She suggests that the style of operation of this group precluded communication and exacerbated suspicion about the programme. Failure of communication continued to occur between the Department and the Expert Group and between the Department and professional and community groups. Straton suggests that these difficulties were increased by the length of time taken by the Ministerial Review which in particular stopped action within the Cervical Screening Unit which had been established within the Department. The Expert Group began to work independently which further contributed to suspicion between it and the Department of Health. The Group appeared to believe that it had executive power rather than the advisory function which Straton believes it was charged with.

ii. The emergence of commonalities between feminists and the medical profession.

The emergence of a new political issue can result in unexpected commonalities amongst interest groups. An alliance between pro-screening members of the medical profession and feminists had emerged prior to the Cervical Cancer Inquiry and the interests of these two groups continued to merge as they experienced marginalisation by the Department of Health. The strategies used by feminists and the medical profession to influence the implementation of the screening programme were very similar. Both groups capitalized on the high level of public interest in the issue of cervical screening. Both intensified this interest by using the media to highlight the short-comings of the bureaucratic actions on the screening programme. The medical profession used its own media forum, the *New Zealand Medical Journal* to mobilise its own members, and feminists used *Broadsheet* to mobilise feminists. Both groups also used the popular media to highlight their concerns. Feminists and doctors also lobbied the Minister to emphasise that the national screening programme would fail if the groups they represented were not involved in its implementation (Clark, 1993). This tactic (sometimes termed 'shroud waving') was especially important because it emphasised the danger of undermining a public health measure which had become a political imperative. What these strategies were successful in doing was to ensure that the discourses of both the medical profession and feminists were in circulation. This increased their social power and provided a basis for the successful challenging of the actions of the Department of Health.

Even at its conception, the national cervical screening programme was imbued with the political interests of the state, the medical profession and health activists. After the Inquiry, the medical profession found itself in the role of a pressure group wanting to influence the implementation of the programme in a climate of unprecedented questioning of medical authority and morality. In doing so it chose to challenge not so much the legitimacy of state intervention in a specifically technical medical matter, (the Cervical Cancer Inquiry had established this legitimacy), but the competence of the Department to establish the programme. The profession had the opportunity in part at least to reestablish its professional reputation and autonomy by being seen to progressively and expertly contribute to this latest medical initiative. In an attempt to avoid further marginalisation in the aftermath of the Inquiry, doctors laid claim to

specialist medical knowledge which they stressed was required to properly establish the programme. However, the medical profession was not a united pressure group. Whilst some of its members were co-operating with the ideals of the screening programme, others were criticising and obstructing its implementation. The profession was also in a position of having to pit itself against doctors who had a bureaucratic role within the Department of Health. This Department had at times been responsible for the implementation of policy in conflict with the professional aspirations of practising doctors. As agents of central government, medical bureaucrats are charged with implementing government policy which does not always further the interests of the medical profession to which they belong. However it appears that there was a dearth of people with medical or nursing backgrounds in the Cervical Screening Unit within the Department. Because of this lack of professional representation there was little confidence in the Department. Doctors felt that their medical knowledge and expertise was not being taken into account in the decision making process (Straton, 1990).

Feminists, like the medical profession claimed specific expertise, much of which was related to their experience of being or acting on behalf of health consumers. They particularly claimed 'gender expertise', that is, an expert knowledge of women's subjectivities, preferences and fears in relation to cervical cancer screening. This latter expertise was difficult for male bureaucrats or for the predominantly male medical profession to challenge in a climate where professional abuse had been so intimately linked with issues of gender insensitivity.

iii. The construction of the health consumer and the national screening programme.

The Cervical Cancer Inquiry itself exacerbated the trend of patients to become constituted as 'consumers'. A lay perspective on medical matters was an essential part of the process of examining events at National Women's Hospital. Evidence was heard from over eighty patients and relatives of patients. This was balanced with evidence from members of the medical profession from New Zealand and overseas (Coney, 1993e:22). An acceptance that women should be consulted in the post-Inquiry actions on cervical cancer, acknowledged that women had rights as 'consumers' of health services to have an input into the development of future

services which they would ultimately use. The construction of women as 'consumers' of health care by the Inquiry reflects a change in the nature of the relationship between patients and doctors. Not only has health become increasingly linked with lifestyle and the consumption of a range of goods (such as food, sport and leisure activities) (Nettleton and Bunton, 1995), but also with the consumption of medical products and services. It can be argued that this more 'market oriented' approach to medicine has decreased the prestige of medicine and the social distance between doctors and patients. Patients, recast as 'consumers' have increasingly directed more sceptical eyes over the products and services being offered by medicine. The mystique of the medical 'art' has been reconstructed as technical and utilitarian practices which require monitoring and vetting in ways similar to other services in the market-place. This in turn has allowed for a greater scrutiny of medical work and increasing demands for consumer needs and wishes to be acknowledged. The new discourses of the medical consumer have had the effect of constituting a new type of patient (Armstrong, 1982) who is encouraged to hold opinions and have preferences on medical services. Patients are also expected to be active agents within a 'culture of rights' ensuring that their needs are adequately met within the medical market-place. In response the medical profession is expected to determine the preferences of patients by encouraging them to 'speak their needs'. Whilst this change may be viewed as progressive for health consumers it may also be viewed as a means by which professional power finds new means of expression. The 'health consumer' constitutes a new medical object open to the ever increasing products and services of medicine. As in consumer culture, medical products and services are increasingly constructed as rights which patients ought to demand and avail themselves of. In this context choice becomes highly valued. As Grace, (1990, cited by Coney, 1991:20) suggests, health consumers may have the illusion of choice but these choices are often predetermined and outside their control. Whilst the medical profession has gained increasing knowledge about what consumers want from health care, this has not always been reciprocated because of the complexity of medical knowledge and the difficulties patients have in accessing it. What information has been provided to women as health consumers is frequently in the form of media releases which reframe choice as a means of controlling risk. Women now have options on how they can respond to osteoporosis or menopause for example but these choices are frequently offered within a medical discourse which constructs

women's ageing bodies as deficient and sick. It can be argued therefore that the construction of women as health consumers has placed the medical profession in an increasingly advantageous position to constitute and exploit women's medical 'needs'. Exploiting the more market-based form of medical practice by articulating the demands of women health consumers has placed the women's movement in an ambiguous position of supporting the increasing medicalisation of women's bodies.

iv. The Ministry of Women's Affairs and the national screening programme.

In the post-Inquiry climate, feminist discourses gained an unprecedented level of social power and authority. Not only were these discourses more widely in circulation, they had moral legitimisation in challenging patriarchal medicine. Significantly, feminists also had a state vehicle in the form of the Ministry of Women's Affairs to support and promulgate their interests. This Ministry played an important part in the establishment of the cervical screening programme. The advent of this Ministry in 1985 was indicative of the increasing bureaucratisation of the feminist movement. Macdonald (1993:9) suggests that the earlier spontaneity of feminism was replaced in the 1980s and 90s with a more sophisticated and dispersed movement with groups working towards specific rather than general feminist objectives. From being a social movement outside mainstream institutions the feminist movement became located inside institutions where activism took the form of establishing equal employment opportunity and sexual harassment programmes, women's officers and women's caucuses. The Ministry represented recognition by the state of the women's movement at a national and parliamentary level. This arose according to Macdonald from the growing influence of feminists on social policy and the more liberal leanings of the fourth Labour government. The Ministry advanced and legitimated feminist attempts to influence social policy even further. Its goals were to assess the effects on women of all government policies and to advise the Minister of Women's Affairs on matters relevant to women. Other goals included, monitoring and initiating legislation and regulations, promoting equality for women and advising the Minister of suitable women for nomination to statutory bodies (Ministry of Women's Affairs, 1986, cited by Macdonald, 1993:237).

Ferguson (1984:83, cited by McKinlay, 1990:74), suggests that bureaucracies dictate a form of discourse which constrains those within them by imposing a hierarchy of

direction which controls information flows and reduces individuals to their function within the organisation. From this perspective, bureaucracies are institutions in which feminist discourses are co-opted or ignored and feminist values are marginalised. The Ministry of Women's Affairs however can be viewed as a structural strategy to influence social policy in a way which lessens the potential for cooption and marginalisation of feminist aspirations. As an initiative of the state, the Ministry at its inception was a powerful symbol of liberal government, responsive to issues of gender equity. However whilst having the overall aim of working towards gender equality, the Ministry acknowledged in the early stages of its development that its main function was to implement the policies of the government of the day (Ministry of Women's Affairs, 1986 cited by Macdonald, 1993:237). Therefore whilst the establishment of the Ministry can be viewed as a progressive act which would legitimate and advance the feminist platform, it can also be viewed as a means by which feminist discourses could be managed, constrained and controlled in the service of implementing government policy. This is particularly so when an elected government has a conservative rather than a liberal agenda. From this perspective the Ministry of Women's Affairs can be viewed as an example of the way in which the state is able to neutralize pressure groups to the point where they lose their power to represent oppositional discourses. Certainly in more recent years under a more conservative government, the Ministry has come to be viewed by feminists as having been captured by 'market forces'. Coney suggests that since the late 1980s, the Ministry cut off its links with communities and its activist stance was replaced by a single role of policy advice (Rae, 1996).

At the time of the Cervical Cancer Inquiry the Ministry of Women's Affairs, because of the political stance of the Labour Government, found itself in a position of being able to support health policies which largely reflected the aspirations of the feminist moment. The Ministry echoed the calls of women's health groups (and of professionals) in its lobbying of the Minister of Health for a change in direction for the national screening programme especially in relation to the need for a greater level of consultation (Clark, 1993). Where the Department of Health had appeared to be resisting the establishment of a national cervical screening programme, the Ministry of Women's Affairs had for some time been supporting the concept. The Ministry was in fact quite active in doing so and the confidence it felt after the Cervical Cancer

Inquiry is evidenced by a document the Ministry published after the Inquiry. In a booklet aimed at both Maori and Pakeha women the Ministry summarised the recommendations of the Inquiry and provided practical guidelines for the implementation of them. The Ministry encouraged women to become politically active in ensuring that they gained a cervical screening service that met their needs:

Write letters to newspapers or get your women's groups to write an article for the local newspaper on the incidence of cervical cancer and what needs to change.

Give feedback to health service providers, doctors and others, on their service/sensitivity: complain if their service is unsatisfactory... (Ministry of Women's Affairs, 1989:18).

The activist advice given to women suggests that the Ministry had some reservations that the recommendations of the Inquiry would be implemented. The Ministry had recognised, as the Inquiry was in progress, that the Department of Health remained unwilling to indicate that it had a clear commitment to a national cervical screening programme (Keene, 1988). What is significant however, is that the Ministry felt able to openly promote an activist, feminist stance. This suggests that the dominant discourses of the time promoted and supported such a stance. In the immediate post-Inquiry era feminist discourses had gained considerable currency within a context of the abuse of professional power and a government moving quickly to distance itself from any accusation of collusion with such abuses. In a climate of the state attempting to right medical and gender wrongs, the Ministry was able to promote policies which did not compromise its implicit agenda of representing the liberal causes of New Zealand women. For feminists, the alliance with the Ministry was an important source of support and legitimation.

v. Bureaucratic resistance to the national screening programme.

The relationship between the Minister of Health and her Department became the focus for political struggles early on in the implementation of the screening programme. The Minister and the Department disagreed on a number of aspects of the programme. As well as having different views from the Minister on whether the national screening programme should be controlled centrally or devolved to Area

Health Boards, the Department of Health at a more fundamental level resisted the implementation of a national population-based screening programme. The basis for this resistance has been attributed to a number of factors. One of the most significant of these relates to the way in which cervical cancer emerged as a priority health issue. Whilst the Department of Health had been evaluating the need for a national screening programme since the mid 1980s, cervical cancer was not considered to be a health priority. Clark (1993:67) suggests that the fact that deaths from the disease were not high in relation to other preventable causes of death meant that the Department did not accord it priority status. On the other hand, feminists argued it as a priority on the grounds of the potential to prevent invasive cancer through what they considered to be simple and effective diagnostic and treatment procedures. The Department of Health constructed cervical cancer as having a lower priority because of its statistical status compared with other illnesses. The Minister, the Cervical Cancer Inquiry and women health activists constructed cervical cancer as a social and political health priority and emphasised women's rights to access what they considered to be an essential health service. Despite these competing perceptions the Department determined that cervical cancer was not empirically important. From this perspective, cervical cancer becomes an exemplar of the social location of illness and the ways in which social factors mediate medical truths.

Other factors mitigating against the national screening programme were internal to the Department of Health and reflected broader structural features of New Zealand society at the time. The Inquiry had in its findings determined that cervical cancer should be designated a 'health priority', a view which received immediate political support. Whilst political will favoured the programme its implementation took place within a context of a fiscal crisis and the ideological challenging of the legitimacy of the welfare state in New Zealand. The welfare system ushered in by the 1938 Social Security Act required a commitment from the state to provide health care on the basis of need. The growing economic crisis which had occurred from the mid 1970s, increasingly focused the attention of the state from budgetary expansion to cost-shifting and rationalisation strategies (Fougere, 1994:109). This meant that public expenditure on health and other social sector areas came under intense scrutiny. As part of the process of reform introduced by the Labour Government between

1984-1990, the State Sector Act of 1988 paved the way for the restructuring of the health sector. This included a reorganization of the Department of Health which resulted in greater emphasis on policy development, review and monitoring rather than the provision of services (Beaglehole and Davis, 1992). A more decentralised approach to health aimed to make Area Health Boards, which had replaced Hospital Boards more disciplined and business-like and more efficient in their delivery of public health services. In 1989, Helen Clark the Minister of Health announced a new health charter and delineated health objectives for New Zealand. The charter identified overall principles for the New Zealand public health service and a second document set out health objectives in key areas (Bowie and Shirley, 1994). The three priority areas which were noted in this latter document related to tobacco control, reduction of road accident deaths and injuries and the secondary prevention of cervical cancer (Beaglehole and Davis, 1992:421). This was an important legitimization of cervical cancer as a priority health issue. It positioned it within a context of other serious health concerns. The reforms of the health sector under the National Government have continued to rationalise health provision and to shift the cost of health care to users. Central to recent strategies has been a restructuring of health care to create a 'quasi market' with the aim of separating the funding of health care from its provision within a context of managed competition (Fougere, 1994).

Prior to the Inquiry, cervical cancer was not viewed by the Department of Health as a health priority. After the Inquiry it became a political priority as the government moved quickly to respond to public concerns. It has been suggested by Grew (1992:64) that the imposition of policy at ministerial level in relation to cervical screening, engendered resistance from 'bureaucrats' in the Department of Health because they felt alienated from the policy-making process. The political determination of cervical cancer as a health priority meant that the usual consultative processes between the Minister and the Department had not taken place. The deadline of November, 1989 for the implementation of the programme was politically motivated to ensure that the government was seen to be acting urgently on the issue. This deadline according to Straton (1990) led to unrealistic pressures being placed on the Department to implement the programme. Officials within the Department are likely to have felt disenfranchised from the decision-making process and to be unwilling to fully co-operate with the ideals of the programme.

The restructuring of the Department, and the health sector in general, has also been identified as contributing to the apparent reluctance of the Department to fully implement the cervical screening programme. The Department underwent a number of changes of personnel as its functions as a policy-making unit became rationalised. This resulted in a lack of continuity and disruptions to the implementation of the screening programme (Grew, 1992). Changes in personnel in the Cervical Screening Unit resulted in a lowering of morale and a loss of 'institutional memory'. Lack of staff with a medical or nursing background was also perceived as inhibiting the implementation of the programme as was the lack of communication and clarity in the relationship between the Expert Group and the Department (Straton, 1990:56). Resistance may also have resulted from political as well as pragmatic factors however. Senior managers in the Department were described by Coney as 'hostile' to the Expert Group which had been set up to advise on the development of the programme. This was attributed to competing ideologies between the philosophy of the screening programme and the directions of the restructuring of health which were occurring at the time:

Top management (at the Department) are in love with devolution, and they saw the screening programme as an anathema because they thought that everything should be devolved to Area Health Boards (Reid, 1991:14).

'Devolution ideologues' as Rosier (1991a:7) termed them were viewed as fragmenting the screening programme, which she argued would lead to its failure. Feminist commentators were anxious, even before the report of the Inquiry had been released, that the Department of Health was committed to a screening programme operated by Area Health Boards rather than advocating a centralised approach (Rosier, 1988c). The devolution of responsibility to Area Health Boards as part of health sector restructuring was based on the Labour Government's philosophy of 'less government'. Policy implementation was to be separated from policy making and devolved to regions to allow for what was considered to be greater efficiency and accountability.

One of the significant factors behind the restructuring of the health sector was an ideological change which promoted individualism in health as opposed to collective responsibility and intervention. The screening programme was paradoxically framed

by the Inquiry and later by subsequent Ministers of Health within an earlier nineteenth and early twentieth century model of public health. Within this model, public health was managed by umbrella state actions in which the medical gaze emanated from a centralised form of surveillance which managed individuals within a context of public space. In contrast, the 'new' public health focused on environmental and personal prevention measures at the level of communities (Ashton and Seymour, 1988). A tension therefore existed between the model of centralised surveillance being advocated for cervical cancer and the decentralised surveillance which was more in keeping with new approaches to public health and health sector restructuring.

These health sector reforms were carried out by a department which Coney (1993e:175) describes as being in the 'thrall of managerialism' in which the previously doctor-dominated Department of Health had been taken over by managers. The Corporate ethic of the 'new managerialism', which became embodied in the New Zealand health sector during the 1980s and 1990s, was borrowed from business (Beaglehole and Davis, 1992). This form of managerialism displaced diplomatic management with a more interventionist, style considered to be more appropriate to late modern and post-Fordist organizational life. Central concerns of the new managerial ethos were audit, accountability, rationality and efficiency (Nettleton, 1995:218;221). The Department of Health had in many ways moved into an environment which was an anathema to the requirements for a centralised public health initiative which required wide public consultation and sensitivity to the needs of interest groups. Helen Clark (1993:71) as Minister of Health concluded that the Department wanted to be rid of responsibility for the screening programme and appeared reluctant to direct policy at a national level for a programme which was to be delivered regionally. What is ironical is that a Government which had introduced wide-reaching public sector reforms expected the Department to operate to some extent as if the reforms had not occurred. In light of the practical and ideological incompatibilities which had developed between the Department and those advocating a centralised national screening programme, it is not surprising that the implementation phase was fraught with delays and difficulties.

The individualism which was fundamental to the restructuring of the health system found expression in beliefs that health care should be delivered in a way which

promoted individual responsibility and choice (Upton, 1991). The lifestyle model of health which had increasingly dominated health policy in New Zealand has been criticised by a number of commentators including Bunkle (1994). She suggests that this model takes little account of the factors outside individual control which influence health status and access to health resources. The Department's construction of health services as personal matters did not according to Coney (1993e:176), acknowledge the public health element of the cervical screening programme which was aimed at the mass participation of well people who may not have been actively seeking health care. She and others believed that because of these factors, the programme required a centralised approach to achieve its aims. One of the major concerns expressed by Coney in a paper to the Expert Group was that devolution of the screening programme to Area Health Boards could result in cervical screening being subject to varying political will at a local level. This, she believed would result in difficulties in reaching and evaluating national targets, wasted resources and the disadvantaging of women in poorly served regions (*ibid*). These debates underscore the negotiated status of what, on the face of it, appeared to be the rational application of science to a medical need. Feminists and some members of the medical profession found themselves in an alliance which attempted to support a model of welfare which was being undermined by political changes.

In 1990 Helen Clark issued a ministerial policy statement on the screening programme based on the advice of the Expert Group. Some officials in the Department were concerned that the Minister was accepting the advice of the Expert Group in preference to that of Departmental officials, which, as Clark (1993:71) pointed out, resulted in a 'degree of obstruction'. In 1991 however, the Minister of Health in the newly elected National Government disbanded the Expert Group and set up a Technical Advisory Group. There was concern amongst feminists that the new group would not have the consumer representation which characterised the Expert Group and that Department of Health senior officials would have more power to influence the Minister. The disestablishment of the Expert Group was considered to be an ignorant and incompetent action by Rosier (1991a:7) who also surmised that it may have arisen out of the Department's fear of losing control of the programme. The disenfranchisement of Maori, Pacific Island and older women from decision making in relation to the programme concerned Coney because she felt that these

groups would experience screening as being imposed upon them (Reid, 1991:14). The disbanding of the Expert Group was described by Clark (1993:71) as a 'triumph of bureaucrats over the interests of women'.

The new National Government froze the funding allocated by the former Labour Government and eventually released it to Area Health Boards without a guarantee of additional funds (Louisson, 1991:24). By 1990, most Area Health Boards had appointed managers of cervical screening programmes and were required by the Department of Health to submit implementation plans and budgets for cervical screening programmes (Calvert, 1990). The defeat of the Labour Government was a signal for feminists that gaining support for their interests would be much harder won. National was viewed as the party of employers and professionals rather than the people. The Labour Government was viewed as having been receptive to women's interests and suitably sceptical of those of the medical profession (Coney, 1993e).

vi. The 'opt-on' register

The Department of Health made a number of decisions in relation to the national screening initiative which Coney (1993e:169) describes as having 'handicapped the programme ever since'. The most significant of these was that women would voluntarily place themselves on the national register. This was a departure from overseas population-based screening programmes which were operated on the basis of an 'opt-off' register, where women had to deliberately abstain. Written consent from women in New Zealand had to be obtained before the results of the cervical smear tests could form part of the centrally held register. The 'opt-on' register was not supported by feminist health activists who thought that it would result in low numbers of women enrolling. Their concern was that the need for women to be informed of the register's existence and to sign a consent form would result in low coverage (*Broadsheet*, 1992). There was also the concern that the requirement for written consent would send a signal to women that they were making a major medical decision which had serious import. Written consent in medicine has historically been associated with surgery or other major medical procedures but in this case was aimed solely at allowing laboratories to legally pass information to the register. Women were encouraged through the feminist literature to lobby the Government for an 'opt off'

register and to enact legislation which would be required for such a change (*Broadsheet*, 1992).

The opposition of women health activists to an 'opt-on' register, represents an interesting paradox. Since the 1970s, feminists had vociferously constructed the medical profession as patriarchal and paternalistic. These views were reiterated when doctors involved in the events at National Women's hospital were criticised by feminists for suggesting that women could not make informed decisions on medical procedures (Rosier, 1987a). By opposing the 'opt-on' register, feminists were in effect suggesting that women could not be relied upon to make rational and informed decisions about the benefits of being on the register. The 'opt-on' register was instead constructed by feminists as a possible impediment to widespread compliance with the aims of a national screening programme. One feminist did view the register as a means by which women could 'take control of their lives' (Rosier 1991b:6) but in general feminists viewed it as a negative aspect of the programme. The perception of women as being unable to distinguish between informed consent for a major surgical procedure and informed consent for the purposes of having their smear results transferred from the laboratory to a register, suggests a construction of women as naïve in medical matters. It can be argued that in light of their response to the 'opt-on' register that the feminist health movement coopted existing medical values and standpoints in constructing women as in need of management and control. The paradox inherent in this view does not appear to have been widely debated in the feminist literature. Instead, for Coney in particular, the debate on the merits of an 'opt-on' versus an 'opt-off' register were framed in terms of individual versus collective rights, a tension which she suggested was particularly acute in the New Zealand environment (Louisson, 1991). She acknowledged that New Zealanders were not used to health registers and were apprehensive of them but also argued that registers were part of everyday experience, whether New Zealanders liked them or not (Coney, 1991). Sanitised of its gender implications, by a 'rhetoric of good', the issue of the cervical screening register became focused on ways to achieve what was constructed as the rational and benign aim of screening as many women as possible.

The 'opt-on' register was also criticised by feminists for its potential to place too much power into the hands of doctors. There was concern that doctors who opposed the

register could control the enrolment of women by not offering them the choice of being placed on it (Coney, 1993e). In this context, the register was viewed as a potential tool for the medical profession to exercise political discretion to their own ends. Feminists were concerned that, for those doctors who did not favour cervical screening or who were unhappy with the centralised imposition of a health strategy, the register could serve as a site for resistance. By spurning the register, individual doctors had the power to maintain a greater level of control over the management of cervical cancer than feminists felt was desirable. Feminists were concerned that those women who were unaware of the register, or who were unwilling to challenge medical power and demand their right to be placed on it, could be disadvantaged in the medical relationship.

The contested nature of the 'opt-on' register highlights a number of issues. The first of these is the way in which the medical profession and feminists, in relation to this issue at least, can be seen to have occupied the same epistemological space. In advocating for the 'opt-off' register feminist discourses constituted women as uncertain, uninformed and in need of management. Feminists constructed women's potential resistance to the register not as a symbol of their autonomy but as an impediment to medical objectives. The feminist stance on the register became one of, 'for her own good', in the same way as countless other medical measures have been constructed by the medical profession. Feminist health activists have historically been concerned that in their attempts to gain access to health services for women that there was a danger of giving ground to the 'established order' (Calvert, 1981:95). Cooption has also been identified by Bunkle, (1994:234) as occurring when feminist language and concerns are adopted by the state to support New Right agendas. For feminists, the cervical screening programme became an imperative with considerable political implications. The unintended consequence of this imperative was that surveillance of women's bodies became a priority which overrode the political considerations which had previously informed feminist discourse. Feminists found themselves in a position of supporting a paternalistic approach to medicine and contributing to the increasing medicalisation of women's bodies.

By April 1993, 217,000 women out of a total eligible female population of one million had enrolled on the national register (Goodger et al, 1993:149). In July 1993,

legislation, (Section 21 of the Health Amendment Act) was enacted requiring the results of all cervical smears to be automatically sent from laboratories to the National Cervical Screening Register. This was to occur unless women from whom smears had been taken made an objection in writing (*NZMA Newsletter*, 1993a:10). The aim of the changed registering system was to have 80 per cent of women in the target age group (20-69 years) having regular smears and where necessary follow-up treatment by 1995 (*Health*, 1993:13). This change was seen by some members of the medical profession as essential if there was to be a high participation rate in the programme (Cox, 1991:454). The Department of Health however, persisted in pursuing an 'opt-on' register in defiance of government policy but was eventually forced to capitulate and support an 'opt off' register (Clark, 1993:71). This represents a failure on the part of the Department to promote individualism in health care. The 'opt-off' register represented a return to an earlier model of welfare delivery in contrast to the Department's challenging of 'welfarism' and promotion of an ethos of the individual's 'right to choose'.

vii. The 'opt-off' register.

The cervical screening register was viewed by one medical commentator as part of an infrastructure for recalling women with normal smears to have their next smear and to follow-up women with smear abnormalities for further investigation or treatment. It was also identified as a means by which clinicians could receive feedback on the quality of smear-taking as well as giving feedback to laboratories about the quality of smear examination and reporting which was occurring. The register was also intended to be a useful resource in establishing a woman's 'smear history' and assisting in the interpretation and management of a current smear result. The register was also viewed as a valuable resource for providing an overview of rates of cervical screening and enabling the targeting of strategies to increase screening levels and for monitoring their impact (Straton, 1994:261). The national register was designed to ensure that women automatically received a reminder letter in the post, indicating that their smear test was overdue. If a smear test showed an abnormality, women were to be sent a letter indicating that the smear was abnormal and advising them to discuss their results with the person who had taken a smear. In most cases this was likely to be their general practitioner (*Health*, 1993:13).

The 'opt-off' register was supported by women's groups who felt that this system would counter the resistance of doctors who were refusing to enrol patients under the 'opt-on' system (*Broadsheet*, 1992; *GP Weekly*, 1992a). Maori women however expressed concerns that choice had been removed from them with the change to the 'opt-off' register and calls were made by them for a national Maori 'opt-off' register to be established which would be controlled and managed by a Maori guardian group (*GP Weekly*, 1992b). Cultural concerns of Maori were eventually met by the establishment of a 'Kaitiaki' or guardianship group to protect the data of Maori women which was held by the register. Government departments and researchers were not permitted to have access to the data without approval from the Kaitiaki group (*Health*, 1993:13). It is paradoxical that the screening programme was originally modelled on a western concept of a health service and that it took lobbying by Maori to ensure that their rights (which included protection, participation and promotion under the Treaty of Waitangi) were encapsulated in the programme. This is especially ironical in the light of Maori women having been consistently singled out as a high priority group which needed to be targeted for cervical screening.

At the same time as the status of the register changed to an 'opt-off' system, other changes were also made. The scope of results reported to the register was broadened so that laboratories could send histological as well as cytology results to be registered. The rationale for this change was identified as 'improving the register's quality assurance functions' (Goodger et al, 1993:149). The suggestion that the register be expanded in this way was mooted by Paul et al (1991) in their report to the Department of Health.

In summary the 'opt-off' register may be viewed as the rational application of technological innovation to benefit health. However its paradox lies in its paternalistic approach to the practice of medicine at time when such an approach was perceived to be an anathema to the empowerment of women. The sending of reminder letters to women to attend for a smear test exemplifies this paternalism. The sustaining notion behind this part of the programme was that women were unable to manage their bodies in their own interests. Paradoxically also, the programme has been largely organised on a welfare state model which has promoted the centralised surveillance of women. This model has laid the foundations for the programme's

paternalism within a metaphor of the beneficence of the state. In other areas of health care, the state has increasingly placed responsibility on to individuals. This is powerfully symbolised by the shifting of health costs in the 1980s and 90s, from public to private purse (Bowie and Shirley, 1994). In her review of the National Screening Programme, Straton (1990:61) noted the paradoxical nature of the centralised approach to the programme. She suggested that 'it did not make sense' to have one aspect of health being centrally controlled and administered and argued for Area Health Boards to be given policy, guidelines and funds to develop their own programmes in line with regional needs.

5. The Response of the Medical Profession to the National Screening Programme.

For some members of the medical profession the national screening programme represented the rational application of a medical intervention. Involvement in the establishment of the programme presented the opportunity for members to monitor state meddling in medical matters and to ensure that medical expertise was translated into outcomes of benefit for patients and the profession. The recommendations of the Cervical Cancer Inquiry had, on the surface at least, settled the debates of the previous decade as to the efficacy of cervical screening (Gray and Gaiser, 1990). There was however resistance from some doctors to the establishment of a national cervical screening programme. This resistance was considered by one medical commentator to result in part from the legacy of the events surrounding the Inquiry itself (Straton, 1994:261). Resistance took a range of forms from, establishing an oppositional discourse in the medical media, to refusing to co-operate in the clinic. In 1991, when the 'opt-on' register was operating, doctors in the central North Island and Marlborough refused to enrol patients on the register (*NZ Doctor*, 1991). There was a belief by a number of general practitioners that the register duplicated what they considered to be their own effective computerised systems for recalling patients (*NZ Doctor*, 1991; Straton, 1994). Some of these systems had been put in place after the Inquiry, but before the national screening programme had been established, in a climate of heightened doctor and patient awareness of cervical cancer (Gunn, 1991). The view that the register duplicated doctors computerised registers, was criticised by one medical commentator who suggested that it showed a lack of understanding of the broad functions of the

national register (Straton, 1994). It is more likely that those who opposed the centralised register resented the encroachment of the state in what they considered to be medical work. The establishment of a register run by bureaucrats meant that not only were women under surveillance by the Department but so too were the profession.

Feminist commentators expressed frustration at the medical profession's attitude towards the register which they suggested indicated that doctors thought that they could do 'everything better themselves'. They called on the profession to support the programme in the 'best interests of women' (Chambers, 1989:52). The Department of Health attempted to neutralize concerns expressed by doctors by constructing the national register as an 'adjunct' to the recall systems already established by general practitioners. The register was described by Gillian Grew, the National Co-ordinator of the cervical screening programme as an additional 'safety net' to those already established by general practitioners (*NZ Doctor*, 1991:9). Other members framed their discontent in terms of the amount of administration that they were having to be involved in as a result of the scheme (*NZ Doctor*, 1991).

The Department of Health and the Minister found themselves in the difficult position of requiring the co-operation of doctors whilst at the same time implementing a screening programme in a way which many doctors opposed. In 1989, the New Zealand Medical Association reminded the Department that the programme would not succeed if practitioners did not co-operate and that they needed more involvement in the implementation process. Many doctors considered that they had not been properly listened to nor had their views been taken into account in subsequent decision-making (*NZ Doctor*, 1991). This concern was expressed by Gray (1990b:191) who suggested that an 'inflamed environment' had existed since the Cervical Cancer Inquiry that had led to a perception that medical opinion was not to be trusted as it was possibly 'biased and hostile'. This had, he considered led to a situation where policy for the national screening programme had been developed by administrators from the Department of Health without expert medical knowledge. Dr Peter Moodie, who represented the Royal College of General Practitioners on the Cervical Screening Advisory Committee, suggested that general practitioners were not opposed to cervical screening but were opposed to the political aspects of the

programme:

There is not a GP in the country who's against a good programme. All GPs are behind all good screening programmes. The problem with the cervical screening programme is that it was born out of a political agenda and was never well conceived. It should have been a grass-roots programme which began with the people who do the work (Dekker, 1994:18).

The lack of control over the implementation of the programme was described by one doctor as making him a 'political pawn' (Hunter, 1992:9). These comments indicate the level of disenfranchisement many doctors experienced. The top down nature of the programme struck at the very heart of medical authority and autonomy. Many general practitioners reported a perception that the register, (particularly the 'opt-off' system) had been imposed upon them:

If there had been co-ordination of smear-taking at a regional level, with a gradual move to a central Register, some feel the programme might have been better received (NZMA Newsletter, 1993b:6).

Other members of the profession expressed concerns that doctors would be 'legally vulnerable' to unintentional failures to implement correct procedures in relation to the 'opt-off' register (ibid).

Doctors were accused by feminist commentators of maintaining a paternalistic approach to cervical smears by telling women that they did not need the register because they, as general practitioners were taking care of women's needs. Doctors were also accused in some cases of enrolling women on the earlier 'opt-on' register without their informed consent (Rosier, 1991a:7). Resistance from doctors was also suggested as being based on pecuniary concerns with members of the profession boycotting the national register because they were angry that the subsidy offered to smear-takers to encourage them to take smears had been removed (NZ Doctor, 1991; Rosier, 1991a). Pecuniary reasons were also identified by Coney as being responsible for doctors being reluctant to support initiatives, such as free screening clinics, because of concerns that these would take patients away from their practices

(Louissen, 1991:23). Other members of the profession expressed doubts that the holistic care provided by general practitioners would be able to continue if women consulted independent smear takers (Gray and Regan, 1994).

Oppositions which were expressed by doctors as professional concerns were deconstructed by other commentators who viewed these as gender issues. Susan Dahl, co-ordinator for the programme suggested that ill-feeling about the programme had arisen because of 'gender politics'. She saw the impetus for the programme as having come from women's groups rather than doctors and suggested that this had put women's groups at odds with the profession. She also suggested that the programme symbolised women taking control of their own bodies and that this had contributed to ill-feeling amongst the medical profession (Dekker, 1994:19).

Some members of the profession argued that the register was not fulfilling its objectives and suggested that those women who really needed to be 'organised into a doctors surgery' to be screened (because they had never had a smear), were not being sufficiently targeted (Dekker, 1994:18; Gray and Regan, 1994; Hunter, 1992). Others expressed concern that the cervical screening programme, although an important medical initiative, was consuming resources which were needed by other screening initiatives such as those for breast and prostate cancer (NZMA Newsletter, 1993b:6). The cervical screening programme was viewed by one medical commentator as evidence of the 'fallout' from the Cervical Cancer Inquiry as a programme 'costing millions and of doubtful value' (Pryor, 1990:355). Some doctors also expressed concerns that sending the results of cervical smears directly to women as well as to doctors, interfered with the doctor-patient relationship:

I am concerned with the smear register's ability to send out letters to my patients, which may seem to contain conflicting information to that which I am giving them and I think that this may undermine faith that patients may have in what I have said to them (Hunter, 1992:9).

In response to this Straton (1994:262), suggested that this part of the screening programme was important in ensuring that women had accurate information in lay language. She also reminded the profession that they had nothing to fear from

patients receiving their results from the register if they were in the habit of actively and promptly informing their patients of the results of tests and their meaning. She also reminded the profession that they shared the same goals as those promoting the screening programme in reducing the incidence of cervical cancer. She suggested that it would be unfortunate for the women of New Zealand if territorial disputes and misunderstandings undermined a programme which aimed to save many women's lives.

The Cervical Cancer Inquiry, and the events which followed it, have contributed more than any other event in the history of medicine in New Zealand to the secularisation of the medical mystique. Whilst this secularisation has also occurred in relation to the medical profession internationally because of a growing scepticism about the efficacy of medicine (Kelleher et al, 1994), the events surrounding cervical cancer opened up for public attention the extent to which medicine could morally fail. In the post-Inquiry environment the national screening programme itself represented a failure on behalf of the medical profession to successfully employ occupational strategies of limitation, exclusion and subordination to protect their professional territory and status. Already, the restructuring of the health sector had challenged medical autonomy by the imposition of managers who at a time of fiscal probity began to scrutinise and manage the activities of doctors (Beaglehole and Davis, 1992). Corporate rationalization, as Alford (1975:15) suggests, presents a challenge and contradiction to the monopoly held by the medical profession over the production and distribution of health care. Threats to medical hegemony have also arisen from the professionalising strategies of other professions such as nursing and from interest groups such as feminists. After the Inquiry these challenges merged and organised around the implementation of the cervical screening programme and around the implementation of other recommendations made by the Inquiry. What Alford terms the 'repressed structural interests' of feminists became a dominant discourse which was picked up by social institutions and political interests. Feminists played an influential role in the establishment of the screening programme and occupied a space of influence which would have previously been taken up by medical interests. The initiative for the establishment of a national screening programme was removed from the profession and placed into the hands of bureaucratic managers who themselves were under pressure to act by the Minister

of Health. The screening programme increasingly became a political event which the medical profession contributed to but did not manage, lead or control. In the post-Inquiry, environment the profession was not in a political position to forcefully mount resistance to the proposed screening initiatives. Those doctors who did publicly oppose the programme did so largely on technical and administrative grounds, claiming that the programme was not so much philosophically flawed but

... This book (but a limited) protected doctors from

ultimately about who should control and regulate bodies. These struggles are in effect the expressions of knowledge and power inscribed on women's bodies. The discourses which emerged in relation to the surveillance of women in the interests of screening reveal a number of paradoxes and unintentional consequences. These discourses reveal the productive as opposed to the repressive nature of power in the way that Foucault identified, and alert us to the ways in which power is exercised.

The national cervical screening programme did not arise out of the rational application of medical science but arose out of socio-political disputes which marginalised some discourses and enabled others to gain increased circulation and social power. Cervical screening was transformed from a diagnostic method to a political imperative, social cause and bureaucratic project. The discursive strategies which accompanied these transformations resulted in shifting authorities, as stakeholders laid claim to special expertise and knowledge. Feminists laid claim to expertise on women's subjectivities. They marginalised both the medical profession and the Department of Health in this area by privileging their knowledge of what women needed and wanted. They were supported in this claim by the Ministry of Women's Affairs and the then Minister of Health, Helen Clark. The state legitimated women's discourses which emphasised gender as a central issue in the implementation of the programme. Paradoxically feminists found themselves in a position of coopting medical constructions of women as requiring management and regulation in their support for an 'opt-off' register. In their zeal to ensure that women had the best possible access to a health service highly valued by feminists, they succeeded in removing from women the autonomy of being able to choose whether they accessed that health service in the first place.

The Department of Health contested feminist constructions of cervical cancer as a gendered socio-political cause by attempting to mobilise discourses which emphasised instrumentality and rationality. This view was set within a context of a bureaucracy in the throes of major changes. Whilst the Department attempted to mobilise discursive strategies which promoted a fiscally restrained, decentralised and individualistic approach to the programme, the Minister of Health and feminists resisted this approach. The paradox in this aspect of the programme is that the

Department was expected to implement a public health strategy which was anachronistic in its welfarist, centralised approach. What was particularly ironical was that the Minister of Health expected them to do so. Oppositional discourses mobilised by feminists and members of the medical profession who resented the imposition of the programme by bureaucrats constructed the Department as non-consultative, resistant and insensitive. Eventually under the Labour Government the Department was forced to capitulate and implement the programme in line with the wishes of feminists and the Minister. (There is some evidence that under the subsequent National Government this trend has been at least partially reversed).

The attitude of the medical profession represents another paradox in relation to the national screening programme. During the 1960s, general practitioners were beginning to see routine cervical screening as being professionally advantageous. This interest subsequently waned under the authoritative contrary discourses which emerged from National Women's Hospital. General practitioners found themselves in the paradoxical position in the post-Inquiry environment of resisting a health initiative which could form the basis for regular GP visits by women who were on the national register. General practitioners instead mobilised oppositional discourses in the interests of boundary maintenance. They contested not so much the worth of the programme but the fact that it was being imposed upon them. They laid claim to medical expertise and attempted to marginalise the discourses of the Department of Health who were constructed as inefficient and lacking in understanding of the special relationship between women and their doctors.

The discourses which were silenced during the implementation of the programme were those which could have raised questions about the moral appropriateness of a surveillance system which would monitor all New Zealand women throughout their adult life. Such was the power of the view that routine cervical screening was unequivocally in the interests of women, that these oppositional discourses did not emerge. In the post-Inquiry environment, opposition to cervical screening was associated with the discredited views of Green who had been very publicly maligned. It placed those commentators who may have wished to express concerns about the hegemony of medicine and the medicalisation of women's bodies in the position of being associated with a view which was marginalised and stigmatised.

Under these circumstances, oppositional discourses have been slow to emerge. Whilst the national screening programme appears to have been a challenge to medical authority it has in fact placed the medical profession in an even more authoritative position. Adult women in New Zealand now receive a reminder notice to have a cervical smear test. The state has ensured that medical surveillance of women has been regularised and codified.

CHAPTER TWELVE

Selling Screening: The Promotion of the National Cervical Screening Programme

1. Introduction

The 'selling' of cervical screening to women has been an important part of the implementation of the national cervical screening programme. The success of this population-based programme has been contingent upon asymptomatic women recognising that they have an unmet health need and taking action to prevent a disease which may remain hidden in their bodies. Constructing 'at risk' bodies within a context of health promotion has been central to a campaign aimed at convincing women that they must co-operate with the ideals of the screening programme. Health promotion seeks to effect change in the bodies of specific populations (Casswell, 1988:715) and is a socially organised rather than a random approach to health (Beaglehole, 1992:29). The principles of health promotion were espoused by the World Health Organisation in a number of initiatives in the 1970s and 1980s, which concluded that social and lifestyle changes were necessary to bring about health in aggregated bodies (Parish, 1995). Health promotion has emerged as a field of health work in New Zealand since the mid 1980s (Grace, 1991). Health promotion goals are now regularly emphasised as being as important to the delivery of health care as health protection and disease prevention. At the centre of health promotion is a focus on the lifestyle of populations. This interest, in lifestyles according to Lupton (1995:54), has historically been economic in origin. She argues that health has been promoted in the interests of a disease free, productive population and in an attempt to preserve and redirect the increasingly limited resources available to health care. This chapter analyses health promotion discourses which have emerged in relation to cervical cancer. It argues that these discourses, rather than reflecting a rational scientific approach to healthy populations, contain a number of paradoxes which reveal their socio-political origins. **Part Two** of this chapter discusses a number of sociological critiques which expose the political nature of health promotion. **Part Three** analyses health promotion discourses which emerged in relation to the national cervical screening programme and shows the social location of these discourses. **Part Four** examines the construction of subjective women in the context of promoting cervical screening to New Zealand women. **Part Five** identifies the ways in which

resistance to cervical screening has emerged. Paradoxically resistance has not emerged from feminists, who appear to have been unwilling to challenge aspects of cervical screening which could be perceived to be disempowering and paternalistic. **Part Six** concludes the chapter by drawing out the arguments which challenge the view that health promotion is the rational application of scientific medicine. It shows that the paradoxes apparent in the 'selling' of the cervical screening programme reveal the social location of the health promotion campaign.

2. Sociological Critiques of Health Promotion

Many critiques of health promotion have tended to accept, unquestioningly, the prevailing orthodoxies of this approach to the management of the health of populations. This has led in some instances to a lack of critical analysis of the political dimensions of health promotion and also a lack of problematisation of the knowledge it creates. This has resulted in an uncritical acceptance that health promotion is based on humanistic and utilitarian objectives of producing healthy bodies (Lupton, 1995). The lack of problematisation of the epistemologies and practices of health promotion has resulted in an acceptance that to promote health is to apply the principles of rational science to the unquestionable needs of modern populations. The social location of health promotion and the social constitution of its objects of interest, are often obscured by an appeal to unquestioning acceptance of its scientific objectives. Lupton (1995:5) argues that a sociological critique must expose the political dimensions of public health and health promotion:

What needs to be brought to light and critically interrogated are the covert political and symbolic dimensions of these institutions; the ways in which the practices and policies of public health and health promotion valorize some groups and individuals and marginalize others, the concepts of subjectivity and rationality they privilege and exclude, the imperatives emerging from other socio-cultural sites that intertwine and compete with those of public health and health promotion, and the discursive processes by which these institutions are constituted and supported.

Sociological critiques which have emerged, identify health promotion as an inherently political activity which represents a relatively recent form of social control and regulation. Bunton (1992:4) argues for example that health promotion activities are

often intrusive and can have detrimental consequences for civil rights and for the amount of control individuals are able to exercise over their daily lives. Structural critiques have pointed to the failure of health promotion to take into account the material disadvantages of people's lives:

The structural critique is therefore about power. It draws attention to the fact that ideas about healthy living are promulgated by those who are white, middle class and often work within sexist, racist and homophobic value systems (Nettleton and Bunton, 1995:45).

Health promotion activities have also been criticised for their propensity to focus on 'at risk' groups, resulting in the marginalisation of social groups who are identified as 'targets' and 'deviant'. By identifying the personal behaviours of these 'target' groups for health promotion initiatives, racist and sexist stereotypes are often reinforced. At the same time attention is drawn away from structural factors which may impact upon health status. An example of this has been identified by Thorogood (1992:56) in her discussion of the eradication of rickets in the white population in the United Kingdom, where a national policy led to the fortification of commonly used food items with vitamin D. In contrast, the campaign to eradicate rickets in the Asian population has focused on lifestyle changes which has including dietary prescriptions such as eating cornflakes and margarine and promoting the benefits of exposure to sunlight.

Critiques which emphasise surveillance aspects suggest that health promotion activities are increasingly expanding their focus into everyday and organisational life (Bunton, 1992). This expansion is, according to Armstrong (1995), part of an increased focus on the monitoring and surveillance of healthy populations. Constructing new identities by paying attention to the subjectivity of individuals is, according to Arney and Bergen (1984b), reflective of this new health enterprise. Techniques which have been employed by health promotion to this effect include qualitative interviews, participant observation and health diaries which, Nettleton and Bunton (1995:47) suggest, penetrate into the lives and minds of subjects. They note that healthy minds and healthy subjectivities are as much a part of health promotion as are healthy lifestyles and healthy bodies. Lupton (1995:134) argues however that health promotion discourses compete with a myriad of other discourses such as the

media, the commodity culture, the family and education system in the construction of subjects. As a result, the imperatives of public health and health promotion may be contested by the competing claims of other socially located pleasures and prescriptions.

Health promotion has also been critiqued from the perspective of the sociology of consumption. This has led to a focus on the social marketing aspects of health promotion strategies, especially when a particular way of living is promulgated in the interests of health and a more satisfying way of living (Nettleton and Bunton, 1995). The construction of the 'health consumer' in accordance with the model of consumer capitalism has lead Grace (1991:334) to view health promotion activities as a form of marketing:

This model provides for the construction of the consumer as a needing, wanting individual who can assess his or her own needs and wants and can take steps to fulfill these by purchasing or otherwise obtaining the goods and services required to service these needs and wants.

The commodification of health as a consumer product is consistent with discourses of 'empowerment' in health promotion which seek to construct individuals as active agents able to take control of factors which will enhance their health and well being (Grace, 1991; Thorogood, 1992). Demands for the 'empowerment' of individuals by health activists appear to have been translated into what are commonly portrayed as sensitive and effective health promotion strategies. For Grace (1991:334), however, what has actually happened, is that health promotion discourses mask the collusion of health promotion with consumer capitalism. Health has become what Grace describes as 'market relations' rather than political challenge. Health activists have paradoxically become part of the health consumer enterprise which has dissipated the potential for political change in health related social processes:

The health promotion discourse dissipates the dynamism of these movements for change. It is ironic that a discourse which articulates a concern to promote health in the name of freedom and "wholeness" functions to alienate people from their capacity to engage in protest, and effectively operates to subject them to the

political and economic order (op. cit:341).

Grace suggests that the relationship of provider to consumer neutralises political opposition and resistance, with political struggles becoming redefined as struggles over market relations. Discourses of empowerment in this context often mask the paternalistic nature of health promotion activities. It can be argued also that health promotion discourses have appropriated the concept of 'empowerment' from the women's and self-help movements, turning it into a means to secure women's co-operation with health ideals.

Sociological critiques have therefore problematised the 'taken for granted' nature of health promotion. As a result, Lupton (1995:158) argues, it can be demonstrated that public health and health promotion are not socially neutral activities based on medical science but are in effect strategies of moral regulation. She suggests that they privilege a version of subjectivity which incorporates rationality and mind/body dualism. They also construct bodies as being in need of monitoring and control and represent specific social groups as the threatening 'other'. That is not to say that health promotion activities are a conspiratorial form of social control. They are, as Lupton suggests, sites of struggle over the meaning and control of body practices. Whilst health promotion draws attention to the 'sins' it seeks to control, it also creates pleasures associated with the rational, well managed body.

3. Health Promotion Discourses and Cervical Cancer.

The cervix has been the focus of health education discourses since the middle of the twentieth century. These intensified during the 1980s and 90s, particularly in response to the advent of the national cervical screening programme. Health promotion discourses in relation to cervical cancer have encouraged women to become aware of unrecognised needs which, if attended to, could save their lives. Attending for cervical screening has been constructed as a rational empowering act in response to a needing body. Not being screened has been represented as risky and potentially life-threatening. Posner (1991) argues that representing cervical screening as an issue of life and death is based on a fundamental deception in which lay fears are fostered for dubious medical objectives. Lupton (1995:94), suggests that health promotion activities deliberately aim to induce anxiety about disease in

individuals in an attempt to persuade people to present for screening. It can therefore be argued that 'empowerment' has become the handmaiden of anxiety in health promotion discourses.

The health promotion campaign, centred around the national cervical screening programme, was initiated and supported by the Department (later termed 'Ministry' of Health) and the Public Health Commission. Promotional strategies initiated by the Department included the use of television and magazines. In 1991, Gillian Grew, the Department of Health's National Cervical Screening Co-ordinator announced that a campaign on cervical screening was being initiated which primarily aimed to reach Maori women, women from Pacific Island communities, as well as women from older age groups. A media campaign which was described as 'a call to action' to mobilise these women formed part of the promotion of the national screening programme. Other parts of the campaign were based on the idea that women could encourage other women to have smear tests. This was to be achieved by having women speak to each other about cervical smears in a 'natural and good-humoured' way, to encourage each other to attend for screening (Burns, 1991:20-21). This health promotion technique can be seen as an attempt to 'normalise' cervical smears as a routine experience shared by all women who have similar needs and interests in relation to their bodies.

Cervical smear testing was relocated from the clinic into the homes of New Zealand women by the popular media, which in an anecdotal way, emphasised 'womanly', rather than biomedical discourse. Women's magazines, Maori media and television were the major means for reaching a broad cross-section of women (*Health*, 1993:13). In 1993, a publicity campaign utilising the popular media was initiated by the Ministry of Health. This campaign featured five women representing Maori, Pakeha and Pacific Island groups who were identified as 'helping to save their own lives'. These women were described as having had regular smear tests as well as being enrolled on the national screening register. The register in these advertisements was portrayed as a 'safety net' which helped women stay alive (NZWW, 1994:73).

Medical experts and prominent New Zealand women were also deployed in the

publicity campaign for the register, by speaking out about the benefits of the screening programme (Burns, 1991:21). An initiative was also launched which encouraged women to write letters to other women suggesting that they have a cervical smear (Clark, 1993). The 'letter to a friend' campaign initiated by the Department of Health provided women with ready-prepared letters explaining the importance of having cervical smears and enrolling on the national register. It was anticipated that women would send these letters to their friends, daughters, mothers and grandmothers (*Health*, 1991).

Advertisements which appeared in women's magazines promoting cervical screening and the national register sought to represent women as a homogenous group and in doing so to ameliorate differences of race and socio-economic status. Discourses of egalitarianism underpinning this approach ignored possible social differences which may contribute to the unequal distribution of rates of cervical cancer amongst women. Presenting cervical screening as the 'great leveller' deflected attention away from social inequality. What was emphasised instead, was the individual and collective 'need' of all women to monitor the health of their cervixes and present for screening. What was also implicitly stated was that women had their gender and their vulnerability in common. The national screening programme and its screening register were in this context, constructed as a 'safety net' to prevent women falling into the 'abyss of the unscreened'.

Central to this health promotion campaign, also, were discourses which advocated a biomedical solution to cervical cancer. The campaign's discursive strategies avoided references to possible behavioural changes women could make to protect themselves from cervical cancer apart from those which were medical in origin. These centred around co-operating with the screening programme by attending for screening and remaining on the 'opt-off' register. Despite the continued linking of cervical cancer with sexual intercourse in the medical literature (Munoz et al 1992), the health promotion campaign avoided reference to behaviours women could change in relation to their sexuality. Whilst medical discourses had for some years been emphasising the sexually transmitted nature of cervical cancer, health promotion discourses concentrated on 'marketing' a product which was sexually neutral. These discourses avoided for example, references to sexually 'promiscuous'

behaviours. Nor was any emphasis placed on the possible risk reducing potential of barrier contraceptives such as the condom or diaphragm in preventing the transmission of the causative agents implicated in the disease. Instead, cervical cancer was cleansed of its sexual history and reconstructed as a technical problem which required a biomedical solution. This aspect of the health promotion campaign was a deliberate and considered strategy. In 1990, a division of the Department of Health, (Health Education Services) produced a booklet entitled *Promoting Cervical Screening* in which advice was given to health workers who had the role of promoting cervical screening to women. This advice included ways in which information on cervical cancer should be presented to women. The Department emphasised that risk factors, especially those associated with sexuality, should be de-emphasised in health promotion activities:

An emphasis on so-called risk factors should be avoided. Cervical screening is the only known effective preventive strategy.

Specifically, sexuality should not be emphasised. Women may be shy about their sexual lives and not wish sexuality to be a subject for public discussion. If a link between sexual behaviour and cervical cancer is highlighted, having a smear test can appear to be a statement about a woman's own sexuality. This could deter some women from taking part in screening, particularly older women who are the most underscreened group (Department of Health, 1990:13).

This statement from the Department of Health echoed a recommendation from the National Cervical Screening Expert Group (NCSEG), who also suggested that educational programmes on cervical cancer should avoid any emphasis on risk factors. This was especially so in relation to linking cancer of the cervix with sexually transmitted diseases which the Expert Group feared could imply promiscuity and deter women from taking part in screening (NCSEG, 1990:38). Cervical screening has therefore been presented to women as the only feasible option to protect themselves against cervical cancer. Posner (1993) argues that in any screening initiative, participants should be in receipt of full information so that they can make decisions about whether they want to take part in a screening programme. By avoiding discussion of the sexual issues surrounding cervical cancer, the New Zealand health

promotion campaign can be described as paternalistic and disempowering. In the past, feminist health activists would have viewed paternalism of this nature as fertile ground for political activism. In the market oriented approach to cervical screening however, the perceived good of screening was constructed as the most desirable way to meet women's health needs. It can be argued that in this context, information on cervical cancer which was delivered to women was 'managed' to ensure that what was perceived by feminists and the Department of Health to be a desirable health product could be effectively delivered with little opposition. Singleton (1995:156) suggests that feminists and health activists have found themselves in a difficult position in relation to cervical cancer. As a consequence of their commitment to women's health needs they have found themselves unable to problematise aspects of screening programmes for fear of threatening the existence of screening initiatives.

Another significant feature of the health promotion campaign for cervical screening was that men were largely excluded from it. This occurred despite the fact that male sexual partners had been implicated in medical discourses in transmitting a virus identified as being responsible for cervical cancer (Paul et al, 1991; Munoz et al, 1992). To acknowledge the 'male factor' in cervical cancer would have meant acknowledging the possible sexual origins of the disease. This in turn would have thwarted the goal of constructing cervical cancer as a sexually neutral disease. Men's role in the health promotion campaign was divorced from sexuality and reconstructed as one of supporting and encouraging women to have regular cervical smears:

Men may need encouragement to see they have a role to play by being supportive, eg, by encouraging their wife or partner to have a smear test, or by offering to accompany her (Department of Health, 1990:17).

This construction of women's husbands or partners is reminiscent of historical constructions of men as agents of medicine in ensuring women complied with medical prescriptions. It also served to absolve men from any responsibility for a disease which women carried the total responsibility for preventing.

In support of its stance of avoiding discussion of sexuality in relation to cervical

cancer, the Department of Health (1990:17) clarified what it termed 'misleading media publicity' which it claimed had linked cervical cancer with sexuality. The Department blamed the media for leading some women to believe that they did not need to be screened and that by attending for screening they were confessing to sexual promiscuity. Media publicity was also identified by the Department as having been responsible for the 'victim blaming' of women who had developed cervical cancer. Such statements implied that constructions of cervical cancer as a sexually transmitted disease were largely generated by the media and as a result could be contested by the Department because they lacked the authenticity and authority of medical accounts of the disease. What the Department failed to acknowledge was that the popular media had in fact been representing established medical opinion which, since the 1980s had linked cervical cancer with sexual intercourse. The Department appears to have been unwilling to more directly contest the medical origins of these knowledge claims. Orthodox medical discourses on cervical cancer were incompatible with the aims of health promotion. Health promotion publicity aimed not to confront women with their personal responsibility for causing cervical cancer through their sexual behaviour but to encourage in them personal responsibility for keeping 'safe' through screening. The fact that media constructions largely reflected widely published medical beliefs on the aetiology of cervical cancer appear to have been ignored by the Department in its primary aim of creating a climate where as many women as possible would present for screening.

Whilst the media was criticised by the Department of Health for its representation of cervical cancer as a sexually transmitted disease, the same media was viewed as having an important function in promoting cervical screening. Health workers were encouraged by the Department to use a variety of means to draw women's attention to screening. These included using 'stunts' or 'gimmicks', 'eye catching photos', 'interviews with women who had abnormalities detected' and 'talkback radio' (Department of Health, 1990:18-19). Mass media campaigns for the purposes of health promotion frequently fail to achieve their aim according to Lupton (1995) because they often have the over ambitious aim of persuading people to give up pleasurable activities or take up others they have avoided. She also suggests that they often conceptualize the audience as naïve. However the use of the media is strategically important to the state in that it demonstrates that state actors consider

a health issue to be a 'problem' and are taking action on it. The state through this means appears to be active, authoritative and responsive to the needs of the public. This is likely to have been the case in relation to the cervical cancer campaign given the level of controversy and public concern which led to its inception. The discursive strategies of such campaigns often centre around the concept of 'risk' with an implicit message that the warnings given are for the benefit of the public who must need to heed the advice. The state is able to be seen to have performed its duty in the interests of public health by locating the causes of ill-health at the level of individual responsibility. For Lupton (1995:129) the use of the mass media for health promotion is a largely conservative pedagogical activity of dubious worth:

...it is a politically conservative pedagogy which generally uncritically accepts its objectives and is directed towards infusing audiences, seen as empty vessels, with knowledge, rather than a pedagogy which is oriented towards encouraging critical thinking and challenging of the status quo.

Lupton links the use of the mass media in health promotion with some forms of commercial marketing in that these discourses attempt to unsettle their audience with messages of decay and death. These messages aim to promote the consumption of goods and services for the management and maintenance of the self. These very public discursive strategies also promote a binary distinction between those who follow the advice being given and those who do not. Individuals who attend for screening are identified as responsible, rational and healthy. Those who do not are exposed as irresponsible, irrational and unhealthy. This has particular implications for groups who are defined as 'priority' groups in that they are implicitly constructed as problematic and requiring a high level of attention by health agencies. Oppositional discourses are difficult to mount under such circumstances because health promotion messages which appear in the mass media are usually sanitized of any controversy or uncertainty. They present what are constructed as rational truths about bodies and about biomedicine in an unequivocal manner. Underlying such messages however is often a high degree of uncertainty as to why illness occurs and how it should be prevented or treated. The mass media campaigns for cervical cancer for instance did not mention the potential for errors in the cytological analysis of smears or in the taking of the smears. Informing the public about uncertainties was

regarded as unhelpful and contrary to the goals of promoting screening. This aspect of the health promotion enterprise is indicative of the inherent paternalism of many health promotion campaigns.

The gendered nature of health promotion strategies in relation to cervical cancer became apparent when men wished to be part of the prevention programme. Those men who responded to the increased publicity around cervical cancer and also wanted to be screened for the wart virus implicated in biomedical constructions of the disease, encountered difficulties in doing so. Armstrong (1988:15) reported that when her partner requested an examination and colposcopy of the penis for the wart virus, he had difficulty locating a doctor who would carry out these procedures. One gynaecologist was reluctant to perform a biopsy on her partner's penis to check for the virus because he had never done this procedure before even though he had previously encountered male patients with the condition. He was also reluctant to carry out a biopsy because he was concerned about the level of pain he would inflict. This led Armstrong to compare her partner's experience with that of women who are routinely offered cervical biopsy without a comparable degree of concern on behalf of the medical profession.

Another area which received little emphasis in health promotion discourses in relation to cervical cancer was the potential for screening to produce false positive or false negative results. In a pamphlet published by the Cervical Screening Programme, Public Health Service, Wellington Region (1993) entitled *Understanding Cervical Smear Test Results*, women were informed of a range of issues related to smear tests. These included the role of the human papilloma virus and the range of abnormal results which could indicate changes to the cervix. Whilst 'unsatisfactory or less than optimal smears' were alluded to in the pamphlet in terms of factors which interfered with smear taking, such as mucus or blood, no mention was made of the potential for false positive or false negative results. In 1994, *Broadsheet* acknowledged that women had a right to be informed of the risks of false negative smears. The national cervical screening programme was identified by *Broadsheet* as being in a process of reviewing literature on cervical smear testing to ensure information was not being promulgated which overstated the value of cervical smears (*Broadsheet*, 1994:15).

The construction of 'at risk' groups in relation to cervical cancer involved special attention being paid to Maori women in promoting screening. They were singled out as a group who needed an especially sensitive approach to the way information was presented about cervical cancer:

Many women have little knowledge of their anatomy and are bewildered by technical language and medical jargon. There needs to be translation of medical terms into simple language and local vernacular (Manihera and Turnbull, 1990:458).

Education of Maori women was identified as needing to address the issues of stigma associated with cervical cancer because uncleanliness and sexual promiscuity were considered to be linked with the disease in the minds of young Maori women. As these women were considered to be an especially 'high risk' group, this was considered to be of concern in relation to the aspirations of the screening programme:

If it was understood that the initiating factor came from their male partner and may occur as a result of their first, and possibly only, sexual contact, some of the guilt and reluctance to come forward for screening, may be overcome (ibid).

Maori women were sought to promote cervical screening to other Maori women. Maraea Nia Nia, the cervical screening programme Maori co-ordinator for Healthcare, Hawkes Bay, identified her task as increasing the numbers of Maori women having cervical smears. One of the impediments to achieving this aim was that cervical smears involved the most tapu area of Maori women's bodies. Health promotion strategies involved attempts to reach Maori women through community groups where education sessions were held. Flyers were put up in shop windows and leaflets on cervical screening were distributed in supermarkets for customers to take away. In Flaxmere, employers assisted the campaign by inserting flyers into workers' pay slips (*Healthy Lives*, 1994a:9).

In promoting cervical screening to Maori women, the Ministry of Health was careful to avoid any connection between what they stated as being the comparatively high

rate of cervical cancer in Maori with sexual behaviours. The Ministry in its more recent publicity material stated 'that there was no explanation' for the higher incidence of cervical cancer in Maori women (*Health*, 1995:9). In doing so the Ministry once more reconstructed cervical cancer as a sexually neutral disease of unknown aetiology. It not only challenged the prevailing medical orthodoxy on causes of the disease but succeeded in this construction to divorce cervical cancer from its social location. The possible role of socio-economic factors in the uneven statistics of cervical cancer were not explored. Instead Maori women were presented with little information as to why they were singled out as a 'targeted' group. They were however reminded of their individual responsibility to prevent the disease.

Pacific Island women have been similarly targeted as a high risk group in relation to cervical cancer. 'Word of mouth' and community based education sessions have been used to promote cervical screening to this group of women also (*Healthy Lives*, 1994b). Also targeted were mid-life and older women (those over 35 years) who were perceived to be less likely than younger women to visit health clinics and doctors for family planning and for the care of children (*Health*, 1995; NCSEG, 1990). These women were also considered to be less likely to visit general practitioners or family planning clinics for matters which required a vaginal examination. They were also thought of as women who were likely to have a high probability of being less well-informed in comparison to younger women on cervical cancer and to have misconceptions, embarrassments and apprehensions about cervical screening (NCSEG, 1990:29).

4. Gendered Sensibilities and the Construction of Subjectivities.

Central to the promotion of cervical cancer was the construction of women as a group with specific 'needs'. Lampe, an advisory officer for the Ministry of Women's Affairs highlighted the importance of the national screening programme being 'sensitive to women's needs' (Keene, 1988:18). The Report of the Committee of Inquiry also noted the importance of paying attention to women's sensitivities in relation to the screening service being offered. This report stressed that the service should not be 'intimidating, embarrassing or extremely uncomfortable' and that results needed to be communicated to women in a supportive and non-threatening atmosphere. The Cervical Cancer Inquiry also suggested that recall systems, involving personal

contact with women, should be staffed by women (Committee of Inquiry, 1988:209). Discourses constructing women as a gendered group with special sensibilities in relation to the provision of health care, is indicative of a number of social trends. Primarily, it indicates the cooption of feminist constructions of women into mainstream discourses, especially in terms of the development of health policy. The emergence of women as a collectively subjective and experiential group in relation to cervical cancer screening represents a construction of women which conforms to the ideals of the new public health and the concepts of health promotion of the late twentieth century. Theories of the social production of health and disease which form the basis for the new public health also provide the basis for the social management of populations in the interests of health. Whilst the 'old' public health focused on risks outside the individual the 'new' public health focuses on human agency and risk.

Constructions of women as requiring a cervical screening programme 'sensitive to their needs' has provided the justification for an intensely personal and individualistic approach to the provision of a health service. Winning the minds as well as the bodies of New Zealand women has been central to the screening campaign but understanding these minds in order to manage them was an initial priority. To this end, health workers have been advised when talking to groups of women about cervical screening, to invite audience participation to 'find out where your audience is coming from'. Uncovering women's 'attitudes' and 'concerns' has been a priority of the campaign (Department of Health, 1990:15). This 'personal' approach has extended to the letters women receive when they are automatically enrolled on the cervical screening register. These letters 'welcome' women on to the screening programme and thank them for 'taking part', by having a cervical smear (Gavigan, 1992:1). The subjective woman is welcomed into the community of the screened.

Constructions of femininity in relation to the cervical cancer screening programme have not been essentially different from constructions which have been pervasive throughout the history of western medicine. The implication that women are inherently frail and unhealthy and in need of medical management has always been part of Western biomedicine (Ehrenreich and English, 1976). Health promotion discourses which encourage women to take responsibility for maintaining their own safety in relation to cervical cancer are in keeping with historical constructions of

women as vulnerable and at the same time responsible. There are similarities too in relation to historical efforts at controlling venereal disease and those aimed at controlling cervical cancer. Measures such as the Contagious Diseases Act have been identified by Kehoe (1988:39) as indicative of attempts to make women responsible for a disease transmitted by both men and women. She also argues that health promotion discourses encourage women to take responsibility for birth control and for the use of condoms to prevent AIDS. Historically women have not only been responsible for the safety of themselves but for others as well. Kehoe suggests that beliefs that men cannot control their sexuality pervade discourses on the control of sexually transmitted diseases and on birth control. The difference between the campaign for cervical screening in relation to earlier campaigns focusing on sexually transmitted diseases, has been that this recent initiative deconstructed the sexual location of cervical cancer. Cancer of the cervix was reconstructed as a technical problem requiring a medical solution which women were responsible for accessing. However, Posner (1991:181) argues that cervical screening emphasises the historical tendency for women to carry the weight of society's guilt about sexual freedom. She suggests that the physical state of a women's cervix potentially reveals hidden defects which symbolically expose secret, sexual transgressions which are magnified in the medical examination. In removing cervical abnormalities, sexual transgressions are symbolically absolved, comparable to the religious experience of receiving absolution after the confession of sin. Cervical screening can also be viewed as being indicative of the disciplining of bodies to erase imperfections. Abnormal cervical cells are indicative of a disorderly out of control body, if not in the sexual sense, at least in the cellular sense. Cervical screening can therefore be described as a form of ritual surveillance, cleansing and ordering of the body.

Health promotion discourses have added a new dimension to historical notions of femininity by constructing women as being able to be 'empowered'. As Grace (1991) suggests, discourses of empowerment and discourses of marketing are closely linked in that individuals are encouraged to identify their own health needs in the process of becoming a health 'consumer'. Whilst health needs appear to arise out of the empowered consciousness of the individual, Grace suggests that such needs actually arise out of the pre-determined agenda of the health promotion project. This is particularly evident in the cervical screening campaign where decisions were made

about the type of knowledge women should be exposed to. Women were only alerted to needs which conformed to the agenda of the health promotion campaign. They were not alerted to issues related to sexuality and cervical cancer. This stance was legitimated by constructions of women as having 'sexual sensibilities' which would translate into embarrassment, guilt and shyness if sexual activity was linked in health promotion discourses with cervical cancer. Only 'empowering' needs were therefore emphasised in the screening campaign. Women were not constructed as having needs in relation to knowledge about the possible sexual nature of cervical cancer nor in relation to the limitations of the technology of screening which sometimes provided them with inaccurate smear results.

Being aware of the special sensibilities of what were identified as 'priority' groups was an important part of promoting cervical screening. Maori women were constructed as 'tired of hearing unfavourable statistics about their health' and health educators were urged to promote screening by adopting a 'positive approach' (Department of Health, 1990:20). The primary aim of this 'positive approach' was to increase the screening rates of Maori and Pacific Island women. Attempts were also made to identify the cultural sensibilities of these groups and to use these as a basis for promoting a new 'need' which consisted of the imperative to access cervical screening services. For some commentators, such an approach is inherently racist because it relies on a socially constructed view of what it means to be a 'Maori' or 'Pacific Island' woman. They argue that constructing groups as 'homogeneous' and undifferentiated can result in poor health 'status' being linked with ethnicity and race (Douglas, 1995). Maori women have for instance been consistently identified in the medical as well as popular media as being less likely to co-operate with smear taking regimes when compared with non Maori women (Cox et al, 1994; *The Dominion*, 1993; *Health*, 1995; Robyns, 1991; *Te Maori News*, 1992). Factors such as low socio-economic status which may be common to many groups in society and adversely impact on health, are often not linked to the particular health issue in question, whereas race and ethnicity clearly are. With its focus on individual lifestyle and behaviours, health promotion often appears to do little to address the issues which have accorded groups priority status in terms of health promotion initiatives:

Health promotion programmes must be developed within a wider organisational

framework that has equality and equity as core values. This said, it must also be recognised that health promotion in itself cannot overturn the injustices in society as a whole that contribute to the racism and discrimination that affects the health of black and minority ethnic communities. Health promotion can only be part of a much wider movement towards a just and fair society (Douglas, 1995:77).

Constructing all women as having a need for regular cervical smear testing has deflected attention away from any responsibility males may have for maintaining or monitoring their 'sexual health'. This view ensures that the pervasive historical construction of women as responsible for their own health and for the health of others is maintained. Despite being implicated in medical constructions of causes of cervical cancer, no health promotion initiative has made men a 'priority group'. No programme has been established to ensure that men adopt barrier methods of contraception to avoid transmission of what is believed to be the causative agent of a serious life threatening disease. Nor have men been constructed as having a 'need' for penile screening. In response to queries as to why women rather than men have been targeted for health initiatives, the Department of Health has responded by suggesting that women are a 'disadvantaged' group in relation to cervical cancer and that they had as yet unmet needs (Samson, 1992:3).

5. Resistance to Cervical Screening

The term 'resistance' in Foucauldian theory, tends to conceptualize struggle at a micro-level with individuals failing to acquiesce, consent or conform to the disciplines of the body. Resistance from this perspective is at the level of sometimes barely perceptible routine daily actions in the form of contesting or not conforming to ordinary prescriptive dictums (Lupton, 1995:133). Resistance to cervical screening may be evident in a range of behaviours, such as opting off the screening register, not attending for screening from the outset, ignoring prompting letters to do so and not keeping medical appointments. However, statistics for the national screening programme suggest that there has not been widespread resistance to this screening initiative. Although the rates of registration on the national screening register are variable regionally, 76 per cent of all women in New Zealand between the ages of 20 to 70 had their names on the register by July, 1996 (Ministry of Health, 1996). The lack of total compliance with the register despite extensive publicity suggests that a

level of resistance does exist. One woman was identified in the media as opting out of the programme because she saw it as challenging her sense of autonomy:

Some of them like Helen Holbrook of Wellington, have opted out after initial enthusiasm. She was angered by the time the doctor took to enrol her -"10 minutes out of the 15-minute consultation I was paying for". Later she received a reminder notice a smear was due after she had it early. "I can take control of my own body," she says, "and we can't afford this sort of extravagant duplication" (Dekker, 1994:18).

However such public expressions of dissent have been relatively uncommon in both the popular and feminist media.

Discourses of resistance have however emerged in relation to cervical screening from a number of sources in recent years. Whilst not actually recommending that women do not attend for cervical smear testing, these discourses problematise the unalloyed good which is typical of much of the medical and health promotion constructions of cervical smear testing. The benefits of cervical screening have for instance been contested by sociologists who have identified screening as a form of surveillance medicine which they argue has increasingly targeted healthy individuals (McKie, 1995; Posner, 1991; Posner, 1993). These commentators, argue that cervical screening is a form of secondary prevention aimed at locating medically-defined disease in which there is pathology but no symptoms. Secondary prevention is the process of looking for disease where ostensibly none exists from the point of view of the individual. It is the process by which medicine seeks out patients and as such is a reversal of the traditional doctor-patient relationship (Posner, 1993). For many women, the benefit of cervical screening lies in their receiving a negative result and an assurance that the cervix is healthy and free of cancer. Medical definitions of reality, however, override women's subjective experiences of their bodies as healthy, when they are told that their smear test is positive:

In medical terms, the patient's view that she is well is mistaken and needs to be overridden for her own good (Posner, 1991:170).

This occurs within a context of all women being defined as 'at risk' of contracting cervical cancer as a result of what McKie (1995:442) describes as 'medical uncertainty'. Posner (1993:57) suggests that 'normality' can be defined in different ways for different ends, with statistical, clinical and prognostic normality not necessarily being coincident. She suggests that in relation to cervical screening an operational definition of what is normal may vary slightly from one place to another.

Several commentators have suggested that cervical screening and treatment of abnormalities involves an unacceptably high level of stress and anxiety for women (Britten, 1988; McKie, 1995; Posner, 1991; Posner, 1993; Posner and Vessey, 1988; Lupton, 1995). A positive cervical smear may result in women having a colposcopic examination and removal of what have been medically defined as 'abnormal cells'. The relationship between a woman and her doctor under these circumstances, becomes a relationship between the doctor and a woman's body as her subjectivity becomes overridden by a narrative of cytological abnormality:

She has been picked up by the cervical cytology screening programme as being potentially diseased and currently her cervix is in an ambiguous anatomical state-it has abnormal cervical cells. At this point in time, she may well feel very uncomfortable physically and emotionally distressed, helpless and anxious. This apparently threatening and pathological development has taken place without her being aware of it (Posner, 1993:59).

As McKie (1995) and Posner (1993) suggest, although women may present for cervical screening to achieve a sense of reassurance that their bodies are normal and cancer free, such reassurance may not be forthcoming. Women may in fact find themselves exposed to pain and anxiety as well as experiencing the stigma associated with the sexual implications of having a positive smear. This is still likely to occur despite health promotion strategies which aim to dispel such associations. A disparity had also been identified by Posner and Vessey (1988) between lay and medical objectives in relation to cervical screening. They suggest that women present for screening so that they can feel assured that they are engaging in safe behaviour and also in the hope that their smear test will be negative. In the absence of overt symptoms and in receipt of a normal smear result, a woman may relax in the

expectation that her cervix is healthy until she receives a reminder from the screening register that her next smear test is due. Women have no way of knowing whether the reassurance of a negative smear test is based on rational, error-free data or whether they are still at risk because of technical error in the smear taking or cytological examination. With the possibility of false negative results occurring, women may remain unconvinced of their bodily normality.

The cervical smear test is therefore a procedure in which women remain entirely dependent upon the reality which is constructed for them by the medical encounter. Women's verbal accounts of their bodily experience of the cervix, count for nothing in the face of medical technology. The cervix remains unintelligible to women but highly intelligible to cytologists and the medical profession. It is the medical profession who make decisions about the medical classification of the cervix and through this process, it is doctors who imply an unspoken moral classification of women, given the still pervasive linking of cervical cancer with sexuality. Women are left to accept the technical rationality of the truth of the smear test and to deal with the implications of the moral truths that accompany it. Posner (1993) concludes that whilst screening programmes may be worthwhile for populations as a whole they may not be beneficial for individuals who participate in screening. She suggests on ethical grounds that participants should be given full information about screening tests so that they are able to give informed consent when participating in screening programmes. She concludes that women need to be given pre-screening information about the nature of the test, the risks and benefits of screening and information on the post-screening options. This would involve the medical profession in being honest about areas of uncertainty and acceding to women's right to make decisions about health actions they wish to take. This kind of approach conforms to the original platform of feminist health activists who constructed women as having the right to know and control their bodies. Cervical screening has also been seen to take place within a context of women's sexual activity, cervical screening targets and of unequal power relations between patient and professional (McKie, 1995). McKie contends in relation to cervical screening that underlying assumptions are made that women are heterosexual and that they have not been previously traumatised by experiences of sexual abuse or trauma.

Discourses of resistance in relation to cervical cancer have also emerged from Marxist commentators who argue that screening programmes are based on epidemiological data which obscures the effects of disease on individuals. They suggest that medicine has focused on women's sexuality to the detriment of a class-based analysis of cervical cancer mortality. In particular they argue that the most submerged data of all in relation to cervical cancer has been the effects of poverty and the health risks associated with industrial pollutants to which women are exposed either as a result of their occupations or the occupations of their husbands:

Moreover, we still have no data at all to help us unravel those concomitants of poverty such as physical or financial access to a daily bath or shower, a washing machine and a change of clothes after work which may be necessary social conditions for cervical cancer to flourish (Davey, 1988:33).

Feminists can be said to have engaged in resistance to the medical power which opposed the establishment of accessible screening programmes for women in the first place. However, feminists have not substantially challenged aspects of cervical screening which have been critiqued by other social commentators. The lack of problematising of cervical screening programmes by feminists it is argued, resulted from, as previously noted, their ambivalent position in supporting screening initiatives and at the same time being reluctant to jeopardise them in any way. Robinson (1987:51) has criticised feminists for not adequately discussing the ethics, efficacy or adverse effects of screening. She suggests that feminists were not sufficiently active in asking why the medical profession had advocated screening in Great Britain and at the same time had 'filtered' information on cervical cancer. She argues that information about cervical cancer being linked to sexual promiscuity reached the public forum whereas information linking cervical cancer to the risks of male promiscuity, the textile industry for women workers, men's dusty jobs and the contraceptive pill, had not. Ambivalence is also evident in the ways in which feminists have constructed women who do not avail themselves of cervical screening. These constructions differ little from medical definitions of the non-attender as lacking in knowledge or as fearful of the screening process or its consequences. Singleton (1995:157) suggests that imputing ignorance to women who do not participate in cervical screening undermines the basis of their decision not to take part. The

tendency of some medical professionals to define women who do not attend for screening as 'recidivists' is suggested by Singleton to convey to women that not being screened is at best socially inappropriate and at worst immoral. She points out the contradictions in the lack of resistance of feminists to aspects of cervical screening programmes:

...feminists and women's health writers find themselves, at one level validating the very definition of woman - as ignorant - that they are, at another level, problematising. It is interesting that it seems to be, on the whole, only a few male medical professionals who consider women's non-attendance as a valid response and the dissolution of the CSP (British Cervical Screening Programme) as a reasonable option (Singleton, 1995:158).

The concept of 'empowerment' in relation to screening programmes has come to mean, attending for screening. In contrast, 'empowerment' in feminist discourses has usually been linked with resistance rather than co-operation with biomedical ideals. Singleton suggests that 'empowerment' in both feminist and medical discourses has come to be primarily associated with co-operating rather than countering the idealised views of healthy and rational behaviour epitomised in presenting for cervical screening.

Whilst some women may resist cervical screening at the micro-level of day to day actions, Lupton (1995:156) suggests that these forms of resistance do not challenge the contingent and political nature of public health knowledge and 'truths'. Paradoxically the political vacuum left by feminists has been filled by a small minority of medical commentators and sociologists. The unalloyed good of the national cervical screening programme remains however relatively uncontested.

6. Conclusion

This chapter has problematised the taken-for-granted nature of health promotion discourses and applied this analysis to health promotion strategies for the national cervical screening programme. This analysis shows that health promotion discourses in relation to the cervical screening programme have constructed sexually neutral 'truths' about cervical cancer in the interests of encouraging women to attend for

screening. This is despite cervical cancer having continued to be imbued with sexual meanings in medical discourses. In 1995, cervical cancer was still being described in the medical literature as a disease in which risk factors were: early onset of sexual activity, multiple sex partners and women having partners who themselves had many sexual partners (Elwood, 1995:35). Health promotion strategies, centred on cervical cancer, attempted to refocus the moral implications of the disease from sexuality to screening. Presenting for screening has become the morally appropriate action for any woman who has been exposed to the facts about cervical cancer. Allowing a 'safety net' in the form of the national screening register to become an expected part of life and keeping 'safe' have become moral imperatives associated with screening. Instead of emphasising women's sexual behaviour, health promotion discourses have focused on women's gender, age and ethnicity as qualifying attributes for concern about cervical cancer.

It is unlikely however that attempts at the deconstruction of the sexually located biomedical model of cervical cancer have been more than minimally successful. Many women, through exposure to both the medical and popular media have been well aware of the linking of cervical cancer with sexuality and sexual promiscuity since at least the 1980s. By making women responsible for having a smear test and becoming part of the national screening register, health promotion activities have implicitly reminded women of their dual responsibility for monitoring their sexuality as well as their screening behaviours. Self-blame for having failed in either is now a likely outcome of this process for at least some women. Despite the efforts of the health promotion project, cervical cancer continues to retain its moral meanings. The cervical screening register can therefore be regarded as a 'sexual register'. By having a cervical smear, women are acknowledging that they have had sexual intercourse and in situations in which women are represented as having a positive smear, that they or their partner may have had multiple sexual partners. Whilst many of the taboos against women having pre-marital sex may have dissipated, social disapproval still exists for women who are viewed as transgressing norms of an appropriate number of sexual partners.

The linking of cervical cancer with sexuality was considered to be especially problematic in relation to 'priority' or 'underscreened' groups. These were women who

were most likely to be in the category of 'never been screened' and represented those who were targeted for health promotion strategies. This targeting of specific groups made it even more imperative that cervical cancer be deconstructed as a sexual disease and the screening process itself be divorced from definitions which identified it as a form of medical surveillance of sexual habits.

Constructions of screening as a 'safety net' for a technical, biological problem effecting women of all ethnic and socio-economic groups neutralised possible accusations of racism and classism. The marketing of cervical screening as a health service responding to women's subjectivities also served to neutralise any potential political antagonism to targeting initiatives. Involving women from Maori and Pacific Island groups in the health promotion process, ensured that the cultural sensibilities of women from these groups were acknowledged and catered for. It also meant that the marketing of screening occurred within a context of consumer to consumer contact which gave the impression that the need for screening had arisen from the wishes of the 'priority' groups themselves. Word of mouth education ensured that cervical screening was presented to women in these groups in a way which emphasised the interpersonal and anecdotal and deemphasised the sexual, technical and biological.

Cervical screening can be viewed as representing the utilitarian imperative of the new public health. Women unaware of the disciplinary nature of the mass screening initiative have responded to the benevolence of a medical service which aims to change their behaviour and inform them of the risks associated with their bodies. As Lupton (1994d:32) suggests, individuals exert disciplinary power over themselves through self regulation. The power relations associated with these everyday acts often remain invisible. As a result, screening for cervical cancer remains a relatively uncontested form of medical intervention. Resistance to cervical screening has been evident from members of the medical profession and more recently from sociologists who have identified it as a means of monitoring women's bodies and sexuality.¹⁹ This has led to calls overseas for a more critical examination of national screening

¹⁹ See Chapter Eleven for a discussion of the basis of medical opposition to the national cervical screening programme.

initiatives and for a more ethical approach in informing women of the risks and benefits of cervical screening. Feminist resistance to the cervical screening programme has been muted within a context of wanting to both support this health initiative and at the same time problematise aspects of it. Feminists have unwittingly found themselves contributing to the medicalisation of women's bodies and coopting medical discourses in constructing women as participants and non-participants in the programme. Feminist discourses of 'empowerment' have been coopted by health promotion in constructing screening as a choice in managing risky bodies.

This chapter has revealed a number of paradoxes in the promotion of the national cervical screening programme. These paradoxes are revealing of the socially located nature of health promotion and, whilst they are not suggestive of conspiratorial intent, they are informative of the ways in which discourses construct objects of interest. They are also instructive of the way in which power operates in a productive manner, providing the promises and pleasures of a disease free body and at the same time producing pain, anxiety and powerlessness.

CHAPTER THIRTEEN

Conclusions to a Socio-historical Study of Cervical Cancer.

1. Introduction

This thesis has developed three broad themes in its study of cervical cancer. The first concerns the nature of medical knowledge, the second, the operation of medical power on women's bodies and thirdly the object/subject dichotomy in which women are objects of medical inquiry and at the same time shape medical inquiry as active subjects. These themes have been developed through a critical analysis of medical, feminist and popular discourses on cervical cancer from the 1890s to the 1990s. This final chapter summarizes the major theoretical insights which have emerged from this thesis.

2. Medical Discourses and the Nature of Medical Knowledge About Cervical Cancer

This thesis has shown that medical knowledge about cervical cancer has not arisen out of enlightened scientific discovery but has arisen out of the socially located interaction between knowledge and power. It has shown that women's bodies have been the contested sites for knowledge/power and that the cervix and its diseases have been constituted as variable medical artifacts throughout specific historical periods. This thesis has departed from orthodox histories of cervical cancer by problematising the biological basis of the disease. It has subjected discourses on cervical cancer to a sociological analysis which has revealed their historical specificity and their socio-political location. The insights of Foucault in relation to the operation of power on bodies have been central to this thesis in concert with feminist views of the centrality of gender to an analysis of the body. Foucault's perspective of the social field as a network of intersecting practices and discourses with shifting power relations (Sawicki, 1991:80) describes the way in which the concept of power is applied in this thesis.

This thesis has shown that at the turn of the century medical knowledge about cervical cancer arose out of a complex interplay of sociological events and issues. The mothering bodies of New Zealand women became the contested sites for the professionalising aspirations of the medical profession and the repository of societal

anxieties about women's changing roles and concerns about a diminishing population. The cervix was constituted as a vulnerable organ, traumatized by the birthing process and in need of extensive surveillance by the medical profession. Demands by women for relief from pain contributed to the medicalisation of birth and, it can be argued, the surveillance of the cervix. This construction confirmed birth as a medical event strongly associated with pain and illness. It also confirmed the medical profession as the scientific guardians of women's bodies and located women within discourses of bodily illness and vulnerability.

During the mid-twentieth century medical constructions of cervical cancer were transformed under changing professional and social circumstances. This resulted in a refocussing of the operation of power on bodies. Cervical cancer left the mothering bodies of New Zealand women and became known and understood as a disease of all women. In doing so it became the focus of preventive strategies as general practitioners and the state began increasingly to monitor healthy bodies. Constructed as rational monitors of their own bodies and the bodies of their families, women were increasingly exhorted to carry the gaze of medicine into the home and into the community. Cervical screening was viewed by general practitioners as an important means to elevate their professional standing. This thesis argues that constructions of cervical cancer during this era reflected not only professional interests but also reflected a focusing of medical power on women as they pursued expanding roles in the community.

This thesis has shown that during the latter years of this century, sexualised accounts of cervical cancer began to emerge in medical discourses which focused on the sexually active bodies of New Zealand women. This thesis argues that cervical cancer became a metaphor for social anxieties about women's increasing sexual freedom and what was termed 'promiscuity'. The rise in venereal disease and exnuptial pregnancies as well as the increasing rates of cervical cancer were considered to be evidence of women's immorality. Moral constructions of cervical cancer however invited a form of power which excluded and silenced women when the imperative of the clinic was to invite participation and discourse, particularly in relation to cervical screening. Increasingly cervical cancer was reconstructed as a technical problem inviting medical rather than moral solutions. Understanding the

subjective woman behind the technically flawed cervix became the focus of 'patient centred' medicine. Medical power operated by encouraging women to speak their needs and by ensuring that they understood the medical 'truths' about their bodies.

The socially negotiated nature of medical knowledge in relation to cervical cancer has also been demonstrated in this thesis by an analysis of the epistemological disputes which emerged between the 1960s and the 1980s. Women's bodies became the site for struggles over contested knowledge claims. This thesis has argued that it was not science which brought closure to these disputes but factors external to science which involved state actors, feminists and the medical profession. Similarly, this thesis has shown that the development of medical technology in relation to cervical cancer has been a socially negotiated process in which factors external to medicine have played a part. These technologies have largely been accepted on the basis of their being able to be absorbed into existing practice.

In summary a number of theoretical insights emerge from a sociological analysis of medical discourses within these three historical periods. Firstly, cervical cancer is shown to be socially located and secondly medical power is shown to operate on the bodies of women. Most importantly the traditional view of cervical cancer as a biological given is challenged.

3. The Operation of Power on Women's Bodies.

This thesis has argued that women's bodies have historically been the focus for the exercising of disciplinary power. It has pursued this theme not from an understanding of power as having a discrete or unified origin (for example emanating from patriarchy), but from a Foucauldian perspective of power as having multiple centres and origins. This thesis has shown that power mobilised around cervical cancer has been both repressive and productive. As a result of the disciplinary technologies which have emerged in relation to cervical cancer, new norms of rational, responsible femininity have been created. In self-help discourses, a positive smear test has been constructed as a personally transformative experience inviting the examined, more fully lived life. Women's bodies have been made productive in their consumption of medical products and services which have emerged in support of the diagnosis and management of cervical cancer. Women have been recruited to support other

women to 'consume' these products and services. By having regular cervical smears, women are also involved in ultimately protecting their fertility and their lives from a disease which could, if left unmonitored, rob them of both.

This thesis has argued that the disciplinary technologies which have been mobilised around cervical cancer do not operate through coercion but through the creation of new norms of femininity. The rational, responsible and informed woman who has her cervix registered is an example of this new subjectivity. Women have been offered solutions to the problem of the cervix and have been encouraged to become rationally empowered in availing themselves of these medical solutions. This thesis has shown that health promotion discourses centred around cervical cancer have invited women to construct themselves as physically vulnerable and yet at the same time empowered enough to take control of this tendency to illness. This empowered subjectivity contrasts with coexisting subjectivities associated with promiscuity in medical discourses which invited a coercive form of power. Sawicki (1991:85) suggests that the normative focus of disciplinary power has advantages over a coercive model of power in pursuit of the disciplined body:

If patriarchal power operated primarily through violence, objectification and repression, why would women subject themselves to it willingly? On the other hand, if it operates by inciting desire, attaching individuals to specific identities, and addressing real needs then it is easier to understand how it has been so effective at getting a grip on us.

This thesis has also argued that disciplinary technologies related to cervical cancer have been repressive. Women have not been fully informed about the potential for smear testing to generate false results and have therefore been under an illusion that by attending for smear testing they are assured of a healthy cervix. Women's right to know about sexual theories of causation in relation to cervical cancer has not been honoured in health promotion discourses which have sought to sexually neutralise the cervix. Historically, some of the practices around the diagnosis of cervical cancer can be said to have robbed women of their fertility, their dignity, their health and even their lives. The events at National Women's Hospital have been indicative of the most extreme form of repressive disciplinary power which has emerged in relation to

cervical cancer.

4. Cervical Cancer and the Subject/Object Dichotomy

A third important theme which this thesis has pursued relates to the ways in which women have been constructed as objects of medical inquiry and at the same time have been active agents in shaping medical responses to cervical cancer. This theme is most sharply defined in discussions of feminist discourses on the cervix and cervical cancer. It is argued that feminists have contributed to the medicalisation of women by identifying the body as central to a political platform of freedom from male oppression. Activities such as self-examination of the cervix and self-help health initiatives aimed at empowering women, constituted the body as a political artefact which required monitoring, if not by the medical profession, then by women themselves. It is argued that feminists challenged medical epistemologies whilst at the same time appropriating them. Women became 'knowers' of their bodies but did so through a feminist transformation of the medical gaze. Feminist constructions of 'empowered' women included having access to medical services which were considered to be beneficial to women. Cervical screening was one of these services. This thesis has shown that feminists found themselves in a paradoxical position of not problematising aspects of the national cervical screening programme, such as the 'opt-off' register, which could have been regarded as 'disempowering' of women. This paradox arose out of the contradiction of feminists being unwilling to challenge a medical initiative which was considered to be for the good of women. It is argued that constructions of cervical screening as a medical technique of unalloyed good, have tended to depoliticise the field of relations around cervical cancer. Cervical screening has, through health promotion discourses, been privatised as a matter between a woman and her doctor. Issues of gender and class which may have relevance to the prevalence of cervical cancer have remained largely unexplored by social commentators. Issues associated with race have emerged largely in relation to epidemiological discourses which have targeted specific groups for a greater level of surveillance.

This thesis has argued however that whilst medical discourses on cervical screening have constructed new subjects, such as the 'screened', the 'unscreened' and the 'at risk', it has also created new sites of resistance. Women have been able to refuse

compliance with exhortations to attend for screening, to opt off the national register and to complain about the type of service they receive from the medical profession. Women have also been able to voice resistance to sexualised subjectivities apparent in medical discourses and to call for screening to target men as transmitters of the papilloma virus (McIntosh and Stone, 1988). However women's resistant discourses have had to compete in many instances with more dominant discourses which have established alternative 'truths'.

5. Conclusion

This thesis in its socio-historical study of cervical cancer lends support to the argument that medicine is not distinct from the social. On the contrary, this thesis has shown that historically, medical 'truths' about cervical cancer have been embedded in the social. A feminist-Foucauldian analysis of cervical cancer has revealed the ways in which modern forms of power operate on the bodies of women. It has also revealed the ways in which women have been active participants in the disciplining of their bodies. The medical profession, state actors, feminists and women are shown to interact in an interweave of power. This thesis has therefore challenged orthodox medical accounts of cervical cancer and has opened them for sociological analysis. It has revealed the socially negotiated status of medical knowledge.

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