2013

The "Reproductive Destiny" of Women: Constructing Women Solely as Reproductive Entities in Oral Contraceptive Medical Texts

Andrea Carson
Wilfrid Laurier University

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Abstract

This major research paper analyzes the representation of women and sexual reproduction in Western oral contraceptive medical texts. Drawing on previous feminist and sociological literature on the medicalization of women's sexuality and reproduction, I suggest that these texts draw upon a particular discourse that confines/restricts the social construction of women as reproductive entities. This study is based on a discourse analysis of 10 oral contraceptive medical texts, published between 1965 and 2007. Drawing upon the theoretical frameworks of feminism and medicalization, I interrogate how womanhood and motherhood become inexplicably linked and how women are homogenised based on their reproductive capacities. In these texts, women are represented as having a reproductive destiny/inevitability to birth children, their lives are broken up into reproductive stages, and fertility is represented as being very important to women and their bodies. The implications of this representation for women who fall outside and within the confines of what is considered 'normal' reproduction are explored.

Introduction

Within western medicine, sex is predominantly discussed in terms of mechanical bodily processes, using heterosexual language of penile-vaginal penetration, which carry with it the risk of pregnancy and sexually transmitted infections (STIs). Condoms, birth control pills (oral contraceptive), injections, vaginal contraceptive rings, etc. are among the various forms of birth control and STI prevention in North America. The majority of these contraceptive methods are targeted towards women, and while condoms are very popular, they are one of the only forms of contraception available to men. The purpose of this major research paper is to investigate how medical texts construct women's reproduction. I focus on 'the pill' because it is one of the most popular and routinized forms of birth control, requiring regular daily dosage and ingestion. I analyze oral contraceptive medical texts through a theoretical framework of feminism and medicalization; I seek to understand how dominant medical discourse constructs particular behaviours and bodies as 'normal' and others as 'abnormal'. In particular, I draw upon feminist theory that has identified the ways medical discourse pathologises women and construct a limited view of women and their bodies.

Early History of the Pill

According to a national survey, 68% of practicing physicians consider "natural family planning" a poor route for most women to take (Lawrence, Rasinski, Yoon, & Curlin, 2011, p.124). Contraception is considered the 'smart' choice. There is a wide range of contraceptive methods for individuals to choose from, among them: condoms, (oral) hormonal contraceptive pills, vaginal contraceptive rings, intrauterine devices, birth control patches, and recently "plan B" pills. Beyond preventing pregnancy and STIs, contraceptive methods are said to provide secondary benefits such as reducing the severity of acne and shortening the duration of periods

(Hollander, 2008). While there is a range of birth control methods, I focus on oral contraceptives because they are among the most popular methods of birth control used by women and a method that I am personally familiar with.

In an essay written for *Woman Rebel*, Margaret Sanger first used the term 'birth control' in 1914 to denote the intentional prevention of conception (Zorea, 2012*)*. Many attribute the legalization of hormonal contraception to the efforts of Margaret Sanger. Sanger understood the benefits of contraception and family planning for women and opened the first birth control clinic (albeit illegally) in Brooklyn in 1916. Like most women in the 1940s, she became increasingly dissatisfied with the available methods (i.e. the diaphragm and spermicidal gel). Sanger began lobbying in the 1950s for a pill that would give women more control over their birth control method, and could be taken independently of any sexual act. Sanger's concerns stemmed from not only what she had witnessed as a nurse in New York City ghettos (e.g., women with children living in poverty), but concern for how having that many unwanted children would impact society. Prior to the efforts of advocates such as Margaret Sanger, the birth control pill, and family planning in general, were not openly discussed, embraced or encouraged. The most effective method of birth control available to women in the 1950s was the diaphragm used in combination with spermicidal jelly, for which women had to visit a physician to have the diaphragm fit to their bodies. But physicians did not find fitting women with the diaphragm to be financially, medically, or professionally rewarding, nor did they encourage it. In addition, the diaphragm (and other methods available at the time) did not offer high efficacy or convenience (Watkins, 1988).

After World War II "several family planning organizations began working on an 'anovulent' [sic] pill - one that would prevent ovulation…By the mid-1950s, the drug was ready

for testing" (Zorea, 2012, p.11). Despite being ready for testing, the idea of an artificial contraceptive technology faced scrutiny and resistance. The Catholic Church strongly opposed the pill because they saw it as 'unnatural' and akin to abortion (Zorea, 2012). The pharmaceutical industry also shied away from contraceptive research in the 1950s. The pharmaceutical industry did not want to challenge the anti-birth control laws that were still in place in certain areas of the United States and Canada, nor did they want to incur outrage from the Catholic Church. Following several years of lack of funding for the pill project in the 1950s, Gregory Pincus (soon after meeting Margaret Sanger) launched investigations into the effects of progesterone and progestins on ovulation and fertilization.

The birth control pill was a unique case for clinical testing because unlike other drugs, it was administered to apparently healthy women. Additionally, the medical community knew that hormonal chemicals could have adverse effects on the human body, but they did not know exactly what those effects might be. Nevertheless, Gregory Pincus and his colleagues carried out early small-scale trials at the Free Hospital for Women in Boston. In these trials women were required to take pills as often as every six to eight hours, others had to inject them or insert a vaginal suppository. Every woman had to conduct daily vaginal smears, take their body temperature, and collect urine samples at specified periods during the trial. The time-consuming nature of these tasks often confined women to their homes because they needed frequent access to a toilet. Adding to the invasive nature of these tests, women were required to have monthly endometrial biopsies in which physicians would snip a small portion of tissue from a woman's endometrial lining. It is important to note that when the drug was first being tested on women in the 1950s there were few regulations for testing drugs, and safety guidelines for clinical trials were not implemented until the 1960s (Marks, 2001).

These early trials in Massachusetts did not produce the results necessary in getting hormonal steroids approved by the Federal Drug Administration and much larger investigations were needed. The difficulty in launching larger trials was that contraceptive research was still illegal in Massachusetts. Scientists and physicians eventually decided to begin larger trials in Puerto Rico where there had been a small-scale trial launched at the University of Puerto Rico in January 1955. Many women who agreed to participate in the trial had previously taken part in smaller trials and were eager for an alternative form of contraception. The women who agreed to participate were less likely to drop out than women in previous trials because they were desperate. Many of them had large families and lived in poverty and needed an effective method of contraception that would prevent further children they could not take care of (Marks, 2001).

In all of the trials conducted- in Puerto Rico and elsewhere- there were unpleasant side effects for the women participating, such as vomiting, dizziness, headaches, and nausea. Although many women dropped out of the trials because of these side effects, many women were still eager to volunteer because it was the only way they could access contraceptives. The ethics of the trials on poverty-stricken women in Puerto Rico, Haiti, and Mexico were scrutinized. American drug companies were accused of using 'non-white' women as 'guinea-pigs' by Puerto Rican newspapers. Further, women were not required to sign consent forms in the early trials, something considered by today's standards to be highly unethical in research on human subjects (Marks, 2001). Out of these early trials came Enovid, the first hormonal contraceptive to successfuly prevent conception with apparently no adverse side effects on the reproductive system and menstrual cycle (Watkins, 1998). In 1960 the hormonal birth control pill was approved by the Federal Drug Administration (FDA) in the U.S. for use as a contraceptive. Regardless of the questionable ethics and invasive nature of the clinical trials, not only was the

pill accepted by doctors and patients, but many celebrated the scientists and physicians involved in its development as being scientific innovators.

The Women's Health Movement

While influential in the battle to have the pill developed and approved by researchers, Margaret Sanger and Katharine McCormick were not the only ones advocating the pill's approval. At the time of the pill's development, the sexual revolution was in full swing. Sexual activity outside of wedlock was being practiced and political, social, and sexual norms of the past were being challenged. The pill was a means to liberate and empower women by freeing them from the risks of unwanted pregnancy, and by offering them a form of birth control that did not require the cooperation or knowledge of men (May, 2010). However, not soon after the pill's approval in 1960, many feminists began to challenge the implications of an oral contraceptive pill that required a prescription from a doctor.

The women's health movement in North America gave voice to the frustrations women had with their doctors and the medical institution as a whole. According to Ruzek (1978), the motivation behind the women's health movement was to challenge the paternalistic, condescending, and judgmental character of doctors. Women felt they had little control when it came to decisions of abortion, sterilization, contraception, and gynecological exams. Women wanted to learn more about their own bodies. Feminist groups began getting together to discuss health issues that affected women, and by March 1971 at the first Women's Health Conference in New York, it was apparent that a full-blown feminist health movement had arrived. Oral contraceptives were one of the pivotal issues within the women's health movement, and much outrage and discussion was spurred when Barbara Seaman published the book *The Doctor's Case Against the Pill* in 1969.

Seaman's arguments are important because she questioned the taken-for-granted safety of the pill. Seaman was alarmed at the number of pill hazards being reported by researchers and physicians, and that this information was being withheld from women. What Seaman revealed was that oral contraceptives were not as safe or effective as physicians led women to believe at the time. Having reassured women of the pill's safety, physicians were hesitant and embarrassed to backtrack on this advice at the risk of losing credibility and patient respect. There was growing evidence on the link between the oral contraceptive pill and blood clotting, cancer, heart disease, decreased libido, weight gain, urinary tract infections, and so on. Therefore, although physicians were prescribing women the pill, FDA approval did not guarantee effectiveness or safety (Ruzek, 1978).

Pill Safety

Since the pill's approval in 1960 there have been many studies exploring the potential side effects that can occur with prolonged pill use. Stern, Forsythe, Youkeles, and Coffelt (1977) conducted a study on the progression/severity of cervical dysplasia (a precursor to cervical cancer) in women using the birth control pill. Through a longitudinal observation of women diagnosed with cervical dysplasia, the authors found that the severity of cervical dysplasia was greater in women using the birth control pill as opposed to other methods. They also found the progression of cervical dysplasia (non-reversal) to be more advanced in women with prolonged pill use (more than six months). Thromboembolism has also been linked with oral contraceptives since the 1960s and has been studied extensively by scientists and physicians. According to Marks (2001), "Evidence collected from a number of hospitals between 1963 and 1969 showed that oral contraceptive users faced 4.4 times the risk of thromboembolism compared with non-users, and that the risk was even higher for those taking 100 microgram

oestrogen pills and sequential pills." (p.146). Preliminary trials conducted in Britain in 1967 also found that women taking oral contraceptives were three times more likely to have common types of thromboembolism, such as venous thrombosis, pulmonary embolism, and myocardial infarction, than women who did not use oral contraceptives. Further, women who were smokers were at greater risk of developing thromboembolism than fellow pill users who did not smoke. Later research also substantiated these earlier findings. Research conducted in the United States and Britain in 1978 showed that the risk of a woman developing a form of thromboembolism was five to ten times greater than a woman not on the pill (Marks, 2001).

The hormonal content of the pill has also been a concern for researchers. There have been many studies exploring the potential negative side effects that these hormones can have on the physiology of women's bodies. For instance, a study conducted by the World Health Organization's Population Council (1988) examined breast milk volume and composition and infant growth in women using combined oral contraceptives, progestogen-only oral contraceptives, depot-medroxyprogesterone acetate (DMPA), and women using non-hormonal methods. Detailed examinations of 341 apparently healthy women, with prior success in breastfeeding, were conducted in several countries around the world including Thailand and Hungary. Although they found no significant difference in infant weight or future weight of babies between the contraceptive methods in the study, the Population Council (1988) found that combined oral contraceptives "caused a significant decrease in milk output and total energy content as well as widespread changes in milk constituents." (p.361). As a result, the Population Council (1988) recommended that combined oral contraceptives not be used in the weeks to months after childbirth when women are lactating.

The relationship between hormonal contraceptives and cancer is also a contested issue and a source of anxiety for many women. According to Marks (2001), before the pills approval in 1960, the FDA ruled that chickens could no longer be fed with estrogens to fatten them up because of their potential carcinogenic effects. However, the potential relationship between cancer and oral contraceptives has been hard to determine. It can take 15-25 years for cancer induction to occur in humans. Burkman, Schlesselman, and Zieman (2004) acknowledge that oral contraceptives have the potential to increase breast cancer risk, while at the same time have the potential to decrease the risk of ovarian and endometrial cancer. Given the lengthy induction period for cancer, this is a relationship that is still being explored and a concrete association (negative or positive) might be many years away.

Theoretical Frameworks

Since the1960s, there have been countless feminist and sociological studies that focus on birth control/the pill and the experiences of women. More specifically, there exists a programme of research that focuses on the medicalization and pathologisation of women's bodies in regards to sex and reproduction. I will contribute to this body of literature by examining an area that is underexplored: how women's reproduction is constructed in oral contraceptive medical texts. By focusing my research on oral contraceptive medical texts, I fill a gap in the research: a critical interrogation of the construction of women's reproduction before conception has occurred. In my MRP, I will be drawing upon the theoretical frameworks of medicalization and feminism, as well as previous literature on women's sexuality and contraception, to understand how women are homogenized in medical terms by their ability/capacity to birth children.

Theories of Medicalization

Medicine has advanced and expanded a great deal in the 21st century. Theorists have long-recognized the impact of western medicine on our lives and have been trying to characterize the state of medicine and the medical institution for upwards of forty years. For instance, Irving Zola (1972) commented on the changing character of medicine: "[Medicine] is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts." (p.487). Prior to the dominance of contemporary medicine, the Christian Church was seen as the repository of truth and where people sought answers to their problems. However, now the majority of people in western countries seek the help of their doctors when they are experiencing problems -- whether it be physical, mental, social, or emotional struggles.

According to Conrad (1992), this changing character of western medicine involves the medicalization of our problems; medicalization involves defining any problem in medical terms, with medical language, using a medical framework, and/or "treating" a problem with a medical intervention. Conrad (1992) asserts that medicine does not gain dominance through the political power of physicians, nor does it simply operate in authoritative, top-down ways. Zola (1972) adds to this when asserting that it is exercised through day-to-day "undramatic phenomenon" (p.487) in which people and institutions label each other as 'healthy' or 'ill', and where medicine is considered an important part of our everyday lives and existence. In addition, responsibility is increasingly placed on the individual by asking what it is that they did wrong to facilitate disease; the issue becomes what the individual's role is in their own "demise, disability, and recovery" (p.491). There is no longer a question of *if* an individual will seek and use medical treatment, but *how* and *when* this will occur (Zola, 1972).

There are implications to medicalization in North America. According to Illich (1975), although people have learnt that factors such as environmental conditions, food availability and nutrition effect the health of individuals, it is also understood that these health levels will improve with more time spent on medical services, and the 'expert' services of doctors. In other words, a dependence on professional medical intervention is produced. Further, non-medical or so-called 'alternative' ways of understanding health and healing in social and physical environments are made abject, and the "organic and psychological coping ability of ordinary people" (Illich, 1975, p.77) is decreased. Adele Clarke (2010) adds to the work of Zola, Conrad, and Illich by capturing five interactive processes that have constituted biomedicalization in the United States. First, there is a 'Biomedical Technoservice Complex Inc.' in which research, products, and services are increasingly privatized and corporatized, and made possible by so-called technological innovation. Second, there is an interconnection between health, risk, and surveillance where whole populations have a moral obligation and responsibility to constantly survey themselves and others. Third, there is an increasingly techno-scientific nature of biomedicine. Fourth, production and distribution of information has shifted, and there are all kinds of media through which health information is communicated (consider web advertisements that promote contraception.). Lastly, and perhaps most importantly, Clarke asserts that there is an expansion from obtaining control over bodies through medicalization, to the transformation of bodies through the promotion of ideal properties and identities (bio-power).

Medicalizing the Social

An insurmountable number of behaviours are brought under a medical framework, and more and more aspects of social life are being medicalized. Brown (2000) found that public health literature surrounding AIDS created boundaries between the 'normal' and 'abnormal'

behaviours of people in which the group being defined as 'abnormal' – in regards to sexual activity and AIDS – encompasses an increasing amount of people (including heterosexuals). Because more and more bodies and behaviours are labelled 'abnormal', there is an increase in the scope of western medicine used to treat and understand these 'abnormalities' or problems. Drawing upon the sentiments of medicalization theorists like Illich, Conrad, and Zola, Bourne and Robson (2009) discuss the discourse through which sexual behaviour is now understood using a biomedical lens:

> Sexual health promotion literature almost entirely constructs safety through a biomedical lens; minimizing the risk of bodily fluid exchange and establishing physical barriers between partners. However, this viewpoint may be insufficient when considering the emotionally charged arena of sexual behavior which is, by its very nature, social. (Bourne & Robson, 2009, p.283).

While I disagree with their use of the term 'nature' because I am operating from a sociological viewpoint in which there exists no inherent truth or reality in the world -- only our constructions of that reality -- the idea that sex can be more than biological is important. Medical text and literature separates itself from the social world and examines only observable biological 'realities'. This can also apply to the arena of reproduction in which westernized medicine supervises all points of the sexual reproductive process -- from conception in the form of pharmaceutical birth control, to pregnancy (consider regular ultrasounds), and childbirth that takes place in a hospital and is supervised by doctors and nurses. Sexual reproduction is only understood in biological terms; alternative ways of understanding sexual reproduction and conception (i.e. in holistic terms) is considered risky and unsafe.

Feminist Theory

The theories of medicalization I have discussed thus far do not focus solely on women's bodies, and thus I will bring in feminist theory to foreground my analysis of the construction of women's reproduction in medical discourses on the pill. At its most basic level, feminism is concerned with injustices and inequalities affecting women. According to Haslanger and Tuana, (2008), the term "feminism" was first used in the mid-1800s to describe female qualities and was not initially associated with advocacy and activism. However, following the First International Women's Conference in Paris, the term feminism was used regularly to describe a belief in the equal rights of women and equality of the sexes. In the United States and Canada, "feminism" is rooted in the women's suffrage movement for the vote in the late 19th and early 20th century. It has been common to think of the women's movement in the United States and Canada as occurring in feminist "waves". The "first wave" of feminism involved the fight for women's political rights and occurred from the mid 1800s until about 1920. The "second wave" went beyond the political arena and fought for rights in the areas of education, work, and home. More recently, "third wave" feminists critique prior waves for homogenizing the differences among women, such as 'race', ethnicity, class, religion, etc. and emphasize 'identity' struggles (Haslanger & Tuana, 2008). While feminism has typically been thought strictly as a women's movement, it goes beyond this to become a theoretical, personal, and political way of thinking.

Feminism is a wide system of beliefs to which there are many different viewpoints and theories that often conflict – the term 'feminism' itself is a contested and debated concept. Therefore, it is important for feminist researchers to define what form of feminism and system of beliefs they draw upon when conducting research. Radical, Socialist, and Marxist feminism are but a few examples of different theories/orientations of feminism. In addition, there is a plethora

of subjects that feminist theorists explore. In this study I am concerned with sexuality and reproduction. In the area of sex and reproduction, there exists ongoing feminist concern in giving women "control over their own bodies, providing them with the power and the knowledge to enjoy their sexuality and to have children if and when they wish" (Freedman, 2001, p.59). For instance, many have supported the development of new reproductive technologies (aka birth control) because they allow women to have safer sexual lives. However, new reproductive technologies can also be seen as an attempt to take away some of the control that women have gained over their reproductive lives. There are disagreements as to the role that reproduction plays in women's lives. For some feminists, reproduction is a burden on women and an exercise of male control, while others see reproduction as a fulfilling experience that turns male control into something positive for women (Freedman, 2001). The purpose of this study is not to say whether reproduction is a burden on women, an exercise of male control, nor a fulfilling experience; the purpose of this study is to expose how medical texts on the pill present one particular view of women's reproduction, and the implications this has on women who fit with this reality and those who do not.

The feminist theory I use rests upon the Foucauldian assumption that language and power are intertwined, as articulated by Sawicki, (1991). Through language, discourses construct and privilege certain bodies and behaviours as 'normal', while others are made abject and labeled 'abnormal'. According to Foucault, power does not operate in a top-down fashion, but is productive in that it is employed by different individuals at different times, under different circumstances, and is reproduced in our everyday interactions with one other. Further, these discourses are ambiguous and often contested. The feminism I use does not see men as having monopoly over power, nor total control over phallocentric discourses. I acknowledge that

women often use language to serve their own ends, and men can experience abjection and regulation as a result of discourse as well (Sawicki, 1991). I also align my research with a feminist politics of difference and acknowledge the differences that exist among women. There have been several theories regarding sexual differences that have attempted to emphasize shared experiences of women across divisions of age, religion, culture, and so on in order to create a singular feminist subject. However, Sawicki (1991) draws upon Audre Lorde to argue that it is not the differences among women that causes division and separation, but the failure to acknowledge these differences. By not recognizing these differences we potentially misname women's experiences and how these experiences might effect human behaviour. "The motivation for a politics of difference is the desire to avoid dogmatic adherence to categories and assumptions as well as the elision of differences to which such dogmatism can lead" (Sawicki, 1991, p.29). In this major research paper, I will be interrogating the ways in which women's reproduction is constructed in oral contraceptive medical texts using a feminism informed by Sawicki's (1991) interpretation of the theories of Michel Foucault. In this interpretation, Foucault is said to argue that discourses are entangled with power, that power works in a productive manner by normalizing particular ways of being, and that the differences among women are ignored.

The Medicalization of Women's Sex and Reproduction

In *The Woman in the Body*, Emily Martin (1987) brings a feminist understanding to theories of medicalization by focusing on how women are specifically affected by and regulated through medical discourse. According to Martin (1987), supposedly neutral medical terms reproduce deeply embedded understandings of women and their reproduction. Martin argues "…just as seeing menopause as a kind of failure of the authority structure in the body contributes

to our negative view of it, so does seeing menstruation as failed production contribute to our negative view of it." (Martin, 1987, p.45). The development of western thought and medicine produced the woman's body as machine and the doctor as a technician who "fixes it". Further, female bodily processes are discussed in negative terms, and are experiences from which women "suffer". This discourse of suffering women to be repaired continues today and is evident in many interactions of women with medical 'experts'. For example, women diagnosed as menopausal by their doctors and who no longer have regular periods, might be encouraged to take Hormone Replacement Therapy or a similar treatment to maintain their estrogen levels. Martin (1987) argues that through medical and cultural language, women become separated from their own bodies. Women's bodies are something women must "cope" with or adjust to, they have to control their bodies, the body sends women signals (and they must listen to these signals), bodily processes such as menstruation, labour, and menopause are things that happen to women (not actions they do), and lastly, reproductive processes are separate from the self (i.e. women "get" hot flashed, contractions "come on", women "get" their periods).

Martin (1987) details this theme of 'woman as separated' in her analysis of gynecological exams in which she argues that women are expected to submit to a full pelvic exam of their genitalia and internal reproductive organs from the late teens into old age. Women are subjected to the scrutiny of the doctor while laying flat on their backs with their feet in stirrups, a sheet over their lower half, and a doctor at the end of the table. Thus, women are effectively separated from their body parts (genitalia) being examined. In regards to the oral contraceptive pill, medical texts recommend that physicians perform a gynecological exam on women before prescribing the pill, and annually thereafter. Thus, while gaining control over their bodies by having the ability to control whether they become pregnant, women remain under the authority

of western medicine by taking a physical pill daily, having to consult with a doctor who can choose whether they will prescribe the pill, and having to submit to a physical exam of their bodies and genitalia.

There is a long-standing and well-developed body of sociological and feminist research that expands Martin's feminist examination of the medicalization and pathologization of women's bodies, using both historical and contemporary analyses. Thompson (2010) asserts that female bodies are a site of 'contestation and conquest'. For instance, despite the human papillomavirus (HPV) affecting both men and women, women were the sole targets of the HPV vaccine and the efforts to promote it. This type of bio-medicalization and bio-power privileges the male body as the norm, thus making the female body the sick, unhealthy, pathologised Other who is responsible for both the medical intervention to reduce sexual risk. Further, Polzer and Knabe (2012) use medicalization theory along with a feminist interdisciplinary theory to argue that discourses surrounding HPV transmission have resituated "nascent sexuality" as very risky because it could lead to HPV and perhaps cervical cancer. Thus, sexual exploration and experimentation among girls and young women are represented as highly risky and something to be discouraged by parents. Some research on the pill, as with other specifically women's health concerns, suggests a similar form of medicalization (and pathologisation) of women's bodies.

According to Tone (2012), the introduction of the pill and its popularity "medicalized and feminized contraception" (p. 319); the pill medicalized contraception in that it requires the prescription by a health practitioner and medical monitoring. It feminized contraception because it places the sexual risk responsibility on women (consider that 1.2 million women were taking the pill just two years after its approval) (Granzow, 2007, p.320). The birth control brand *Seasonale* (FDA approved in 2003) is an illuminating example of this medicalization and

regulation of women's bodies because it features an "extended regimen consisting of 84 straight days of use instead of the previously prescribed 21 days, followed by a seven-day pill-free interval" (Loshny, 2004, p.63). Women who use *Seasonale* will only menstruate a few times in one year. While this may seem like a pleasant side effect ("wouldn't any woman choose fewer periods?"), it points to problematic issues of control over and pathologisation of the female body: "Menstruation is being cast in the same way as menopause; as a problem of pathology that needs to be "fixed" or "eliminated" for not just its immediate undesirable effects, but also because of its disease-causing potential" (Loshny, 2004, p.65). Female sex and its biological consequences or "risks" (i.e. STIs and pregnancy) are sometimes presented in paradoxical ways. Clarke (2010) conducted a content analysis of popular women's magazines and found that *Cosmo* and *Glamour* described STIs as frightening, repulsive, and dangerous, while the act of sex itself was described as 'casual', 'friendly', and 'empowering'.

Similar to sex and menstruation, women's reproduction is a time when women's lives become medicalized and homogenized by western medical discourse. Findlay (1993) conducted an analysis of obstetric and gynecological textbooks used in training medical students to uncover the ways that the social climate of the 1950s influenced the medicalization of women's physiology, labour, and pregnancy. By employing technical language of the reproductive capacities of women, medical language was used to present a particular view of the (normal) woman. From this analysis, Findlay argues that:

> "obstetricians and gynecologists…deployed the distinction between the social and the scientific to define and regulate women's behaviour, and to construct an apparently value-free version of pathological and normal gendered

> behaviour…which they then drew upon in producing and regulating the broader social world" (p. 117).

Thus, medical professionals brought reproduction under a medical gaze by using language of 'objectivity' and 'scientific fact' to discipline and regulate women in the social realm. A similar study carried out in the UK by Marshall and Woollett (2000) analyzes pregnancy guide texts to uncover the language and methods used to construct pregnancy in a particular way and to regulate women's behaviours before and after pregnancy. For instance, by presenting 'expert' knowledge and testimonials about pregnancy, and promoting certain practices that adhere to this 'expert' knowledge, these texts encourage women to plan for their pregnancy in certain ways and thus, to engage in self-discipline practices of their pregnant selves (consider pre-natal classes and the stigma around smoking/drinking while pregnant). In addition, these texts construct pregnancy in a way that decontextualizes women and their differing circumstances, individualizes the experience of pregnancy, and ignores the other relationships and identities women have outside of their role as mothers. Pregnancy and reproduction are thus brought into a medical realm that essentializes women, and ignores the social aspects of sex and reproduction.

The Heteronormative Character of Medical Discourse

Medical discourse not only essentializes women and their bodies, it conceptualizes sex quite narrowly as penile-vaginal penetration, and in terms of satisfying the partner (predominately male) through climax or ejaculation. Thus, other ways of understanding sex are excluded (i.e. touching, kissing, or intimacy) and homosexual sex is made unintelligible. Braun and Kitzinger (2001) explored conventional gender and sex norms (heteronormativity) in their comparative analysis of medical and English dictionary definitions of female and male genitalia

('clitoris', 'vagina', and 'penis'). The authors found that dictionaries defined 'clitoris' and 'vagina' by their location in the body, and defined female sexuality as passive and absence. Further, these dictionaries described genitals as being for heterosexual coitus (p.214). Thus, not only are women's bodies medicalized, but through medicalization a particular body is privileged and labelled 'normal'. Alternative ways of being are understood as 'abnormal' and abject, such as assertive female sexuality, homosexuality, and/or sex without penetration. Other studies have focused specifically on contraceptives in order to interrogate the medical discourses that privilege heterosexuality and a male norm. Medley-Rath and Simonds (2010) present a discourse analysis of 43 contraceptive websites and touch on three important aspects that I take forward in my analysis: the heteronormative character of medical discourse; 'expert' or scientific knowledge being used to promote particular behaviours; and the assertion of the failure of women (not science) when contraceptive methods are ineffective.

In conclusion, there is an array of sociological and feminist literature on the medicalization and construction of women's bodies surrounding sex, sexuality, and reproductive processes. However, while there have been studies examining medical, gynecological, or pregnancy texts (Findlay, 1993; Marshall & Woollett, 2000), there is a lack of sociological and feminist literature concerning the representation of women's reproduction within medical discourses specifically on the pill. I will fill a gap in the existing programme of research by asking: how do oral contraceptive medical texts construct women's reproduction? This is an important point of analysis in that the knowledge contained in these texts informs and reinforces western medical discourse and the information that gets passed on to women, potentially regulating their behaviours. To conclude I will address the possible implications of constructing

women's bodies and reproduction in a homogenous way, and present a alternative feminist perspective to this discourse.

Method

To contribute to the existing body of social science literature on women's bodies and the pill, I conducted a discourse analysis of ten oral contraceptive medical texts to answer the research question: How do oral contraceptive medical texts construct women's reproduction? I chose discourse analysis in order to grasp how medical texts on the pill privilege a certain representation of women's bodies. While previous research use popular media as their site of analysis, I, instead, focus my attention in medical texts. This is important to understand because medical texts proliferate medical knowledge through health professionals, which then gets passed on to patients. Current research on contraception mainly tackles the issue of risk, STDs, and women's sexual behaviours, and focuses less on the construction of women's reproduction. This is the core contribution of my research.

The Sample

By medical texts, I refer to any piece of work either produced by or targeted towards medical 'experts' that are for general medical knowledge. By contrast, texts on oral contraception that are written for, and targeted toward, so-called lay audiences will be much different than those geared toward the medical community in regards to how the knowledge is being presented and the technical language used. Medical texts are authoritative -- they represent the frameworks health care professionals draw upon. It is important to understand how healthy sexuality among females is being constructed within medical texts because this information not only has implications for other institutions (such as education and law), but is

presented as 'truth' or 'fact'. This 'truth' or 'fact' has an impact on what people understand is appropriate and what they understand is inappropriate female sexual behaviors.

I focus specifically on oral contraceptives (aka the 'pill') as opposed to other forms of contraceptives because the pill was and continues to be one of the most popular methods of preventing pregnancy among young women. Oral contraception is also unique in that it requires women to consume a small pill/dosage daily for three to four weeks straight (depending on whether the woman is prescribed a 21 or 28 day regime). Thus, women are disciplining their bodies on a daily basis in accordance with medical discourse. This is in contrast to contraceptives that require usage at the point of sexual intercourse, such as condoms or spermicides, and not a regular daily dosage regardless of whether sex is occurring in that moment. Analyzing representations of women in medical discourse on the pill is important. If not the most normalized form of contraception for women, it is certainly the most routinized, which has implications for women's lives.

To obtain the data, I began by searching my home institution of Wilfrid Laurier University, as well as the Interlibrary Loan Service (ILL) catalogue. The ILL service allows students at Wilfrid Laurier University, the University of Waterloo, and the University of Guelph to access materials from these partnered institutions because of a tri-university library that connects these institutions. ILL allows graduate students at Ontario universities to borrow materials from other universities that might not be available from their home institution. More specifically, I utilized the ILL service to loan materials from the Gerstein library at the University of Toronto. The Gerstein library contains medical and pharmaceutical texts that are not available at my home institution and thus, is an important source through which I have accessed my data.

To find the data, I used the Gerstein library search engine, as well as the PRIMO catalogue at Wilfrid Laurier, to generate relevant data by typing in key words such as: "contraception", "contraceptive", "birth control", "the birth control pill", "the pill", "oral contraceptives", etc. Initially, I obtained all relevant data related to contraception (not just 'the pill') to get a broad sense of what was available, but once I reviewed the available texts, I narrowed down the data to include chapters of texts and/or full texts dedicated to oral contraceptive methods aimed at a medical audience. In addition, I used the reference sections of these texts to find other resources that might be relevant to my research. I excluded texts that were (a) popular / targeted towards lay audiences (b) gave a historical account or outline key debates surrounding contraception versus a clinical work; and (c) did not focus specifically on contraceptive methods available to women (i.e. the pill).

In regards to the time span of my data, I am ultimately concerned with how oral contraceptive texts have bearing on the behaviours, feelings, and thoughts of people today, and therefore, will be including all data that is relevant to individuals in contemporary North America. That being said, there are a range of texts I have obtained with a wide range of publication dates -- anywhere from the 1965 to 2007 -- and so I must consider the relevance of all these texts to my research question. I have not been following a rigid guideline as to the texts I can use based on the year they were published. Rather, I have included all relevant data that applies to my research question and that is relevant to the contemporary understandings and debates surrounding the pill. My sample consists of medical texts (see **table 1**) either devoted entirely or partially (a chapter within a text) to a discussion of the pill, which may include a description of: the physiological process of the pill , the clinical issues surrounding the pill,

prescribing the pill, and side effects of the pill. A total of ten oral contraceptive medical texts comprise the sample.

Discourse Analysis

To begin the analytic process, I read and coded two medical texts from the earliest decade within my data set, and continued coding two medical texts from subsequent decades as I found new themes and differences between them. I did not follow strict guidelines as to the number of texts that I would include in my analysis. Rather, I collected and analyzed the data until I reached what is called 'data saturation'. According to Grady (1998), data saturation occurs when "the new data tend to be redundant of data already collected" (p.26). In other words, saturation occurred when the themes that answered my research question were exhausted. Once I reached data saturation and no new themes were being generated, I ceased data collection of analysis.

This research takes a critical discourse analysis approach to the data. The rationale in using a discourse analysis approach was to illuminate the particular constructions of femininity and sexuality that are put forth and reproduced by western medicine. I avoided focusing on the truthfulness of the specific medical claims being made in these texts, and instead focused on what claims are being communicated and the implications of this for women. Further, I did not analyze the way this discourse is taken up by doctors and patients, but spoke about the language through which discourse was communicated. I do not claim to be wholly objective in my analysis and in order to be reflexive I acknowledged the subjectivities that I brought to the table. By acknowledging my subjectivity as a 'white', middle-class woman who uses oral contraceptives, I conducted more transparent research. I also openly acknowledged the theories of medicalization and feminism that I drew upon to inform my findings.

There are a variety of methods in discourse analysis that have been utilized in the social sciences, some of which take an intuitive approach, others a more theoretical approach. Every discipline has their own interpretations of what discourse analysis consists of, and thus, it is important to acknowledge these various definitions and to distinguish the particular form I will be utilizing (van Dijk, 1985). To foreground an understanding of discourse analysis, an understanding of the term 'discourse' is necessary: "discourse consists of a set of common assumptions that sometimes, indeed often, may be so taken for granted as to be invisible or assumed. Discourses are the scaffolds of discursive frameworks, which order reality in a certain way." (Cheek, 2004, p.1142).

Critical discourse analysis in contemporary research is informed by the theories of Michel Foucault. Foucault's primary concern with discourse was the power and knowledge (and thus, inequality) that particular discourses produce. Following Foucault, researchers in sociology are often concerned with discourse and the production of power and knowledge, and want to know what knowledge consists of, how it evolves, how it is passed on, how it function in shaping society, and how it impacts society (Jager, 2001). The goal of critical discourse analysis is to explore the context, authorities, and institutions in which these knowledges are situated, and the ends they serve (Jager, 2001). Critical discourse analysis looks to challenge discourse that has the potential to enable and privilege a certain view of 'reality', while constraining others (Cheek, 2004). Thus, alternative ways of seeing the world are excluded and rendered unintelligible. Brown and Yule (1983) reiterate the importance of analyzing discourses in that "as soon as we know more about the discursive representation and management of…problems and conflicts, we have the design for the key that can disrupt, disclose, and challenge the mechanisms involves." (p.7).

Discourse analysis has become popularized within qualitative health studies, such as Clarke (2010), Polzer & Knabe (2012), and Thompson (2010) to name a few. These studies have explored the representations of women's sexuality and health in textual data. I contribute to this body of work in my analysis of oral contraceptive medical texts and the representations of women as reproductive bodies. The method I used to analyze the data and create themes was discourse analysis as described by Aguinaldo (2012). The discourse analysis here assumes that there is no world or reality that exists outside of our constructions of it. In other words, discourse analysis understands discourses as not simply reflecting or describing what exists in the social world, but "actively" constructs our social worlds. Thematic analysis is a similar method of analysis, however, while thematic analysis creates categories that *represent* the social worlds of the participants involved, discourse analysis looks at *constructions* of the social world of the participants involved (Aguinaldo, 2012, pp. 768-773). Discourse analysis also looks at what is NOT being represented in the data by exploring what is being left out or labeled 'abnormal' by normalizing certain behaviours. Lastly, in discourse analysis, there is typically a theoretical orientation that guides the themes/categories that are created out of the data. I will be adopting the sociological understanding that it is not possible for researchers to be fully objective and unbiased when conducting research and will be adopting a theory of feminist medicalization to analyze text.

In carrying out discourse analysis of text, I read and re-read the data to develop particular categories that exhaust all possible constructions and do not overlap. Further, these categories constitute the range of constructions of woman as reproductive entities within the text. For instance, although I adopted a particular theoretical leaning, I did not infer anything or any category that I cannot prove or substantiate through quotes found in the textual data. In other

words, I am rigorous in my analysis of the data and do not claim any construction that is not made apparent in the data; in my findings/analysis I included excerpts from the medical texts in my data set as evidence. Lastly, of major importance to discourse analysis, and my research, is the political implications of particular constructions; by constructing particular ways of being, alternative ways of acting in the world are rendered abject, unintelligible, wrong, and/or unhealthy. In regards to my research question, I am interested in the consequences of constructing women's reproduction in a particular way (i.e. what other experiences and ways of viewing women and reproduction become excluded?).

The assumption that I went into my research with, and to which the reader should evaluate my findings, was a post-modernist/social constructionist perspective on qualitative data. Kvale (2009) outlines how we should understand concepts such as generalizability, reliability, and validity in qualitative, post-modernist data, and I used Kvale's work to situate my research and the criteria to which it should be judged. This work asserts that the basis for a post-modernist orientation is the understanding of truth as socially constructed; we produce reality and meaning in our social interactions and there are multiple truths that exist in the world. In regards to the research I conducted, I operated with the understanding that discourses of health construct bodies in particular ways, and that these constructions are one among many ways of understanding the healthy body in the contemporary west.

According to Kvale (2009), in post-modernist analysis, generalizability does not state universal truths and/or laws, but rather reveals truths situated in local contexts. This is the definition of generalizability that must be used to evaluate my research. I looked at a particular set of data situated within a specific context, i.e. the pill within clinical 'expert' texts. Thus, my work can only been understood within the context to which it is situated and cannot be

generalized to all forms of health information (from public health campaigns to doctor-patient interactions) nor can it be generalized to other countries, industries, or time periods.

In regards to validity, the criteria to which my research should be judged is the extent to which I substantiated all of the claims made with textual evidence. Each theme should be substantiated with sufficient evidence. In addition, the evidence that I present (text) must clearly align with each theme. I did not assume what the text was trying to say if it was not explicitly stated. The standard to which my research should be judged as valid is the degree to which the findings 'answer' my research question (Kvale, 2009). Further, by reading and re-reading the data and revisiting and critiquing all themes, I tried to ensure the validity of my conclusions in that I am asking the hard questions and scrutinizing the data in a way that my peers, fellow researchers, and critics will be, as opposed to leaving my themes unquestioned because they adhere to a particular theory I am trying to promote.

Next, a qualitative post-modern understanding of reliability should be used when judging my research. In post-modern research, reliability is ensured through consistency in data collection, analysis, transcription (if interviewing), etc. Thus, the extent to which I am consistent to the theories that I assert, with the method of analysis I am using (discourse analysis), and the extent to which I adhere to the specific data I have asserted to be included in my analysis, determined the reliability of the data. For example, when I assert that I will be using theories of feminism and medicalization I must be consistent with these theories and clearly define them. If I claim to be using discourse analysis to analyze the data I must be open and transparent about what that means, and be consistent with this method (i.e. cannot analyze the data using thematic analysis if I have claimed to be doing discourse analysis). Further, when I defined my data set and criteria for inclusion I will be consistent with this and did not include data that did not fall under my

definition (i.e. when I say I am analyzing birth control information I will not be including information about HIV/AIDS).

Findings

I focus on three themes that answer my specific research question -*how do oral contraceptive medical texts construct women's reproduction?* First, oral contraceptive medical texts construct women as having a reproductive destiny in life. Secondly, fertility is of the utmost importance in these texts and infertility is a threat. And thirdly, women's lives are broken up into stages based on their reproductive bodily processes (i.e. pubescent, pregnant, breastfeeding, etc.).

1. Women Have a "Reproductive Destiny" in Life

The oral contraceptive medical texts construct women as reproductive entities through the assertion that women have a reproductive destiny and/or future to fulfill in life. The texts assert the role of physicians when prescribing the pill is not to 'sterilize' women, but to allow them to choose when they will have children and when they will 'fulfill' this reproductive role. Text (6) literally used the term 'reproductive destiny' when describing the usefulness of the pill:

> Clinicians helping a woman to overcome an infertility problem and clinicians helping a woman to avoid an unwanted pregnancy are doing the same thing-helping a woman to gain control of her own **reproductive destiny** (p.30).

In this example, 'clinicians' are described as the helpers who allow women to have children and allow them to avoid a child, but only temporarily. Women are described as having 'control' over their bodies and their reproductive lives, thanks to the help of the pill and the doctors who prescribe it. Thus, physicians are described in a positive manner in these medical texts by

allowing women to space out or time when they will fulfill their 'reproductive destiny', but not ceasing their reproductive role permanently.

The choice of language used throughout the texts reiterates the message that women will have children after ceasing the pill. The job of oral contraceptives is to 'delay' pregnancy, but not to rule it out entirely. For instance, in Text (9) of the sample, the authors state: "Beginning in the 1980s, oral contraception was primarily being used by women early in life, for longer durations, and to **delay an initial pregnancy**…" (p.75); and "Overall, there is no evidence that previous oral contraceptive users have an increased risk of hypertension during **subsequent pregnancy**.*"* (p.63). In both of these statements, the authors choose to discuss 'delays' in pregnancy and 'subsequent' pregnancy. Thus, childbirth is constructed as an inevitability that is normalized, while non-pregnancy and the alternatives it offers (e.g. career, leisure, travel) are treated as a temporary state. According to these medical texts, sexual reproduction will happen at some point in a woman's life and it is up to women (and the medical institution) to control exactly when it happens (not *if* it happens).

What these texts fail to discuss is women as having a choice as to whether she actually wants to sexually reproduce, and the possibility that she may never want children. A more appropriate statement in place of the 'delay of an initial pregnancy' might be 'if women decide they would like to have children'. What is being communicated is that it is important for women to be 'in control' of a pregnancy, and that <u>pregnancy is something she should want</u>. Further, to what degree are women actually in control of their 'reproductive destiny' given that women are required to ingest a pharmaceutical pill at the same time everyday, as well as submit themselves to routine gynecological exams by their doctors before being prescribed the pill?

1.a. All Women Want to Bear Children

As stated above, the role of the birth control pill here is to control *when* women become pregnant, not *if* they become pregnant; the pill is not meant to be a permanent method of sterilization. The pill allows women to avoid unwanted pregnancies *now* (at this particular time in their lives*)*, with the assumption that she will go through a pregnancy and birth children in the future. The assumption is that all women want to bear children at some point in their lives and that all women will have a reproductive plan in life.

> One important factor in helping a couple to make a wise contraceptive choice should be their **future childbearing aspirations**. A person's **reproductive life plan** should be considered… (Text 6, 1982, p.1)

> Some clinicians tell a woman with this history of irregular periods to discontinue pills and use an alternative contraceptive for 6 to 12 or even 18 months **before she would like to conceive**. (Text 8, 1990, p.250)

> …pregnancy, lactation, previous contraception and sexual activity, e.g. postponement of the **first full-term pregnancy** is a recognized risk for breast cancer, while recent data suggest that lactation for six months or more may reduce the risk. (Text 7, 1990, p.34).

Pregnancy and childbirth is described fairly mechanically as a goal to achieve in life (much like a career goal), and no mention is being made of the emotions and social aspects that surround childbirth and pregnancy. Further, the phrase 'before she would like to conceive' in Text (8) makes the assumption that there will be an 'after' at which point women will have this

desire to conceive. In addition, when using the phrase, 'first full-term pregnancy', Text (7) implies that (a) a pregnancy will occur, and (b) there will be more than one pregnancy.

Thus, not only are women understood as bodies that will eventually bear children, a particular view of reproduction and the family unit is being described here. First, by asserting pregnancy as inevitability for women, the family unit is constructed as containing one or more children. Secondly, by describing pregnancy and childbirth in a very physiological way, the texts assume that children in a family are born biologically from a mother. Thirdly, children are born out of a sexual relationship between a man and woman which assumes heterosexuality.

1.b. Women with children have fulfilled their reproductive role in life

In the data set, there is an exception to the assumption that women will become pregnant in the future: she has already given birth to children and has 'completed her family'. The medical texts in the data contain discussions of women (usually 'older') who are married and have had several children, and do not wish to increase the size of their family.

> In most civilized countries the tendency is for marriage at an earlier age and for women to **have completed their families** by the age of thirty. This means that family planning or contraceptive measures may have to be used for some 30 years in the life of every woman. (Text 1, 1965, p.54)

Put another way, these women have already 'fulfilled' their roles as reproductive beings by bearing children, and thus it is understandable that they would wish to either cease having children or space out the time between births. According to the data, this means that the pill, or some other form of contraception, will be used for several years, or even decades, by women in

'civilized' countries. There is no discussion of women who willingly forgo all forms of pharmaceutical birth control and explore alternative options of reproductive control.

What happens then, after women have fulfilled their so-called reproductive duties? 'Older' women at a later stage in their reproductive lives are constructed in an undesirable light:

> …the combined Pill should be avoided where possible in women with suspected gall-bladder disease, and probably avoided in the classical '**fair, fat, fertile, flatulent woman of forty**' *(or thereabouts)*. (Text 5, 1980, p.129)

Further, there is a sort of finality when these texts refer to 'older' women, as if once they reach menopause and cannot reproduce both their attractiveness and usefulness is decreased.

> If she is over 50 and no spontaneous menstruation occurs within 6 months of stopping medication it could be taken for granted that her **reproductive age is over**. (Text 1, 1965, p.67).

These oral contraceptive medical texts do not give much attention to 'older' women since it is assumed that 'older' women have already had children, or that menopause has left them physically unable to have children, and thus, they have no reason to use the pill.

> However, these are certain groups of women in whom factors which influence the risk of thrombo embolism can be identified, and evaluation of these factors should be included in the assessment of the patient's suitability for combined oral contraceptives…**Women aged over 35, whose fertility may be declining anyway...**(Text 3, 1975, p.106-107)

> The progestagen[sic]-only Pill offers **excellent contraception over the age of 40**, and is a very good choice that can be **continued to the menopause.** (Text 7, 1990, p.47)

> Is there any age at which a woman is to be considered **too old for this method**? One helpful factor in deciding these questions is the imminence of the **approaching menopause**. (Text 1, 1965, p.66)

Therefore, both younger and older, infertile women are constructed in similar ways; their lives are defined by their reproductive bodily processes, whether it be that they still have the capacity to bear children, or they no longer can. There is no discussion in these oral contraceptive texts of other ways women define themselves that does not centre around their 'female' bodily processes, such as their professional lives, culture, religion, social relationships, talents, etc.

2. Women's fertility is of utmost importance

Important to the construction of women as reproductive entities is the assertion that female fertility is crucial to a woman's life. According to oral contraceptive medical texts, it is important that the birth control pill delays pregnancy, but it should not cause a woman infertility that did not exist prior to pill use. Infertility should not occur because it is said to be impractical for women; impractical because it compromises her ability to bear children, and as I have presented, sexual reproduction is constructed as the destiny of women.

> **Fertility** subsequent to the use of combined progestagen[sic]/oestrogen oral contraceptives is important not only as a **practical consideration** to the women who use this method, but also as a criterion of the harmlessness of this therapy to the entire reproductive system. (Text 1, 1965, p.32).

Fertility is a 'practical' consideration in these texts because what is being presented is that all women want to or should want to bear children. If fertility is constructed as practical, then as a consequence, infertility is constructed as impractical for women. If fertility is compromised then women are not able to fulfill this role in life, and thus, would be incomplete in some way. Therefore, the job of the birth control pill is to delay pregnancy in a way that allows women to avoid childbirth for a certain amount of time, while still allowing women to fulfill their reproductive roles by not compromises their fertility and health reproductive state.

2.a. Infertility is a threat to be avoided

Infertility is constructed as impractical because it compromises the reproductive life of women, and is therefore discussed as a threat or problem that must be avoided. Infertility in these medical texts is presented as a possible risk, much like the various other issues and concerns that physicians and patients might have about the pill, such as acne, weight gain, migraines, risk of breast cancer, and fertility. However, these texts make sure to continuously reiterate and reassure readers that fertility will be preserved. By drawing upon existing medical studies and statistics on women who are taking the pill, the texts present 'evidence' that demonstrates that taking the birth control pill will not compromise a woman's future fertility/reproductive capacity:

> …there is **no evidence** that COCs can cause permanent **loss of fertility**. (Text 10, 2007, p.63)

> A pill user will not experience **loss of fertility** caused by oral contraceptives, although it may take longer for her to **become pregnant** after taking pills than after using other contraceptives. (Text 8, 1990, p.235).

> There is **no evidence of decreased fertility** in former OC users, although there may be some delay in the return of fertility. By 24 months normal fertility levels are achieved. (Text 7, 1990, p.72)

Some texts even go as far as to claim that taking the pill will actually increase fertility:

> There is no evidence that fertility has been impaired in any women who have had oral contraceptives; indeed, there is considerable evidence that **fertility is increased**. (Text 2, 1965, p.41)

> As increasing numbers of women withdraw from medication to have further pregnancies, there continues to be encouraging evidence not only of normal fertility but probably of **increased fertility** after withdrawal of medication. (Text 1, 1965, p.32)

These texts constantly reassure their audience (medical experts) that their patients need not worry about fertility. The texts present their evidence as to the harmlessness of the pill, as if to say 'trust us, you can plan a family and delay pregnancy without worrying about it compromises your reproductive system'. Much attention is given to the possibility of infertility

after pill use (and the reassurance that it will not occur), very little attention is given to infertility that existed prior to pill use. Infertile women are not of concern to those writing oral contraceptive texts. Prior infertility is simply not an issue that oral contraceptive texts in the sample entertain because the patients that they target are not infertile; they assume young, 'fertile aged' women who would use the pill to plan their reproductive 'destiny'. This is perhaps due to the presupposition that the primary reason that women would want to take the pill is to prevent a pregnancy, and all other issues and/or benefits are viewed as secondary benefits.

> Quite **apart from the peace of mind** that an efficient method of contraception brings there are certain **side-effects** which are welcomed by many women…For the woman whose periods have been irregular, the change wrought by the combined Pill can be little short of miraculous. Many patients can forecast exactly not only the day on which bleeding will occur, but the exact hour of the day. (Text 3, 1975, p.81)

> …in most women, although the tenderness and discomfort [of breasts] goes, the enlargement and firmness remains, much to their delight. (Text 3, 1975, p.84).

2.b. Women's emotional state is dependent on their (in)fertility

Reaffirming the importance of fertility, the data shows that there is anxiety when fertility is compromised (or at risk of being compromised). For instance, when referring to factors that affect pill continuation, Text (9) states that there are "**Fears and concerns** regarding cancer, cardiovascular disease, and the impact of oral contraception on **future fertility**." (p. 114). Similarly, Text (1) states: "**Anxieties** have been raised over the possibilities of **virilization of**

women taking oral contraceptives and of foetal masculinization where pregnancy results" (p.38). The fears and concerns being referred to here are coming from patients (women) who are taking the pill or considering taking the pill. In these texts, it is being implied that women want to know whether taking a particular medication is going to alter their body and biology in the long term or cause them illness. No mention is made of the social or emotional consequences to consider in women's sexual relationships and their choice to use oral contraceptives.

The emotional aspects of sex and the pill are only discussed as they relate to women as reproductive beings. Women's happiness is constructed as being very much dependent on her reproductive integrity. In this discourse, women may become depressed if they see themselves as infertile or sterile: "The **depression** in these long-term patients may have a different origin…by the fact that **she 'feels sterilized'**" (Text 3, 1975, p.97). There is an assumption being made here that women's happiness is dependent on their biological/reproductive capacities and that they are fearful and anxious when fertility is threatened. In order to avoid this anxiety or depression, the texts advise medical experts that they should *reassure* their patients (women) that although these fears and concerns are common, that there is no real threat to their reproductive integrity.

> Though **future fertility** seems to be **a major concern of many women** on the Pill, they can be **reassured** by the available data. There is no evidence that [Combined Oral Contraceptives] cause permanent sterility, and there is no link between duration of use of [Combined Oral Contraceptives] and impairment of fertility or post-Pill amenorrhoea. (Text 7, 1990, p.39).

What is being asserted in these oral contraceptive medical texts, perhaps quite obviously, is that infertility is bad and that the pill should not (and does not) compromise the fertility of the female body. And while this may very well be a positive thing for many people who do not want their fertility compromised, it has the potential to exclude particular women, such as those with pre-existing fertility issues and to construct them (and their bodies) in negative ways. Given that the threat of infertility is a cause for 'fear and concern', then what happens to women who are infertile?

3. Woman Years

The medical texts construct women as experiencing 'woman-years'. Studies testing for the effectiveness of the pill and possible side effects use a uniquely female measurement: when referring to the incidence rates for disease, pregnancy, breakthrough bleeding, etc., available statistics use 'number of cases per woman year' as their unit of measurement.

> [The pill] Ovrette is associated with a slightly lower failure rate, about 1.1 pregnancies per 100 **woman-years** of use. (Text 6, 1982, p.63)

> What can be stated is that in extensive clinical experience, with thousands of women using these oral contraceptives for thousands of **woman years**, for periods up to 6 or 7 years, no cases of pituitary atrophy have been reported and that long-term therapy with such compounds does not inhibit pituitary gonadotrophic function. (Text 1, 1965, p.31)

> Peberdy…has reported a fall in failure rate from forty pregnancies per hundred **woman years** for the cap and twenty-eight per hundred **woman years** with the condom to 9 with oral contraceptives. (Text 1, 1965, p.57)

> Use-effectiveness is difficult to evaluate. We have chosen to use a failure rate of 5-10 pregnancies per 100 **woman years** of Pill use. (Text 4, 1976, p.41)

In the above examples, the medical term 'woman years' refers to twelve months in the life of a sexually active female who has gone through puberty. Therefore, presenting incidence rates in 'woman years' the texts make the assumption that women taking the pill are sexually active and that they are reproductively 'mature' in that they have experienced a period. The texts do not make mention of statistics that include samples of women who use the pill and are not considered sexually mature or who are not having regular heterosexual intercourse. The texts only describe the physiological reproductive processes of women and how this influences their experiences of time. The majority of contraceptive methods are designated for use by women, and thus, more research exists exploring the physiological processes and consequences of these contraceptives on women, which involve breaking women's lives up into 'woman years'. This is a form of medicalization.

By defining women's lives based on woman-years, the texts define women along a continuum of reproductive stages. These texts categorize women as belonging to one or more of the following life stages/categories: 'puberty', 'pregnancy', 'first childbirth', 'post-pregnancy', 'non-pregnant', 'postpartum', 'breastfeeding', 'pre-menopause', 'menopause', 'post-menopause', and so on. For example:

> An analysis of the large database in the Women's Health Initiative concluded that **postmenopausal women** who were past users of oral contraceptives did not have an increased risk of breast cancer. (Text 9, 2005, p.78)

> The spontaneous incidence of [venous thromboembolism] in healthy **non-pregnant women** (not taking any oral contraceptive) is about 5 cases per 100 000 women per year. (Text 10, 2007, p.23)

> Pills may cause a decrease in the amount of milk **a breastfeeding woman** produces, and the FDA-approved pill labeling recommends that pill use begin only after the baby has been weaned. (Text 8, 1990, p.250).

> **Childless women** age 25-29 experienced some delay in return to fertility, but by 48 months, 91% had given birth compared with 92% in users of other methods. (Text 9, 2005, p.82).

Instead of speaking of women based on their literal age (i.e. 25, 40, 35) time and age are broken up for women based on what biological reproductive stage to which women are considered to belong, such as 'perimenopausal years', 'latter years of reproductive life', 'child-bearing age', etc. The appropriateness and effectiveness of the birth control pill in these texts is dependent on the reproductive age of women. For instance, older women, menopausal women, pregnant women, etc. are considered to be less desirable candidates for pill use.

> The need for effective contraception is paramount in the **perimenopausal years**. (Text 7, 1990, p.47).

> …cycle lengths become less regular during **the latter years of reproductive life**. (Text 5, 1980, p.600)

> Of the women of **child-bearing age** in the United Kingdom about two million, or one woman in five, use the Pill. (Text 5, 1980, p.153).

> The fact that malignant melanoma is more common in **the reproductive years** suggests a role for hormones (Text 7, 1990, p.35)

> If oral contraception is desired in the **postpartum period**, it is particularly important to be sure that the patient is not pregnant. (Text 2, p.40, 1965)

By labeling women based on these categories, women are defined solely by their bodily processes, more specifically, bodily processes of reproduction, whether it be that reproduction can no longer occur (menopause), that conception has occurred (pregnancy), or that women are still able to reproduce but conception has not occurred (menstruation). This echoes what Emily Martin (1987) asserts in her discussion of women not performing the actions of their own bodies. For instance, in the sample women are connected with and defined by their bodily processes (i.e. 'non-pregnant' and 'breastfeeding'), and not as women separate from their reproductive capacities, who have the ability to carry out processes such as menstruation. Menstruation, pregnancy, milk production, etc. are processes that happen 'to' women and not 'by' them.

In sum, oral contraceptive medical texts draw upon a discourse that not only medicalizes women's bodies as previous research has shown, but constructs women's reproduction in a

particular way. This representation of women's reproduction breaks their lives up based on reproductive bodily processes, asserts that women have a 'reproductive destiny' to sexually reproduce, and that female fertility is of the utmost importance. This representation is a form of medicalization in that women's reproduction is brought under a medical lens and understood in biological and physiological terms. Additionally, the representation in these texts is also a form of pathologization of women because they are prescribed a hormonal pill that requires daily ingestion to control their menstruation and reproductive processes. These texts privilege the view of women as reproducers who must adhere to 'expert' medical advice regarding their 'natural' female bodily processes.

Discussion

Drawing on theories of feminism and medicalization, my analysis contributes to an established body of literature that has examined the ways in which female sexuality and reproduction is medicalized. Previous research has analyzed popular media data, such as magazines and newspaper articles that are targeted toward a lay audience. My data differs in that I examine oral contraceptive medical texts targeted toward physicians and other medical experts. The sample and the assertions I make are in no way generalizable to other forms of data aside from medical texts. Further, the conclusions being made here do not apply to other forms of contraceptives aside from 'the pill' (i.e. condoms, the vaginal contraceptive ring, etc.). The purpose of this research was not to address the validity of the medical or physiological claims being made in the sample, but to interrogate the discourse(s) being drawn upon and privileged in these medical texts.

My analysis suggests that by constructing women solely as reproductive beings, they are medicalized, pathologised, and essentialized by their capacity to bear children. In other words,

women are understood simply as wombs, and these wombs fall under the authority of western medicine. By privileging the medical discourse of women as wombs, other ways of understanding women's reproduction are neglected, thus creating a dynamic of power. For instance, women who cannot bear children, women who choose not to have children, women who abort a pregnancy, and homosexual women are all made abject through the discourse in these texts. I will suggest an alternative feminist discourse in place of this dominant medical view of women's reproduction.

Hegemonic Femininity

Hegemonic femininity consists of the behaviours and attitudes that are constructed by dominant discourse as ideal and 'natural' for females. These ideal feminine behaviours are normalized and maintained through our daily interactions with each other and our encounters with various institutions. Hegemonic femininity in these oral contraceptive medical texts involves biological motherhood. This may seem to contradict the changing roles of women in North America and the increasing opportunities for women outside of the home, however, as exemplified in these texts, biological motherhood is still the ideal.

The assumption in these texts is that motherhood and reproduction is 'normal' for women and a role that women should fulfill. According to Charlebois (2011) the assumption that motherhood is a predisposition for women results in an unequal, gendered power relation in the family, workplace, and society. These dynamics of power are exercised productively, through bio-power, in that women may monitor and change their behaviour based on a dominant construction of ideal femininity (Sawicki, 1991). As Charleboise (2011) puts it: "…dominant notions of femininity and the pressure to conform to those norms can exert a degree of influence on women's behaviors and consequently their choices…women may conform to this social norm

to avoid cultural marginalization" (p.2). For example, women might decide to have children earlier in life because having children in their 30's and 40's is considered more of a risk in dominant medical discourse.

Deviant Women

The correct way to reproduce in these texts is under western medical supervision. The correct time to reproduce is at a young, fertile age. However, medical discourse cautions that women must not be too young when they have children, and they should use reliable contraception until they are mature enough. Ways of reproducing that fall outside of the 'responsible' and 'correct' way/time are constructed as less than ideal, risky, and even irresponsible. Proper health citizens are women who adhere to medical advice about what they should or should not being doing when it comes to sex and reproduction. Improper health citizens are women who take undue risks when it comes to their sexual and reproductive lives, and who stray from medical instruction. Analysis of the data suggests that older women are constructed as less fertile and as having more health issues with age, and thus, women who choose to sexually reproduce at a later age are viewed as taking risks with their health and the health of the child. This can be considered a form of ageism because older women in these texts are understood as unsuitable to birth children.

What happens to women who do not reproduce? There are women who oppose the dominant construction of biological motherhood, but at a price. Women who do not have children- whether by choice or physical inability- are understood as deviant and deficient (Loftus & Andriot, 2012). What is assumed in these texts is that even if women do not want children today, they will want children at some point (because this is their duty). Infertility is discussed as a negative female bodily state that must be prevented if at all possible. By reassuring women

infertility will not occur after using the pill, these medical texts are constructing infertility as undesirable and thus, women who are infertile as undesirable as well. Loftus and Andriot (2012) argue that infertility is regarded as a failed life course transition and, based on the women they interviewed, negatively effects their sense of self and their relationships with others because of the perceived inability to fulfill the gendered role of mother.

By representing reproduction and childbirth as an inevitability for women (as long as they are physically capable to do so) women who are physically incapable of having children or who have no desire for children are rendered unintelligible. 'Voluntarily childless' women, as they are sometimes termed, have been the subject of various studies in disciplines of psychology, gender and families, as well as feminism and women's studies. Childlessness due to infertility is understood as a medical condition, and therefore acceptable, whereas 'voluntary childlessness' is thought of as a desperate and unfulfilled. According to Letherby (2002), "Motherhood is still considered to be a primary role for women and women who do not mother either biologically or socially are often stereotyped as either desperate or selfish." (p.7). Through bio-power, dominant discourses privilege a hegemonic construction of femininity and behaviours that conform to this ideal construction are normalized. In turn, women who do not sexually reproduce are the deviant spinsters to look down upon. However, not all women considered spinsters are desperate and lonely because they could not fill their 'biological role' in life. There are many fertile women with no desire to birth children that live full and happy lives. There are also many women who undergo abortions that live full and happy lives.

Abortion is a highly debated and contested topic, perhaps because terminating a pregnancy goes against the supposed reproductive destiny of women. Beginning in the late 1960s in Canada, and the early 1970s in the United States, there were national laws legalizing

abortion. These laws differ from province to province and state to state, but what has remained constant are the debates among political activates, women's rights advocates, legislatures, and various human rights organizations regarding the ethics and implications of legalized abortion (Williams, 2002). The debates surrounding the ethics of abortion can be situated in the discourse of these oral contraceptive medical texts. For instance, Vandegaer (2002) argues that women may feel emotional distress following an abortion because they are "suppress[ing] their feelings of maternal grief and shame" (p.187). Vandegaer's claims reproduce a discourse of hegemonic femininity. In this discourse women's emotions are linked to their maternal 'nature'. Therefore, abortion may be understood as deviant and distressing for women because it conflicts with dominant ideas of proper femininity, namely the 'natural' predisposition of women to sexually reproduce.

Sex is More Than Biology

The social aspects and consequences of sex, other than pregnancy, are also ignored. As I have mentioned, Bourne and Robson (2009) insist that the biomedical viewpoint of sex and sexual relationships is insufficient to really do justice to the emotions involved in sexual behaviour; they argue that sex is social, not biological in nature. Women also have different ideas about sexuality, they come from different cultures, ethnicities, family backgrounds, have different personalities, different relationships, different political views, etc. – all of which affect how they experience sex and reproduction. The only emotional information considered important in these oral contraceptive medical texts is the assertion that women will feel less anxiety knowing the pill is a reliable form of birth control, or that increased breast size and cleared acne will boost a woman's self esteem. These texts ignore the complicated relationships

of sexual partners and the diverse range of sexual experiences that fall outside of heterosexual monogamy. Medical discourse that views sex as mechanical and physiological dominates.

While I believe that the medical institution should not have jurisdiction over the social and emotional aspects of sex, alternative discourses that do acknowledge sex as social should not be ignored. Competing discourses should acknowledge the social issues that arise when starting the birth control pill, and should not be overshadowed by medical discourse. There are important aspects to contraceptives and pill use, such as discussions with sexual partners regarding contraceptive methods, relationship changes that might occur once starting the pill, social consequences of either avoiding pregnancy or becoming pregnant, and so on. These issues should not be ignored and should not be considered less important than the physical consequences of sex.

Heteronormativity

These medical texts privilege a biological view of sex that occurs through heterosexual coitus and results in sexual reproduction. This is part of a wider heteronormative, neo-liberal framework that institutionalizes heterosexuality and excludes homosexuality. "Heteronormativity [is] the view that institutionalized heterosexuality constitutes the standard for legitimate and prescriptive sociosexual arrangments…" (Ingraham, 1994, p.204). In heteronormative discourses, gender and (hetero)sexuality become linked (Ingraham, 1994). In the case of these medical texts, gender and heterosexuality are linked when valid motherhood is said to occur in the form of heterosexual reproduction.

However, medicine is not the only institution that privileges a heteronormative discourse. Heteronormativity is reflected in all of our institutions, including education, law, work, and family. According to Charlebois (2011), heterosexuality is a norm in school where children

learn that they are inherently different. The differences between men and women are reflected in the organization of schools, such as separating girl and boys into different physical education classes. This heterosexual norm is also reflected in the social roles children and teens play in school. For instance, Charlebois (2011) argues that the popularity of young girls in school is dependent on the status of their relationships with heterosexual partners/boyfriends. In the legal institution, heteronormativity is apparent in laws regarding heterosexual partnerships. There are longstanding laws that dictate the rights of heterosexual spouses, but a lack of recognition for homosexual relationships and the rights of homosexual couples who want to marry or separate. In the labour force, women continue to be paid less than men. This gender divide in the workplace is linked to the expectation of women to be mothers (Charlebois, 2011). For example, a man may receive a promotion over a female counterpart because the expectation is that women will have children in the future (if they do not already) and will not be able to dedicate the long hours required of the position. Additionally, workplace standards of maternity leave represent a heteronormative bias toward homosexual men with children.

Despite the increasing number of families considered 'non-traditional', such as homosexual parents and individuals who adopt children, institutions continue to reproduce a heteronormative discourse where femininity and motherhood are linked and where the 'normal' family consists of two heterosexual parents. The nuclear family is the ideal family in dominant discourse and consists of a father, mother, and their biological children. Proponents of the nuclear family, and critics of non-traditional families, argue that the nuclear family is fundamental to the creation and maintenance of the family unit (Hird & Abshoff, 2000).

Within the nuclear family there are expectations surrounding gender. Certain behaviours are deemed masculine, while others are labeled feminine. For instance, men in the nuclear

family are considered head of the household whose role as patriarch is to support the family economically by working in the public labour force. The structure of the nuclear family under capitalism creates dependence on a male earner and the assumption of a male right, patriarchal gender relations, and children as the property of parents (Teeple, 2004). Women, on the other hand, are considered nurturing and maternal. Women in the nuclear family are responsible for much of the domestic labour within the household, such as child-care, cleaning, hygiene, etc. This over-responsiblization is also evident in the sexual and reproductive lives of women.

The Over-Responsibilization of Women

Despite (hetero)sexual reproduction involving men and women, men are curiously absent from these texts; women bear sole responsibility for oral contraception and the risks that accompany it. Women are responsible for making the doctor's appointment, having their genitalia examined, and getting a prescription from their doctor that will allow them to engage in heterosexual sex with little risk of pregnancy occurring. And while a male oral contraceptive has been proposed and tested, that pill does not currently exist on the market; women continue to be responsible for contraception. Without women being willing to ingest the birth control pill daily, heterosexual partners would not be able to engage in sex in the same way given that medical discourse individualizes sex and reproduction and places contraceptive responsibility predominantly on women. Therefore, under a medicalized and individualized discourse of sex and reproduction, women become responsible for heterosexual enjoyment in sexual relationships.

If women are responsible for sexual enjoyment and reproductive health and safety, what happens when women partake in behaviours considered unsafe and risky? Through medicalization, responsibility has shifted from the health care provider to the patient/woman

(Clarke, 2010), and thus, blame has also shifted. I would argue that because of this shift in responsibility and blame, when women become pregnant at a young age, contract an STI, or give birth to children who are ill, they are designated as irresponsible by dominant medical discourse. If they had followed 'expert' medical advice, their risk for contracting an illness or becoming pregnant would have been lower. This is an exercise of productive power because women are not physically coerced or punished for their 'irresponsible' behaviour, but are assigned blame for not disciplining their bodies in ways that adhere to dominant medical discourse on what is safe, normal, and healthy.

Feminist Alternatives

I have attempted to uncover the homogenous representation of women and their sexual reproduction in oral contraceptive medical texts. And while I have asserted that these texts present a narrow, biomedical view of sexuality and reproduction, I do not claim that medicine and technology is necessarily incompatible with feminism and the interest of women. As I have shown, feminist activists in North America fought for the pills approval and its ability to relieve heterosexual women of the burdens of continuous and/or unexpected pregnancies. In addition, pharmaceutical technologies have provided pain relief from certain aspects of childbirth. However, there are aspects of the pill that are often overshadowed, such as the early history of the pill's development in Peurto Rico, or the various studies linking oral contraceptives with thromboembolism and cancer.

The ways in which women are represented in medical discourse is problematic. Alternative feminist understandings of women and sexual reproduction must be considered. There have been past attempts to challenge this 'natural', biological view of motherhood and sexual reproduction by bringing motherhood into the social realm. For instance, psychoanalytic

theories of childless women have explored sexual reproduction as a social institution, rather than a 'natural', biological role. However, the social development model of gender identification is perhaps insufficient and may pathologise so-called childless women in that they do not conform to 'normal' gender identity development and the imperative to sexually reproduce; they 'fail' to socially develop (Hird, 2003). Thus, women are still being pathologised, but rather than being medically pathologised, they become socially pathologised.

What oral contraceptive discourse fails to recognize and that needs to be acknowledged, is an "appreciation for the diversity of women's experiences and desires" (Beckett, 2005, p.263). Simply because women may or may not share the same anatomy, does not mean that they all want to have children (and under medical supervision), that they all have heterosexual relationships, or that they all define themselves based on fertility. A feminist alternative discourse should acknowledge the plurality of women's lives and bring into light the ways of being that have been ignored and made abject by oral contraceptive texts and medical discourse. For instance, the experiences of homosexual, heterosexual, bisexual women, transgendered individuals, infertile women, 'voluntarily childless' women, and so on, should be acknowledged. There should also be more of an involvement of men in the responsibility of contraception within heterosexual relationships; even though men do not bear the physical burden of a possible pregnancy, they are certainly involved in these sexual relationships and should play more of a role.

By constructing women's reproduction in a particular way, these oral contraceptive medical texts potentially regulate how women live their lives through bio-power. As a result of the discourse that women have a reproductive destiny to fulfill at a young and fertile age, women may base the age at which they have children around this. For instance, in order to be

responsible, women who are thinking about when to have children (if they decide to) might choose to forgo other life pursuits to have children at a younger age (i.e. age 25 versus 35) because it is considered less risky. If women choose not to have children when they are 'young', or if they choose to forgo reproduction altogether, they now become delinquent as a result of the oral contraceptive discourse, and those who reproduce at an 'older' age are taking undue risk with their health and the health of their child. This is a dynamic that I have experienced, and continue to experience, in my own life.

As a woman who uses oral contraceptives, I have consistently been urged to consider what my 'reproductive future' will look like. Throughout my life, I have experienced the feeling of 'inevitability' that a discussion of reproduction and childbirth bears. For instance, the pain of childbirth has been a common conversation among my female friends throughout the years, and it is always discussed as something that we will 'get over' because it is the price to pay for having children…something that we women must grin and bear because it is our role as women. In more recent years, I have begun expressing to friends and family my desire not to 'grin and bear it' and to not sexually reproduce. This assertion on my part is often brushed off as something I will change my mind about and grow out of once I am older. Whether this is true or not, my choice to not sexually reproduce is understood in a negative light and not taken very seriously, almost as if to say, 'yeah yeah, you say that now but you will have children in a few years'. This is where I recognize the dynamics of bio-power in my own life because as a woman I am regulated and constrained by a discourse that understands the choice not to reproduce as delinquency and childbearing as a 'natural' role in life.

It has been my attempt to uncover one possible discourse that regulates women's bodies and portrays childbearing as 'natural' and inevitable. I have filled a gap in the research by

presenting a discourse analysis of oral contraceptive medical texts that construct women's reproduction in one particular way. Previous research on contraceptives has given attention to STDs and female sexuality and focused less on women's reproduction. Further, research on sex and contraception has used popular literature as the data (i.e. magazines or websites) and has failed to address the representation of women's reproduction in medical texts. In addition, the research that has examined women's reproduction in text has not focused exclusively on the construction of women in medical literature on 'the pill'.

Conclusion

The time constraints and page limits did not allow for a comprehensive examination of all topics within the sample. While I have filled a gap in the literature, there are limitations to this study. Firstly, while I have spoken about heteronormativity in medical discourse, further research should explore the specific heterosexual biases that are present in these oral contraceptive medical texts. For instance, while these texts focus on sexual reproduction occurring between men and women, there are other reasons women take the pill aside from preventing a heterosexual pregnancy. Thus, a woman may take the pill in order to have regular monthly periods or to treat acne, but this does not mean that she is heterosexual or that she is sexually active.

Secondly, there is an aspect of ageism present in these oral contraceptive medical texts that needs further consideration. Older women are given little to no attention in these texts. When they are discussed it is in regards to the riskiness of a pregnancy at an older age. This is important because older women in these texts are considered to be past their 'prime fertility', which may have implications for how we view women who can no longer bear children.

Thirdly, throughout these medical texts reference is made to the so-called positive side effects of pill use, such as increased breast size and clearer skin. Larger breasts and clearer skin are considered a desirable side effect and one that women will openly embrace. This points to ideals around female appearance and attractiveness. Further research should explore how the medical institution and medical discourse takes up the expectations of female appearance, and the possible implications of this for women.

Fourth, while I do discuss the potential ways these texts regulate women's behaviours, I cannot speak of how the specific texts in my data directly impact women's behaviours. I can only entertain the possible implications of my findings and suggest that further research involve interviews with women to gage how exactly they take up medical discourses of reproduction. I acknowledge that I am generalizing when I speak about 'women' and how they are impacted by medical discourse because I cannot say the exact ways that every woman takes up these discourses. Lastly, building off the established body of literature regarding the construction of women as passive and pathological (and men as active) through medical language, further research could explore how women are constructed through the physiological language in oral contraceptive texts.

In this major research paper I have attempted to answer how women's reproduction is constructed in oral contraceptive medical texts. Using theories of medicalization and feminism, I found that oral contraceptive medical texts construct women as having reproductive destinies, with fertility being central. Further, in these texts women's lives are broken up in terms of their 'female' bodily processes. Ultimately, women are being represented as reproductive entities, and femininity and maternity are linked. In constructing women as reproductive entities, behaviours that do not fit with this view of womanhood-as-motherhood are deemed abnormal

and abject, such as the delinquent woman with no desire to birth children. The implications of such a discourse occur when women regulate their behaviours based on the representations of proper reproduction in these texts (i.e. having children before age 30 so as not to be labeled irresponsible and risky). Alternative feminist discourses should acknowledge the heterogeneity that exists among women, should present alternative forms of reproduction/family that fall outside of a narrow medical construction, and should continue to challenge the link between femininity and motherhood. There is more to women than their wombs.

Appendix

Table 1: Oral Contraceptive Texts in the Data Set

Text	Title	Year	Author(s) / Editor(s)	City of Publication	Page Numbers
1	*Handbook on Oral Contraception*	1965	Mears, Eleanor	Boston	1-103
2	Chapter 4: Oral Methods of Contraception, in *Medical Handbook: Contraception*	1965	Kleinman, R.L.	London	29-48
3	10: Oral Contraception, in *Contraception, Abortion, and Sterilization*	1975	Oldershaw, K.L.	Chicago	72-160
4	10: Hormonal Contraceptives: an Introduction; 11: "The Pill": Estrogens and Progestins Comined as Contraceptives; 12: Progestins Alone as Contraceptives, in *Contraceptive Technology 1976-1977*	1976	Hatcher, R.A. Stewart, G.K., Guest, F., Finkelstein, R., Godwin, C.	New York	36-61
5	23: Oral Contraceptives: General Considerations; 24: Oral Contraceptives: Basic Considerations; 25: Effects of Steroidal Contraceptives on the Reproductive System; 26:	1980	Hafez, E.S.E.	Maryland	509-603

	Effects of Steroid Contraceptives on Protein, Carbohydrate, and Lipid Metabolism; 27: Postpill Amenorrhea; 28: Oral Contraceptives and Endometrial, Cervical, and Breast Cancers; 29: Management of Patients on Oral Contraceptives, in *Human Reproduction: Conception and Contraception*				
6	Chapter 4: Combined Oral Contraceptives, and Chapter 5: The Mini-Pill and Progestin-Only Contraceptives in *Contraceptive Technology 1982-1983*	1982	Hatcher, R.A., Stewart, G.K., Stewart, F., Guest, F., Joseph, N., Dale, J.	New York	35-71
7	Combined Oral Contraceptives; Progestaen-only Pills (POPs); Oral Hormonal Contraception in Chronic Disease, in *Hormonal Contraception*	1990	Kleinman, R.L.	London	21-75
8	13: The Pill: Combined Oral Contraceptives, in *Contraceptive Technology 1990-1992*	1990	Hatcher, R.A., Stewart, F., Trussell, J., Kowal, D., Guest, F., Stewart, G.K.,	New York	227-300

			Cates, W.		
9	2: Oral Contraception, and 3: Special Uses of Oral Contraception, in *A Clinical Guide for Contraception*	2005	Speroff, L. & Darney, P.D.	Philadelphia	21-152
10	Combined Hormonal Contraception, in *Contraception Today*	2007	Guillebaud, J.	London	11-67

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