THE MEDICALIZATION OF IMPOTENCE
Normalizing Phallocentrism

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Today, phallocentrism is perpetuated by a flourishing medical construction that focuses exclusively on penile erections as the essence of men's sexual function and satisfaction. This article describes how this medicalization is promoted by urologists, medical industries, mass media, and various entrepreneurs. Many men and women provide a ready audience for this construction because of masculine ideology and gender socialization. While there may be some advantages to this construction, there are major disadvantages to men in terms of the inevitable failure of the promised perfectible erection and the perpetuation of a falsely universalized and biologized vision of sexual experience. Any sexual interests of women in other than phallocentric sexual scripting are denied.

> Taken by itself, the penis is a floppy appendage which rises and falls and is the source of a number of pleasures. The phallus is more than this. It is the physical organ represented as continuously erect; it is the inexhaustibility of male desire; it is a dominant element within our culture. (Bradbury 1985, 134)

Much successful effort in the past two decades has been devoted to defining, describing, and analyzing women's sexual socialization and the construction of female sexuality (Tiefer 1991a). Among the contributing factors has been that of medicalization, including medical ideology and practice regarding menstruation, menopause, pregnancy, childbirth, premenstrual syndrome (PMS), physical appearance, and fertility. Reissman (1983) argues that these areas have become medicalized as

> physicians seek to medicalize experience because of their specific beliefs and economic interests. . . . Women collaborate in the medicalization process because of their own needs and motives. . . . In addition, other groups bring economic interests to which both physicians and women are responsive. (Pp. 3-4)

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This article argues that men and their bodies can also be objects of systems of surveillance and control and that medicalization perpetuates a phallocentric definition of men's sexuality.[1] This construction literally and symbolically perpetuates women's sexual subordination through silencing and invisibility; thus it operates to preserve male power.

METHODS

This article is informed primarily by my impressions and observations working as a sexologist and psychologist in medical center urology departments for the past decade.[2] My responsibilities have included conducting hour-long psychosocial interviews with and preparing reports on men with sexual complaints who consult a well-known urologist (Melman, Tiefer, and Pedersen 1988). At the time his appointment is made, each man is asked to bring his primary sexual partner to the interview; I conduct a separate interview with any partner who comes (Tiefer and Melman 1983).

To date (August 1993), I have interviewed and kept records on close to 1600 men, approximately 60 percent of whom brought sexual partners. Only six of these patients said they were gay, and none of them brought a partner to the interview. Our patients are predominantly referrals from the biggest health maintenance organization in the New York metropolitan area. Their ages range from the 20s to 80s, averaging in the late 50s; approximately two-thirds are ethnic minorities; about half are high school graduates, with equal numbers having more or less education; about half are blue-collar New York City government employees (transit, sanitation, corrections, etc.). In addition, my observations come from sexology texts and conferences of the major American and international sexology (and, occasionally, urology) organizations.

A True Story

In June 1989, a conversation took place during the annual meeting of the International Academy of Sex Research in front of a poster titled "Healthy Aging and Sexual Function" (Schiavi et al. 1990). One of the figures displayed depicted nocturnal penile tumescence[3] measures for a group of 65- to 74-year-old male volunteers. A urologist studying the figure said to the poster's author, a psychiatrist, "So, these men did not have rigid nocturnal erections; they may actually have had disease." "No," the psychiatrist replied, "they were healthy, and in fact they were having sex; their wives confirmed that there was no dysfunction." "But," continued the urologist, "their wives

may be satisfied, even *they* may be satisfied, but since *some* men in that age group *can* have rigid erections, *these* men must have had some impairment."

The urologist promotes a model that champions the authority of "objective facts" as revealed by technologies and the evaluation of body parts. The psychiatrist defends the authority of human subjectivity and personal experience. In the urologist's model, women are invisible and irrelevant; sexuality has yielded to "the erection" as the subject of professional interest and intervention. This article examines the recent expansion in cultural authority of the urologist and the constructions he[4] advocates, as well as their consequences. By "phallocentrism" is meant this preoccupying interest and focus on the penis/phallus in sexuality discourse.

MEDICALIZATION

Medicalization is a major intellectual trend in the 20th century—a gradual social transformation whereby medicine, with its distinctive ways of thinking, models, metaphors, and institutions, comes to exercise authority over areas of life not previously considered medical (Conrad and Schneider 1980). For medicalization to work, the particular behavioral area must be divisible into good (i.e., "healthy") and bad (i.e., "sick") aspects, and be somehow (albeit often distantly) relatable to norms of biological functioning. It helps if medical technology can have some demonstrable impact on the behavior.

Two types of medicalization have been described. Type 1 occurs when a previously deviant behavior or event such as a sin, crime, or antisocial act is redefined as a medical problem; type 2 occurs when a previously com- mon life event (e.g., pregnancy, baldness, memory problems) is redefined as a medical problem, often focusing on physical changes associated with aging. Medicalization transforms unacceptable erectile performance into a subject for medical analysis and management. Surprisingly, definitions and norms for erections are absent from the medical literature. The assumption that everyone knows what a normal erection is is central to the universalization and reification that supports both medicalization and phallocentrism.

Medicalization occurs over a period of time. In the case of male sexual function, there are four groups identifiably active on behalf of medicalization (urologists, medical industries, mass media, and entrepreneurs), with many men and their sexual partners forming a receptive audience. In addition, institutions with a stake in sexual restrictiveness may indirectly support medicalization because of its potential for social control through specifying norms and enforcing conformity.

ADVOCATES FOR THE MEDICALIZATION OF MALE SEXUALITY

Urologists

In the 1960s, in anticipation of an increased patient population to be generated by Medicare and Medicaid, the U.S. government stimulated the creation of new medical schools, and preferred immigration status was granted to doctors (Ansell 1987). As a result, between 1970 and 1990 the number of physicians in the United States jumped from 325,000 to almost 600,000, while the number of surgeons increased from 58,000 to more than 110,000 (Rosenthal 1989). This rapid expansion created competition within and between medical and surgical subspecialties, including urology.

Urologists began specializing in male sexual dysfunction in search of patients and research areas. Using the new nomenclature of sexual "dysfunctions" provided by clinical sexology and psychiatry (LoPiccolo 1978), surveys began to show a significant prevalence of sexual complaints in the general population, among medical patients, and resulting from medications.

Urology-dominated treatments and technologies evolved in the 1970s. They currently consist of various penile surgeries, penile implants, injections of drugs into the penis to cause erection, and vacuum erection devices.[5] Besides its economic potential, sexual dysfunction is an attractive subspecialty because patients are not chronically sick or likely to die from their "disease"; there are also opportunities for diverse outpatient and inpatient services.

It is probably in the realm of diagnostics that urology has advanced medicalization the most (Nelkin and Tancredi 1989). By promoting sophisticated technologies for "differentiating" among various erection problem etiologies and by ensuring publicity of the claim that physical causes of erection problems are paramount, urologists have, over the last decade, come to dominate the "proper" diagnostic evaluation of men's sexual complaints (Spark, White, and Connolly 1983; Rosen and Leiblum 1992a).

A recent issue of the monthly American Urological Association newspaper contained a bordered box that read: "AUA Policy Statement/Male Sexual Dysfunction/Sexual dysfunction in the male is a disease entity, the diagnoses and treatments of which deserve equal attention to that given other diseases" (*AUA Today* 1993, 6). This bold jurisdictional claim is the outgrowth of a decade's professional events. An informal 1978 meeting of urologists in New York resulted in the 1982 formation of the International Society for Impotence Research (ISIR) and its journal, the *International Journal of Impotence Research*, in 1989. The first "World Meeting on Impotence" was held in 1984.

A major overview of the new field of "impotence" in the prestigious *New England Journal of Medicine* was coauthored by three urologists (Krane, Goldstein, and de Tejada 1989).

Urologists have promoted their claims through consistent use of "impotence" language, while sexologists' language claims have been hesitant: "Although we strongly prefer the terms 'erectile disorder' or 'erectile dysfunction,' we have opted, after considerable discussion and debate, to grant each author editorial discretion and freedom of choice in this regard" (Rosen and Leiblum 1992b, xviii).

In 1985, Elliott reviewed the frequency of use of the terms "impotence" and "frigidity" (another term sexologists had rejected) in titles in the *Psychological Abstracts* from 1940-1981. Initially equally popular, there were almost no recent uses of "frigidity" while "impotence" was now far more popular than ever before. In 1992, the National Institutes of Health sponsored a Consensus Development Conference on Impotence.[6] I spoke on "nomenclature," and suggested that "impotence" was pejorative and confusing (Tiefer 1992a). The final conference statement begins:

> The term "impotence," as applied to the title of this conference, has traditionally been used to signify the inability of the male to attain and maintain erection of the penis sufficient to permit satisfactory sexual intercourse. However, this use has often led to confusing and uninterpretable results in both clinical and basic science investigations. This, together with its pejorative implications, suggests that the more precise term "erectile disfunction" be used instead. (National Institutes of Health 1992, 3)

Nevertheless, the final report was still titled "Impotence."

Medical Industries

Manufacturers and suppliers of medical products and services have obvious economic interests in expanding a new medical specialty. Individual pieces of diagnostic and treatment equipment can easily cost tens of thousands of dollars, and the field is very competitive. Pharmaceutical company interest has grown rapidly since the first effective injections of drugs into the penis to cause erections in the mid-1980s (Wagner and Kaplan 1992); clinical trials in my department currently test drugs that can be applied to the penis in cream or pellet form.

Medical industries provide resources to create the cultural authority essential to medicalization. The Mentor Corporation, for example, one of the five current major American penile implant manufacturers (Petrou and Barrett 1991), started the Impotence Foundation in 1986 as a "national information service" (Mentor n.d.) with a toll-free information number, unlimited free

patient education brochures and videos, and complete information and materials for educational seminars (e.g., ad designs, slides and manuscripts) for doctors.[7]

Another contribution to medical hegemony comes from the American health insurance industry's cutback on multivisit services, including mental health services (Kramon 1989). For example, the majority of men I interview are New York City government employees with HMO-type insurance that will completely cover the cost of any surgical or pharmacological treatment for their sexual problems, but that will pay *not one penny* for psychological sex therapy treatment or education.

Mass Media

Mass media play a fundamental role in conferring cultural authority and legitimacy (Nelkin 1987). My belief is that mass media favor medicalized information about sex because focusing on "scientific developments" or "health advice" allows publication of sexual subject matter with no taint of obscenity or pornography. Medicalized writing about sex is "clean" and "safe." You don't see articles in the *New York Times* on techniques of fellatio, but you'll see dozens on penile injections. By quoting medical "experts," using medical terminology, and by swiftly and enthusiastically publicizing new devices and pharmaceuticals, the mass media legitimize, instruct, and model the proper construction and discourse (Parlee 1987). People underline and save "sex health" articles, and I have had patients bring in such material even years after publication.

A two-part "health column" article on "impotence" in the *New York Times* illustrates the medicalized media approach to men's sexuality. The first part begins by publicizing the claim about medical etiologies: "Less than a decade ago, more than 90% of impotence cases were attributed to emotional inhibitions . . . but . . . experts say that more than half, and perhaps as many as three-fourths of impotency cases have a physical basis" (Brody 1988, B4).[8]

"Impotence" language is used. Unnamed "experts" are credited with generating a major shift in sex problems' etiology, although no new epidemiological studies are mentioned. A climate of conviction is created that is reinforced when the *Wall Street Journal* begins a front-page article by claiming that new research suggests "impotence" is usually organic (Stipp 1987). Why should there be any doubt when *Time* magazine devotes a whole page to repeating the assertion that psychological issues are largely irrelevant to "impotence" (Toufexis 1988)? This article, brought to me by several patients, quotes a 76-year-old man with a penile prosthesis implanted after prostate cancer who told his wife he felt like he was 26 years old again. It

also quotes a 40-year-old former policeman with a fractured back whose wife initiated sexual relations by suggesting that he give himself a penile injection.

The title of the *Time* article, "It's not 'all in your head,' " reveals the stigma associated with "mental" causes of sexual malfunction. Popular articles on men's sexual problems often begin, as did the 1980 *JAMA* lead article "Impotence is not always psychogenic" (Spark, White, and Connolly 1980), with the mantra, "Until recently, medical literature attributed [fill in a high number] per cent of impotence to psychological causes. But, now it is estimated that [fill in a high number] per cent can be traced to organic disorders" (e.g., Blaun 1987; Blakeslee 1993).

Science and health journalism seems so superficial and uncritical as to be little more than advertising (Burnham 1987). Emphasis is placed on new technologies, often with the disclaimer, as in the current case of penile injections, "not yet FDA-approved." There is rarely any follow-up of initial reports. The articles are sprinkled with individual accounts of satisfied customers provided to the print or electronic journalist by hospital or manufacturer publicists. The last time my name appeared in a popular magazine article (Sheehy 1993), my hospital public relations director called to ask if I would like to prepare some materials and provide some patients for a possible news release and press conference! Television and radio talk shows also publicize and promote the new medical technologies for men's sexual problems, and I have met with many retirees whose perspective on sexual problems was largely informed by such shows.

Entrepreneurs

These advocates for medicalization include self-help group and newsletter promoters who have created a market by portraying themselves as something between consumers and professionals. Impotents Anonymous (IA), which is both a urologists' advocacy group and a self-help group, had its formation announced in the *New York Times* (Organization helps couples 1984) in a story including cost and availability information on penile implants. The organization's married founders' own story was included. They recently toured with their new book, *It's Not All in Your Head* (MacKenzie and MacKenzie 1988; Naunton 1989). Although the Impotents Anonymous newsletter,[9] *Impotence Worldwide*, features their organizational slogan, "bringing a total care concept to overcoming impotence," only urologists are on the organization's advisory board.

The advocates for medicalization portray sexuality in a rational, technical, mechanical, cheerful way. Sexuality as an area for the imagination, for politi-

cal struggle, for the expression of diverse human motives, or as a sensual, intimate, or spiritual, rather than performative, experience is absent.

MEN AS AN AUDIENCE FOR THE MEDICALIZATION OF SEXUALITY

Men constitute a ready audience for the medicalization of sexuality because of male socialization and masculine ideology, which make erectile function central to masculine self-esteem (Pleck, Sonenstein, and Ku 1993; Metcalf and Humphries 1985). The chronic insecurity and intermittent desperation (Hall 1991) that result from this situation render men vulnerable to offers of "magical" and permanent solutions such as those offered by the technological fixes of modern urology (Tiefer 1986).

In recent years, numerous texts have underscored the pressures experienced by heterosexual men as standards for masculine sexual performance escalate in response to the "sexual revolution" and women's "new" sexual expectations (Zilbergeld 1992). Men themselves contribute to these insecurities by endorsing naturalizing belief systems about sexuality and women's sexual satisfaction. Patients I see often insist, despite my demurral, that women (a uniform class) cannot be sexually satisfied without intravaginal intercourse, and claim that their motivation for the erectile dysfunction evaluation and treatment is to keep their wives from leaving them. Interviewed separately and asked if they thought the marriage could break up because of the erectile difficulties, the wives are often surprised and offended at the idea!

Phallocentric beliefs burden and pressure men, but at the same time they maintain sexual privilege. The "needs" of the naturalized erection dominate the sexual encounter script where phallocentric sexual activities generally ensure men's pleasure and satisfaction. Assumptions of universality free men from regarding themselves or their partners as sexual individuals.

In addition to maintaining the phallic focus, the medicalized construction of sexuality offers men an "objective" world of science and medicine to minimize anxieties provoked by public disclosures of sexual inadequacy. Although any performance failure challenges masculinity as constructed within the ideology of "machismo" (Mosher 1991), at least medicalized discourse keeps the sexuality focus on the physical, and avoids inquiry into motives, values, wishes, feelings, or fantasies (Seidler 1992). The mantra of sexual medicalization, "It's not all in your head," replaces the stigma of failed responsibility with the face-saving excuse of physical incapacity men learn in sports and the military.

Are all men equally attracted to a medicalized message? Schiavi et al. (1990) describe men (not a clinical sample) whose erections were not adequate to have vaginal intercourse with their wives on at least 50 percent of their attempts over the past six months, yet who reported high levels of sexual and marital satisfaction. These men would seem to have sexual activity scripts and masculinity constructions which don't require long-lasting, rigid erections.

WOMEN AS AN AUDIENCE FOR THE MEDICALIZATION OF MEN'S SEXUALITY

Literature produced by the medicalization advocates often depicts women as supporting the medicalization of men's sexuality. For example, women offer testimonial to their pre-implant unhappiness and post-implant sexual and relationship satisfaction in patient education videos available from implant manufacturers.[10]

What about women's actual voices and self-representations? My interviews with the women sexual partners of the urology patients suggest that some do subscribe to a medicalized and phallocentric construction of sexuality. Sometimes they derive physical pleasure primarily or exclusively from coitus, and they talk, like urologists, about sexuality as requiring and centering around erections. Women who want to become pregnant often focus on their partner's erectile function as the centerpiece of sexuality.

Another subgroup is unhappily resigned to male privilege. They say men and women are sexually different, and that men's phallocentrism is limiting, but they go along with the status quo. When asked how they would conduct sexual relations, they say, "I'm not sure, but there's got to be something better."

Other women I've spoken with strongly diverge from the medicalized and phallocentric construction. They often "cannot understand why he is so upset," since both partners enjoy nonintercourse activities. Some worry that their own sexual enjoyment (often increased since their partner's erection difficulties began) is endangered by penile injections and implants. "He'll want to use it all the time, and what will that do for me?" one wife angrily asked. Many women have asked me or asked me to ask the urologist to "talk sense" to their partner and make him less obsessed and unhappy.

Feminists have problematized coitus as the prime form of sexual activity if women's erotic pleasure is as important as conception or men's pleasure, yet coitus remains the prime component of the script of heterosexual relations (Clement 1990). The feminist critique, for the men and women I interviewed,

has merely added the clitoris to the standard phallocentric script, with intercourse still the main event, and anything else foreplay, afterplay, or "special needs."

MEDICALIZATION AND PHALLOCENTRISM

I realized that medicalization was about phalluses rather than penises when I tried, at the NIH Consensus Conference on Impotence, to introduce the idea of multiple meanings of erections. Disputing the notion of the "standard normal erection," I argued that "different men and different couples expect and rely on different degrees and durations of penile rigidity to accomplish their sexual goals" (Tiefer 1992a). Neither the audience nor the final report took any note.

In the world of medicalization, erection is not a means to an end; there is a universal erection that is normal, and deviations are abnormal and need treatment. The normal erection is implicitly defined as "hard enough for penetration" and lasting "until ejaculation"—informally, that means a few minutes.[11] Anything less is "impotence." Occasionally, men come in who have medically proper erections, but who can't have two or three ejaculatory episodes. Like all our patients, they want their penis function to conform to their standards of masculinity. They request treatment, but nothing is available.

Medicalization reifies erections. Although no sexual encounter or relationship occurs in the examining room, within the medical context a man's sexuality is present when penile arteries or veins are technologically observed or when a history focuses on erections (how hard? how often?) abstracted from any context. The message throughout the medical encounter is that the penis and the erection are what count, and are *all* that count. The patient takes home a machine to measure nocturnal erections (hardness and duration), but nothing to assess his relationship, his knowledge of sexual techniques, his comfort with bodily expression, or anything about his partner.

Although the news reports make it sound like diagnosing and treating men's erectile problems follow well-established patterns, there is considerable disagreement within the field (National Institutes of Health 1992). The symbolic need for a universal phallus has prevented examination of the range of real erections (not to mention variations in their subjectivity); moreover, the available medical and surgical treatments for erectile problems have worrisome psychological and interpersonal consequences that are ignored by the media and the follow-up literature. Kabalin and Kessler (1989), for ex-

ample, report a 43 percent malfunction and re-operation rate for 290 patients with penile prostheses they operated on between 1975 and 1985. Our own follow-up research indicates that a variety of pervasive worries about health and safety may accompany the penile implant despite satisfactory function (Tiefer, Moss, and Melman 1991).

Additional connection between medicalization and phallocentrism comes from mental disorders' classification (American Psychiatric Association 1987; Tiefer 1992b). The current edition lists nine "sexual dysfunctions"; heterosexual coitus, requiring proper erectile function, is their sole focus. This nomenclature legitimates medicalization by relating sexuality to the (supposed) universal, biological norms of "the human sexual response cycle" (Masters and Johnson 1966; but see Tiefer 1991b). There is no place in the medical model of sexuality for the idea that erection and orgasm are social constructions given meaning by personality, relationship, values, expectations, life experience, or culture (Tiefer 1987).

CONCLUSION: IN PURSUIT OF THE PERFECTIBLE PENIS

The new scholarship on men occasionally makes reference to the unbridgeable gap between the real and vulnerable penis and the mystical, all-powerful phallus (e.g., Metcalf and Humphries 1985). Modern technology seems determined to bridge that gap, or at least to keep alive the hope that a perfectible biology is just around the corner. The complex ritual and devices attached to the penis in the examining room by white-coated technicians transform sexuality as they reduce it to neurology and blood flow. The spotlight directed on "the erection" within current medical practices isolates and diminishes the man even as it offers succor for his insecurity and loss of self-esteem.

Men may enter the system innocently looking to understand the cause of a change in their bodily and sexual experience; the options they are given for understanding and coping shape an ever more phallocentric experience. Their partners and any ideas or feelings those partners might have are usually (our protocol is unusual in this regard) irrelevant to the process. Erections are presented as understandable and manipulable in and of themselves, unhooked from person or script or relationship. A discourse of vascular processes—blood flow into the penis, trapping mechanisms in the penis, venous outflow—takes over. Patient education literature teaches that organic factors account for erection problems, and patients may be led further and further into diagnostic tests to locate specific deficiencies. Since specific causes are usually not

identifiable, some generalization ("your blood pressure medication," "some hardening of the arteries") is offered, and a medical treatment recommended. Because the remedies do create rigid penile erections, the patient is understandably convinced that the biological rhetoric was correct.

Women occupy an essential place in the discourse (the need for vaginal "penetration" being the justification for the entire enterprise), but women are only present in terms of universalized vaginal needs; their actual desires and opinions are (conveniently) invisible, suppressed, neglected, denied.

It is not clear how one might slow or reverse this trend. "Basic" research on the cellular and neurochemical operations of the penis prepares a future of more organic "defects." The men's movement notwithstanding, there is no end in sight to the medicalization of men's sexuality, nor to the phallocentrism it perpetuates.

NOTES

1. Some of these ideas are published in Tiefer 1993, and were also presented as the senior lecture at the Society for Sex Therapy and Research, Montreal, 1992.

2. Urology is a surgical subspecialty for conditions affecting the male genitourinary tract (i.e., kidneys, bladder, prostate gland, internal genitalia, penis, scrotum). The boundaries between gynecology and urology are contested in terms of women's care.

3. "Nocturnal penile tumescence" refers to the periodic erections men have while sleeping. These erections are monitored with take-home instruments. Men with normal nocturnal erections are assumed not to have organic impairment.

4. In 10 years of work in this field, I have met or read the work of only two women urologists but dozens of male urologists.

5. Surgical insertion of a permanent penile prosthesis replaces the man's own erectile tissue with permanently rigid (though bendable) cylinders or with indwelling components that can be inflated and deflated (Melman and Tiefer 1992). Injections are directed into the side of the penis, cause an erection lasting up to several hours, and must be repeated for each erection (Wagner and Kaplan 1992). Vacuum devices create an erection through external suction and the use of constricting bands (Witherington 1988).

6. A Consensus Development Conference assesses competing medical conceptualizations, workups, and treatments to arrive at a consensus of current knowledge as a guideline for practitioners.

7. Free materials are available from the Impotence Foundation, P. O. Box 60260, Santa Barbara, CA 93160; or 800-221-5517.

8. Copyright © 1988 by The New York Times Company. Reprinted by permission.

9. Available from the Impotence Institute of America, Bruce MacKenzie, Publisher, 119 S. Ruth St., Maryville, TN 37801.

10. For example, "Impotence Treatments: Making the Right Choice" available from American Medical Systems (a division of Pfizer), 11001 Bren Road East, Minnetonka, MN 55343.

11. The urologist I work with says five minutes, but neither he nor the other workers in this area put that in writing.

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