TAKING THEIR CUT: CONSTRUCTING THE FEMALE PATIENT THROUGH AMERICAN HEALTH POLICY, 1990 - 1993

Megan Scanlon

A Thesis
Submitted to the Graduate College of Bowling Green State University in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

December 2005

Committee:
Lynda Dixon, Advisor
Jeannie Ludlow
ABSTRACT

Lynda Dixon, Advisor

The topic that is addressed here is the embodying of the female patient through the political-medical discourse that accompanied the Women’s Health Equity Act and breast cancer politics between 1990 and 1993. Through an examination of women’s health policy during these formative years together with Foucault’s theory of the gaze and embodiment, this paper will formulate the manner in which the female patient comes to personify certain characteristics and medical concerns as an effect of the relationship between politics and medicine. In addition to the central thesis supplementary themes materialize throughout the paper. One motif is the cyclical relationship between politics and the media. When one party brings a subject to the forefront, the other reacts and strengthens national attention concerning the matter. Women’s health as a disciplinary field also raises questions regarding theories of the body by constricting patients to binary categories of male/man and female/woman, a concept that draw parallels to the codification of race/ethnicity in society. As a policy issue women’s health illustrates the contradictions that exist between the body, disease, the goals of medical care, and our self-image in relation to policy makers. Reviewing this period of research and the formation of women’s health policy exposes the multifaceted relationship between politics and medicine. Simultaneously, policy crafted between 1990 and 1993 highlights the deep roots of cultural bias concerning the social value of female bodies and their feminine body parts.
ACKNOWLEDGMENTS

Any foray into research and writing can be a long and sometimes isolating experience. Without the support of my friends, family, and professors, I'm certain that this thesis would not exist. In particular, I'd like to thank Meg Patterson for her meticulous notes and considerate comments, Claire Romanski de Slepowron for incessant encouragement, Christina Hayes and Nicole Rheaume for showing interest, Jenny Haberlin, Katie Nussbaum, Katie Schuller, Katie Southwell, Kris Gulden, and Kristen Hamilton for their friendship during my academic career, Elise Fleming for helping me maintain my sanity in Bowling Green, my sister Kelly for research assistance, and the staff at the Center for Choice for listening to my rants. Insightful comments from Lynda Dixon, Walt Grunden and Heather Huyck greatly strengthened my argument and research for this paper and related topics. I must also thank the Women's Studies Department at Bowling Green State University for providing me with the opportunity to pursue a graduate degree at no cost. Finally, the inspirational work of Jeannie Ludlow taught me that my scholastic experience and graduate education can exist far beyond the boundaries of the classroom.
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When Dr. Adriane Fugh-Berman attended medical school in the 1980’s, her anatomy lab instructor told students to cut off the female cadaver’s breasts and discard them. Now, as a general practitioner in Washington, she wonders how many of her fellow students took away the message that despite the epidemic of breast cancer, women’s breasts possess no medical significance. Within a few years of Fugh-Berman’s graduation from medical school, however, breast health gained cultural and political significance and grew to become synonymous with “women’s health.” These conflicting notions of form and function regarding the female body typify common themes in women’s health that have traditionally dominated the medical model for women in America. In the biomedical field women are routinely viewed as objects that are controlled by reproductive capabilities, while lacking power to make autonomous decisions over their own wellbeing. Outside of reproductive health women’s bodies are rendered virtually invisible. When they are examined under the lens of medicine they are viewed in fragments, typically with focus on the ovaries, the uterus, and any part of the body that is foreign to men. Moreover, women have received little attention in medical school and in the biomedical field. Health issues affecting women, like osteoporosis or the menstrual cycle, have been the subjects of surprisingly little research, in contrast to issues affecting men. Likewise, the instruments used in heart surgery are designed for men’s hearts and larger arteries, since heart disease was traditionally seen as a man’s disease. Without adjustment for size these instruments and androcentric treatments often account for grave medical mistakes, though new studies now prove that heart disease is the leading killer of women.

Following a report from the General Accounting Office in 1990 that proclaimed a mere 13% of federally funded health research was spent on women’s issues, a new era in women’s
health erupted. The findings, which were quickly splashed across headlines from coast-to-coast, solidified what many women believed for years, that their health, like many other aspects of their lives, was not considered as valuable as their male counterparts. This incited women, like Dr. Fugh-Berman, to seek legislative action for women’s health. Between 1990 and 1993 the United States witnessed an unprecedented surge of national attention focused on women’s health. This new age of research and the formation of gender-specific medicine exposed the multifaceted relationship between politics and medicine while also highlighting the deep roots of cultural bias concerning the social value of female bodies and their feminine body parts. Although a great deal of feminist scholarship in the social sciences and humanities has focused on the gender implications surrounding the new field of women’s health by scrutinizing underlying notions of biological difference, few have engaged with recent political formations and the consequences of gender-specific legislation that largely control gender identity. Indeed, it is this political component and the embedded power structures in similar societal institutions, including medicine and the media, which largely establish gender identity by attaching monetary and cultural values to certain female bodies and body parts. The topic that is addressed here is the embodying of the female patient through the political-medical discourse that accompanied the Women’s Health Equity Act and breast cancer politics between 1990 and 1993. Through an examination of women’s health policy during these formative years together with Foucault’s theory of the gaze and embodiment, this paper will formulate the manner in which the female patient comes to personify certain characteristics and medical concerns as an effect of the relationship between politics and medicine.
I: TWO HUNDRED YEARS OF WOMEN’S HEALTH POLICY

The political-medical discourse surrounding women’s health and related public policy in American history has simultaneously shaped social movements and provided the impetus for reform. That is, women react to policies and law that modify their health care while also demanding that the Government take necessary action to improve the status of their wellbeing. Patients, doctors and politicians are involved in the creation of women’s health policy, though it is clear that each group holds disproportionate degrees of power when making law. Traditionally women’s health policy tended to emphasize gender roles and create a female subject that prioritizes motherhood and feminine characteristics, such as the ideal womanly body type. This politically constructed medical subject becomes evident after reviewing each segment of the women’s health movement in America.

American women have always spearheaded social reform in the field of domesticity. Women have formed self-help groups, influenced social policy through advocacy, and pushed for new types of health delivery by women. Work by Carol Weisman and Judy Norsigian delineates the progress made by women in American history that led to the creation of health policy specifically for the female gender. The first collective movement occurred in the 1830’s and 1840’s. This “Popular Health Movement” was a broad-based social movement focused on educating individuals about their health and ways to prevent disease. The movement attracted women because they were considered the caretakers of their families and communities. Consequently, it focused on health education and the promotion of healthy lifestyles, emphasizing the value of proper diet, exercise, dress reform to eliminate corsets, and the use of sexual abstinence in marriage to regulate family size. This movement included a reaction against the role of elitist, formally trained physicians who promoted heroic treatments, including blood-
letting, harsh prescriptions and amputations. Female midwives and lay practitioners granted some degree of legitimacy to women as domestic healers and typically provided gentler treatments than their male counterparts. The legacy of women’s health policy and history in the United States from this era maintained that the female patient focus on her role as the primary nurturer for the family, which included autonomy over childbearing.

Following the Civil War, women experienced expanding opportunities for education and employment and formed increasing numbers of women’s clubs and associations. There was a rapid growth in the number of women attending medical schools, with women ultimately making up 6 percent of all physicians in the United States, a number that was not rivaled again for nearly a century. However, these women lacked equal status with their male colleagues, since female physicians were generally excluded from training and working in mainstream hospitals. In light of this, women created women’s hospitals where both female doctors and nurses could be trained and employed. These hospitals, some of which became showcases for obstetrics and gynecological care, represented a clear example of an institution created by women for women. Women also worked to disprove the notion that their bodies were perpetually fragile by focusing on education as the best means to prove that their sex was as capable and agile as a male body.

The post-Civil War period also witnessed a successful campaign to legally prohibit contraception and abortion. Although this is historically viewed as a campaign led exclusively by male physicians, clubs and female physicians strongly favored this action. At the time women believed limiting contraception and abortion would hinder male promiscuity and the sexual exploitation of women. Members of the upper-class felt certain that the inability to curtail unwanted pregnancies would thwart the actions of sexually deviant persons from lower-classes. From this perspective the social measures passed against birth control could arguably be seen as
an advancement of women’s status. In addition to birth control measures doctors and patients alike continued to focus on the family and matters of reproduction when it came to women’s health. Authors Paul Starr, Roy Porter, Judith Leavitt and Ronald Numbers all address the dramatic shifts in American medicine following the Civil War that applied not only to women but also to all patients as a result of the professionalization and politicization of the biomedical industry.

Activists in the Progressive Era worked to reverse the actions of their foremothers. The birth control movement fought to legalize contraception as a method for women to protect their health and limit family size. Concurrently, an effort for maternal and child health highlighted the need for improving prenatal care and child health services. This group of activists successfully pushed for the establishment of the Children’s Bureau as well as the first governmental support in America for women’s and children’s health services through the passage of the Sheppard-Towner Act in 1921. The Sheppard-Towner Act specifically addressed the maternal health needs of women, and the health of children, across all economic and social lines. The Act was not only the high point of the Children’s Bureau activities, but was also the culmination of the entire women’s social reform, welfare and health movement of the first part of the century. Molly Ladd-Taylor thoroughly analyzes the legacy of the Sheppard-Towner Act in her book, *Motherwork: women, child welfare, and the state, 1890-1930*. Rima Apple also addresses the importance of the Sheppard-Towner act in her work *Women, health and medicine in America*.

Sheppard-Towner is historically significant in normative terms for the basic elements of equality, universal coverage, education and preventive care. The Act also rested on its underlying policy that children’s health is a foundation of the nation’s future. This ideology relies on the social responsibility of mothers and led the way for childrearing to become a task that
necessitated governmental oversight. The Act did not pass easily, however, and only survived until 1929. Sheppard-Towner was intensely opposed throughout its brief existence by the growing and consolidating medical profession, led by the American Medical Association. The campaign to defeat Sheppard-Towner and the work of the Children’s Bureau was philosophically intensive, with attacks claiming that the Act’s programs were “socialist medicine.” In *Frothingham v. Mellon*, the Supreme Court heard a challenge to the law brought in 1922 by one of the Woman Patriot organization’s leaders, Mrs. Randolph Frothingham of Boston, Massachusetts. In its brief for the court, the United States argued that the health of its people should be a manifest concern of government, and that, in essence, health care was a question of public right. Later, after conservative lobbying groups rallied against Sheppard-Towner, the Act was defeated in spite of the Court’s earlier ruling defending the need for public health care.

The rout of Sheppard-Towner marked the move toward privatization of women’s health care, the growth and consolidation of the medical profession, and within the profession, the growth of obstetrical and gynecological specialties. This dramatically shifted the power of authority pertaining to women’s health and family health into the hands of doctors and politicians. At the same time the American Medical Association was becoming a formidable powerhouse in the field of health and health policy, weakening the possibility for universal health care and intervention from the Government. The demise of Sheppard-Towner also signaled a decades-long decline of women’s expertise and leadership in the field of maternal and child health care. Women were no longer the primary caretakers of their children or their own bodies. When the Act was dismissed funding and educational opportunities disappeared also. Incongruously, women’s health legislation is rarely written without acknowledging women’s corporeal ties to children and claim to motherhood. While legislation habitually delegates
women to the role of childbearer and childrearer, the defeat of this Act ushered in a new form of paternalism for legislators and doctors regarding women’s health, one that undermined a woman’s ability to make decisions regarding her own health under the guise of federal protection.

The women’s health movement of the 1960’s and 1970’s was the first period that worked to acknowledge women’s health as its own right, apart from children, husbands and families. Following Sheppard-Towner, women’s health policy continued to center on domestic roles and reproduction until this age of activism altered many aspects of American life. The 1960’s and 1970’s paved the way for women to enter many leadership roles in community affairs, including health and medicine. This period of women’s health embodied the social ambiance of its day. Political activities in these decades were part of a grass-roots movement that challenged medical authority in many components of women’s health and women’s health care delivery. Activists noted that at the time, only 7 percent of physicians in the country were women, equal to the percentage of obstetrician/gynecologists who were women. The women’s health movement addressed a milieu of topics including an increase of female representation in medicine, childbirth reform, product safety, self-help, the over-use of hysterectomy, mastectomy and cesarean section, and perhaps the most memorable objective, legalized abortion. From the late 1960’s through the mid-1990’s, women’s health moved from grassroots groups and the quest for knowledge, through the growth of women’s studies and women’s health centers, to seeking changes in medical curricula and health advocacy. Thus the overall movement in recent decades was from political and medical critique, previously witnessed by reactions to the Sheppard-Towner Act, to a novel demand for advocacy. Over the same period, women’s health, as part of women’s concerns in general and women’s studies in particular, progressed through shifts of
emphasis across continents. As women gathered in local conferences health issues, including violence against women, became important topics of discussion and planning. The authors that comprised the Boston Women’s Health Collective and collaborated on the keystone work *Our Bodies, Ourselves* serve as a primary source on the social and medical shifts that took place during this period. The subsequent work and new editions on women’s health in America produced by the Boston Women’s Health Collective also function as a demarcation of the women’s health movement. Many other authors cite this era as the real beginning of the women’s health movement in America, including Maureen Casamayou, Lesley Doyal and Barron Lerner. Regardless of the true birth of the women’s health movement, the recurring topics surrounding the female body and the need for policy are noticeable throughout American history.

Several themes emerge throughout the history of women’s health care law and public policy for American women that highlight the expectations of politicians and the medical community about the female patient. Among the leading factors in shaping health care policy for women is their role as primary caretaker and the assumption that each woman will be the fostering hub of her family unit. Two other major themes include continuous efforts to control fertility and manage childbirth and the need for women to take the initiative and use organizational strategies to improve their welfare. Oftentimes these organizational strategies involved grassroots campaign, education for social reform, and mobilizing the media to acquire attention. What was lacking from this methodology was direct access and representation of women in political and medical roles.

Accordingly, governmental oversights of sexual conduct, female reproduction and womanhood are historically intertwined with notions of gender identity and proper social roles for women. This supposes that all women will fulfill their biological potential only when they
become mothers. As seen throughout American history, “motherhood” has always been a topic of concern for the government, which simultaneously empowers the state as the “protector” of female citizens while undermining the autonomy of women. Thus the Government knows what is best and most pressing for women and their health needs. Constructing motherhood as a government project to ensure that the health of the child be the primary task of the mother is also problematic. This notion underscores the idea that men will not want to be involved in the parenting process or have equal responsibility as fathers.

In addition to legislation concerning a woman’s reproductive system, health policy that is defined in terms of male/man and female/woman upholds the dualism that exists between the sexes. Feminists have argued that gender and sexual preference are richly varied and must be decoupled from biological sex, yet government policy maintains that there are only two sexes, which ultimately invites the idea that one is superior to, or more highly valued, than the other.8 Recent work by Anne Fausto-Sterling has provided new theories on gender and medicine and how science would differ if research were not embedded in a patriarchal society. Fausto-Sterling analyzes underlying political and social motives that are difficult to detach from research and medicine. Likewise, studies by Sue Rosser and Susan Sherwin on the limited nature of the nation’s health insurance and medical welfare system have provided evidence for new problems faced by many American women. One example comes from the graying of America, a phenomenon in which the older population has become overwhelmingly female. Generally, as women age, the inequities and disadvantages experienced by women in medical care also increase. In other words, while longer life expectancy sounds like good news for women, disease trends indicate that in actuality women will face greater health problems in their old age, such as osteoporosis and Alzheimer’s disease.
Beyond general health policy and healthcare for women in America, many studies now focus on the social construction of breasts. In recent years breasts have dominated the medical and political scene when women’s health is the topic of discussion. These analyses concerning the history of the breast offer profound context for the current political and social preoccupation with women’s breasts in place of the whole female body. Carolyn Latteier published a book dedicated to that theme, *Breasts: The Women’s Perspective on an American Obsession*, which surveys the history of the breast in America. Beginning with body image issues, Latteier dabbles in a wide array of topics involving the breast such as medicine, implants, evolution, and breastfeeding. The author also discusses psychoanalytic and relations theories concerning the importance of breasts for men and women. Two other significant works on the cultural and historical significance of breasts are *A History of the Breast* by Marilyn Yalom and “Breasted Experience: The Look and the Feeling,” by Iris Marion Young. Each author muses over the images and icons associated with breasts in modern society that contribute to the elevated status of the female chest in American culture. Yalom dedicates a section to “The Commercial Breast” that explores the relationship between a breast saturated popular culture with the scarcity of breastfeeding mothers and topless bathers. By making breasts so scarce in real life, America makes them more precious as commodities. Each work mentions that throughout history, images of women’s breasts have rarely been based on women’s experiences. Instead, most images are created by men, for men’s enjoyment. Women have only just begun to articulate all of the feelings breasts evoke for them – from the pleasures of lovemaking to the nightmares of breast cancer. With modern political and medical emphasis on the breast, American culture continues to fixate on this segment of the woman’s body.
Those involved in the creation of the 1990’s women’s health agenda are aware that recent activism, and each movement prior to their own, did not emerge in a vacuum, but out of a social environment in which a wide array of movements contributed to reshaping the sociopolitical landscape and related definitions of femininity and womanhood. Indeed, the very definition of health has been rewritten following efforts made by women and others to include a more complete perspective on patterns of disease and health that include mention of lifestyles alongside physical and emotional wellbeing. Just as women reacted to social changes and events in their time, activists today are challenging political and social classifications as they work through the concepts behind gender-specific medicine. The Women’s Health Equity Act, first introduced in 1990, is a prime example of modern health policy that attempts to create a new definition for women’s health. However, this act is limited by the biomedical categories of gender along with the social construction of womanhood. Women today are demanding more from physicians and politicians regarding their health needs, but the framework in which these provisions are proposed is still limited to existing ideals of motherhood and femininity. The overwhelming success of the breast cancer movement and related legislation, as part of and opposed to the Women’s Health Equity Act, demonstrates the ways in which policy manages to dictate women’s health needs and control the interests of the female patient. Such policy also upholds traditional notions of gender, a political and medical construct worthy of explanation.
II: GENDER AND/OR SEX

The social construction of “sex” as key a biomedical term is fundamental for the understanding of women’s health in a modern context. Like the concept of sex, “race” is a biological grouping that shares a similar path of social construction. In the 19th Century, the construction of “race” and “sex” was driven by social struggles over human inequality. Before the Civil War, the dominant understanding of race was as a natural or divine category – black and white differences were innate and reflected God’s will. This was a common argument made in favor of slavery. These differences were believed to be manifest in every aspect of the body, in sickness and in health. “Race” became engrained as a result of slave society, in literature, laws and people’s minds, and continued when reconstruction failed. Theories of women’s inequality followed a similar pattern. In the early 19th Century, traditionalists cited scripture to prove women’s inferiority, reaching far back to the time when Eve was created from Adam’s rib. Incidentally, the idea that women were created from a part of the male body added to the belief that women were identical to men apart from their reproductive organs. Women were frequently deemed biologically inferior to men by the medical profession, which promoted the argument that a woman’s place is in the home.

In the early 20th Century, Social Darwinists had considerable influence in shaping public views and public policy. They perceived two new threats to American superiority: the massive tide of immigration from eastern and southern Europe and the declining birth rate among women of Anglo-Saxon and Germanic descent. The passage of the Immigration Restriction Act in 1924 codified the idea of “race/ethnicity,” and led to biological classifications based on this political construction. This system of classification was then used as the explanation for racial/ethnic
differences in disease rather than examining lifestyles and socioeconomic status. Other developments in the early 20th Century encouraged biological explanations of sex differences in disease and in social roles. The discovery of sex chromosomes in 1905 reinforced the idea that gender was a fundamental biological trait, built into the genetic constitution of the body. That same year, Ernest Starling coined the term “hormone” to denote the newly characterized chemical messengers that permitted one organ to control, at a distance, the activities of another. In the realm of medicine, researchers turned to sex chromosomes and hormones to understand cancers of the uterus and breast and a host of other sex-linked diseases, replacing the need to worry about environmental influences. This gave employers the opportunity to argue that sex chromosomes and hormones determined which jobs women could, and could not, perform. Similarly, employers and physicians determined the occupational hazards to which women could be exposed, making women’s health and sickness a matter based solely on their biology and void of any social or economic factors.

This framework and system of classification regarding sex as well as race has shaped knowledge and medical practice in the United States to the present. Vital statistics present health information in terms of race, sex, and age, limiting the social variables that are linked with gender and ethnicity. Recent studies and theories pertaining to political and medical classifications of the body have illuminated some of the ways that would allow us to develop an alternative understanding in place of current categories. “Women’s health” as both a subject of intellectual analysis in the social sciences and an organizational focus brings these arguments to the center of biomedical studies.

Beginning with gender, as a social and political construction, it is imperative to comprehend that this is most often used in the social sciences as a reference to the cultural
elements that contribute to the social roles and values attached to men and women in society. Sex refers to the biological elements that distinguish a male from a female. For the most part, however, United States biomedical researchers use the two terms interchangeably, with a particular trend recently of using “gender” preferentially because it lacks the connotations of sexuality. The problem is neither simply semantic nor bibliographical. It could be argued that the very concept of “women’s health” as outlined by the National Institute of Health’s (NIH) agenda for future research leaves little conceptual room for gender analysis. Traditionally, factors affecting health that move beyond a strictly physical realm of causality is put down as “behavioral.” In other words, the personal choices of the woman (housing, sexual partner,) determine her environment and risk of disease. This analytic separation of the individual from her larger social situation is one of the distinguishing features between biomedicine and public health. Although these distinctions are important for developing interventions to treat or avert disease or disability, it is in this gap that many researchers locate the inadequacies of biomedicine and ultimately, the need for women’s health.

The confusion of “sex” and “gender” in biomedical discourse inadvertently points out the difficulty of defining sex and gender: where does “sex” stop and “gender” begin? Many biologists now recognize that “sex” is not a single, all-encompassing characteristic, imprinted on the organism at the moment of conception. Rather, biological sex is continually in a state of negotiation, reflecting a long sequence of interactions between genes, hormones, and uterine and extra-uterine development. Moreover, even in the fully formed organism, it is not always clear whether disease is due to one’s sex or one’s gender. When writing women’s health policy it becomes apparent that characterizing all women universally as biological beings will not necessarily characterize all women as gendered beings, with the result that any claims about
“women” as a universal category becomes suspect. The analytical work of historians, anthropologists and comparative sociologists over the last half of the 20th Century shows that the notion of gender in these fields changes in relation to time and place. As a result, observations that are made of women in one context cannot be assumed to be true of women in general. Similarly, women today have very different health care needs than their foremothers. Different diseases and conditions that existed in the past are no longer present, such as the need for corset reform or the fear of over-exertion in the late 19th Century. Distinct health threats for the modern female patient are now evolving, such as autoimmune diseases. Legislators and physicians must adapt to these changing needs and address the female patient in a new context. Similarly, women’s health policy and United States biomedical policy, must work in a way that recognizes both social and political ramifications of emphasizing gender differences when constructing the medical body.

Before analyzing the women’s health movement and policy between 1990 and 1993, certain theories of the body and terminology relating to gender must be understood. Different, perhaps conflicting, definitions for women’s health have been used in various disciplines in recent years, reflecting an analytical and material fragmentation of the ways women’s health has been researched and pursued. Within medicine, women’s health is often defined by obstetrics and gynecology; within public health, women’s health needs are frequently seen as being met by maternal and child health programs.15 Health policy typically perceives women as wives and mothers; they are important for childbirth, childcare and domestic nutrition. The situation is further complicated by the fact that the category “woman” reflects more than half of the population. The definition of “women’s health” that is applied in this paper is taken from the legislative text written on the subject of women and their health needs that is brought forth in
Congress. What the federal government deems most valuable and turns into law ultimately defines “women’s health” at the national level by constructing a female patient and medical community with certain priorities as a result of health policy.
III: THE EMBODIMENT OF THE CONTEMPORARY FEMALE PATIENT

The relationship between patients and their doctors, and representatives and their constituents, demonstrates positions of power and the use of such faculties. These relationships are frequently uneven with men holding the position of power. A sociopolitical critique of women’s health and gender-specific medicine must include knowledge of power structures that exist in society, specifically with regard to patients and their physicians and hierarchies within Congress. Many feminist thinkers, and students of Foucault, have been critical of the Western tendency to identify the essential self with a divine soul or disembodied reason, and seek to refocus attention on the body and aspects of the person associated with the body: gender, emotions, sexuality, and reproduction. Feminist thought has also worked to illuminate the way in which women’s bodies are controlled within American culture. From an early age and throughout their life, women are bombarded with messages from family, school, church, and media for how their bodies must look and act, many of these ideals contradictory or simply unachievable. For example, recent studies on women’s health from a feminist viewpoint suggests that the objectification of women’s bodies, and the idealization of slenderness, helps foster the phenomenon of anorexia nervosa; but by labeling this a “disease,” the medical establishment obscures the cultural roots of this condition, thereby supporting existing power relations. Rather than exploring cultural factors related to the disease and the social factors surrounding a woman’s physical appearance, the person is simply considered unwell.

In contrast Foucault contends that we must think of the social influences that add to the construction of the modern medical body. The radical history of European social institutions found in *Discipline and Punish* and *The History of Sexuality* written by Foucault, contain
insights that are applicable to American society. Foucault believed that subjectivity could best be understood by deciphering how social institutions construct the body. As a result many rituals found in political and medical organizations shape and define disease and those who are afflicted with it. The medical body, according to Foucault in *The Birth of the Clinic*, is a four-dimensional extension in space and time that is created and recreated through performance. As Foucault discusses in this work, medicine defines and describes diseased bodies labeled as deviant and in need of rectification. Foucault also theorizes the ways in which the medical body is subject to the clinical gaze, a mechanism similar to the “panopticon” discussed in *Discipline and Punish*. The clinical gaze is a device that is both a penetrating glance and sage observation. Foucault believes that the myth of the clinical gaze is based upon the belief that the physician can see into the heart of a problem in order to diagnose and treat it, and that this ability to know by gazing is a result of scientific and medical observations. The clinical gaze is also applicable to politics. When politicians address medical topics they are attempting to treat a social problem that they have observed by means of legislation. This reinforces the power of the gaze by assuming that politicians and doctors have the ability to solve a problem through money and medicine. With regard to female patients, doctors and politicians are able to view and observe women in American society and prescribe necessary treatments according to political and medical beliefs, constructing a woman with particular values apart from her own judgment.

This medical way of gazing extends beyond the boundaries of the clinic to shape our self-understanding and practices in a variety of domains, such as sexuality, diet, and psychology. This knowledge system is also a complex power system, exerting surveillance over bodies that offers and imposes treatment. The control is not simply exercised from without, but internalized, such that subjects in seeking their own liberation concerning health, beauty and normality, monitor
and operate upon themselves. Thus a female patient may not realize the full impact that the political-medical discourse has on shaping her own quest for health. Looking inward for purposes of emancipation from illness or in search of health prevents substantive criticisms of social practices and political trends. The current women’s health and beauty industry epitomizes a liberation discourse in which internal gazing and judgment, rather than a sustained critique of visions of female beauty proliferated within our culture, are presented as the prelude to individual freedom. This internalized and societal gaze infiltrates the medical field as well, particularly when women come to physicians for help and understanding on how to adjust their bodies to their social lives, whereas the medical model assumes that women should adjust their social lives to their bodies.

The medical model in America is an effective illustration of Foucault’s theory of embodiment. To embody something is to put into a body an idea or spirit. Likewise it may mean that one may give a concrete form to or express a concept through principles, thoughts, or intentions, within art, action, word combinations, or institutions. Thus, an embodiment of an idea or principle is its physical form, realization or expression, or the incarnation of that idea. Embodiment labels a way of living or inhabiting the world through one’s acculturated body. The modern female patient may therefore embody preconceived notions regarding her health and appearance based on American standards.

The sociomaterial aspects of the patient that vary with the process of embodiment are often the foundation for medical treatment. Physicians may inadvertently alter the care given to their patients based on the individual’s race, class or gender. Those who can afford private physicians have vastly different medical experiences than those who are on Medicaid. Consequently, what the patient comes to embody socially and politically influences medical
treatment. The political discourse that accompanies medicine also impacts the process of embodiment for the patient. Female patients may embody different values than male patients as a result of social standards. While embodiment is a continual process that alters and changes our bodies over time, it may not necessarily include a physical change, though it does require a material entity. Rather than focusing on biology alone, embodiment explores the process of delineating and substantiating the medical body. Studying the clinical gaze and the process of embodiment begins to blur the boundaries between the body as a “concept” as developed in scientific research and the body as “experienced,” a subject with room for growth. For example, while breast cancer has existed as a life-threatening illness throughout world history, it is becoming a disease that receives more attention over other illnesses in America due to the embodiment of the female patient. As a result of the political and medical gaze, patients and physicians are ever more worried about breast cancer. The female patient now embodies an increased fear of this illness in relation to increasing sociopolitical awareness. Patients also participate in their embodiment, as evidenced by the many women who brought breast cancer to the political front to better their own experience and treatment. However, the history of women’s health policy highlights the political production of the female medical body that populates American society. Between 1990 and 1993 policy history was modified to include breast health.

The body is the primary site of political inscription in Foucault’s critical praxis, yet the patient does not exist as an unwitting sufferer of power relations. There is no looming source of power that controls the bodies of an individual. Rather, Foucault argues, an exercise of power relies on a complex play of supports in which the apex and the lower elements of the hierarchy stand in a relationship of mutual support and conditioning. In the context of the medical practice, the patient’s body may be exploited or brutalized due to its place at the bottom of
clinical hierarchies, but the patient is not, as a result, any more controlled by power relations in society than are physicians. Patients may enter a clinical setting and feel as though they are at the mercy of the medical establishment. To obtain treatment and cure a patient’s behavior one must proceed in accordance with clinical protocol pertaining to particular diseases and to the clinic more generally. Additionally medicine encourages “the active patient,” those who function as self-observing actors, monitoring their own body and lifestyle for signs of abnormality and deviation from the role of responsible individual citizen and urged into compliance by the medicalization of everyday life. Active female patients therefore are taught that they have the duty to care for the presentation and health of their bodies along with that of their families. From a policy perspective, women’s health is defined in terms of familial roles, reproduction, and breast health, creating a medical model that values these issues above others.

Gender differences may be further compounded by the dependency and inequality inherent in the doctor-patient relationship. When the power between the parties is unequally distributed, effective participation is undermined and control of the ultimate decision is minimized. Without power, patients cannot place their own values, whether on a personal, cultural, religious, or otherwise group defined basis. When patients find themselves unable to control their own decision-making, the likelihood increases that unwanted risks might be imposed on them. Paradoxically, all this medical attention may harm women, as evidenced by recent concerns about high rates of hysterectomies and cesarean sections. In the area of mental health, women are consistently treated more frequently and aggressively than men. For example, numerous studies conducted over the last twenty years have shown that when men and women present the same physical or emotional complaints, women are significantly more likely to receive antidepressants, tranquilizers and other psychotropic drugs.24
Another area of bias in the provision of health care for women is the willingness to ascribe women’s medical complaints to an emotional or stress related condition. Hormones and genetic weakness have often been targeted as the cause of medical complaints. Women are characterized as weak and complaining. Women who visit a doctor because of chest pain, dizziness, or fatigue are likely to be treated for stress or depression. Conversely, when men complain of these symptoms, they are likely to be evaluated for heart disease, and then aggressively treated for heart disease, thus increasing the likelihood that they will recover from the condition. Women, because of delays in treatment, are less likely to experience positive health outcomes. In other health situations, women are treated too aggressively. For example, women who complain of vaginal bleeding or ovarian cysts in the past have been treated with complete hysterectomies. Women with lumps in their breasts often received a total mastectomy. Older women, beyond typical childbearing years, were particularly prone to this type of aggressive surgical intervention. The medical community, primarily consisting of men, justified this with the explanation that reproductive organs and body parts were not necessary for women who could no longer bear children. Because medical doctors have held a traditionally elevated position in American culture, women were socialized to “accept what the doctor ordered.”25 The female patient is not cultured to argue with her physician or question the actions of the political and medical community.

Power disparities between female patients and their doctors are made more complex by the institutional authority of the physician and acquiescence to that authority by the patient, most frequently fostered by gender expectations. This power gap can make it difficult for patients to assert their informational needs. For example, women who believe they have serious diseases may present their worries in a vague manner in an effort to avoid being labeled hypochondriacs.
The most challenging relationships tend to be between male physicians and female patients. Some research has shown that male physicians may discourage information exchange with female patients. For example, compared to male physicians, female physicians engage in significantly more positive talk, partnership building, question asking, and information giving. Similarly, when with female physicians, patients talk more during the medical visit and appear to participate more actively in the medical dialogue. The longest visits are between female physicians and female patients and the shortest between male physicians and female patients. A few recent studies have, in fact, surveyed women’s attitudes about physician-patient communication. In the 1993 Commonwealth Fund study of over 2500 women and 1000 men, 1 out of 4 women (compared to 12% of men) said that they had been “talked down to” or treated like a child by their physician. Nearly 1 out of 5 women (compared to 7% of men) had been told that a reported medical condition was “all in your head.” These statistics bring a quantitative assessment to a previously qualitative discussion.

Gender bias extends beyond communication styles into all aspects of health care; it pervades medicine, beginning with medical school admissions and education, encompassing research facilities and medical journals, and culminating in how women are treated individually as patients and collectively for research. Of course gender bias is not limited to the medical profession; it permeates legislation and Congress. Federal regulations restricting the participation of women in clinical trials have codified societal distrust of women’s capacity to decide what was best for them, their offspring, and families. Without representation of females in clinical studies and in the halls of Congress, women have not gained the ability to make appropriate decisions concerning their reproductive health and validate their own participation in medical trials. Thus, it becomes clear that a fundamental element of notions of “gender” as
developed by most social scientists and argued by politicians is not simply that gender systems are socially and culturally constructed based on biology and science, but that they serve to differentially allot power in society. An examination of women’s health through the lenses of politics and policy necessarily looks for ways in which women’s unequal access to power and resources disadvantages them in terms of their health. These political forces cannot always be readily distinguished from larger socioeconomic factors, but it is precisely that inextricability of variables that led to the contemporary casting of women’s health issues in terms of basic human rights.
IV: THE POLITICS OF MEDICINE

The social transformation of American medicine in the second half of the Twentieth Century focused on the economic and moral problems of medicine rather than scientific progress. Enormous increases in cost seemed ever more certain; related improvements in healthcare ever more doubtful. In this era feminists claimed that as patients, nurses, and other roles in health care, they were frequently denied the right to participate in medical decisions by paternalistic doctors who refused to share information or take their intelligence seriously. Feminists objected that much of what passed for scientific knowledge was sexist prejudice and that male physicians routinely excluded women from competence by keeping them out of medical schools. The most direct consequence of the growing women’s health movement, helped by in part by the passage of Title IX in 1972, was a sharp increase in the number of women entering the profession. As late as 1970, only about 9 percent of medical students were women; in 2003 the proportion reached 50 percent. The younger generation of women physicians demanded that male physicians change their attitudes and behavior and modify institutional practices to accommodate their needs. The influx of women in the medical vocation, analogous to the entry of women in government positions, fueled the increasing attentiveness to women in medicine and politics.

During the 1980s women voted in increasing numbers and showed signs of independence from men in their electoral behavior and in their attitudes about such issues as social welfare. This political assertiveness went beyond changes in voting behavior to include a willingness on the part of growing numbers of women to offer themselves as candidates for public office,
especially at the state level. Journalists dubbed the elections of 1992 as “The Year of the Woman” because of the record number of women both running and winning elective office.\textsuperscript{30}

Women’s health is a field of science that sprouted from political motivations, ushered into the limelight by the new group of women who came to possess political power at the state and federal level. History makes it clear that women’s bodies have always been politicized, though physicians, researchers and politicians would argue on the extent of hegemony in each era. Regardless of the actions of Congress, physicians habitually direct women’s health concerns. Focusing on gender differences is beneficial for research and illuminates many new treatments for gender-specific diseases, but such labeling also has setbacks for women when the center of attention detracts from the overall health of women. Prior to 1990, most of the political debate concerning female health concentrated on a woman’s ability to reproduce. For years, abortion was the only women’s health issue lawmakers touched. And even then, as Senate debate over late-term abortions amply illustrated, terminating a pregnancy is frequently cast as a matter of morals, not medicine. Abortion, and other politically charged topics in women’s health, are clearly driven by personal interests. Science is often performed with political consciousness. Even when science attempts to remain as objective as possible, personal and cultural factors still infiltrate research and medicine. A previous example of this relationship is illustrated by the political and medical constructions of race in the early 20\textsuperscript{th} Century in response to the influx of immigrants to the United States. The modern view that science and culture are separate and that hybrids between each field do not exist lies at the heart of women’s health policy and communication problems. Either implicit or explicit in concerns to bring women to positions of authority and influence in politics and medicine have been critiques of the alleged objectivity of scientific medicine. If science were truly objective, the sex of the researcher or physician would
make no difference to the content of politics and medicine. In the United States, political calls for increased research on women's health were put forward hand-in-glove with calls to increase the representation of female researchers. The rise of women to positions of power and voice in both politics and medicine is, arguably, one of the principal reasons for the redefinitions of “women's health” in the 1990s.

Modern medicine has become synonymous with complex infrastructures and overwhelming superstructures: with universities and professional organizations, multi-national pharmaceutical companies and insurance companies, research sites and lobbies, government departments and corporate finance. The relationship between the medical profession and the federal government is incredibly complex and noticeably influenced by personal interests. Thus it is easy to make the connections between politicians and their individual experiences with a particular disease, but seemingly difficult to understand the vast networks affiliated with health policy. The medical profession depends on government money for institutions, research, education, and salaries; and governments have followed and justified various policies on medical grounds. During the late 20th Century medicine became integral to the social and political operation of industrialized societies. Over time medicine in American society inexorably became associated with economics, central and local administration, the law, the social services, and the media. This social transformation of medicine and health care policy is made apparent through the rise of an epidemic that serves as the political predecessor for women’s health legislation between 1990 and 1993 – AIDS.

AIDS organizations became firmly established at the national level in the 1980s. At first, gay-community based AIDS service organizations started with an uncritical view of modern medicine, one that expected to find a cure for AIDS. Such an approach to modern medicine was
quickly replaced, however, by a critical political analysis of medicine and health care. AIDS organizing of the 1980s became the most visible effort of the gay and lesbian community, just as reproductive rights were often the most publicized of the women’s movement in the 1970s. The founding of ACT UP (AIDS Coalition to Unleash Power) in New York in March 1987 marked a revolutionary shift in AIDS organizing and activism. This “diverse, nonpartisan group of individuals united in anger and committed to direct action to end the AIDS crisis” consisted predominantly of white gay men and lesbians. ACT UP effectively used the media and engaged in many actions of civil disobedience that targeted institutions such as government agencies, pharmaceutical industries, and anyone who was perceived as harmful to their declared goal – ending the AIDS crisis. Although ACT UP was not the beginning of AIDS activism, their organization came to symbolize AIDS activism in the late 1980s and early 1990s through their direct and visible approach in the media. Indeed, studies have shown a positive relationship between media coverage of AIDS and federal funding for the disease.

The success of AIDS activists attracted attention from other disease advocates. One of the founding members of Y-ME, a breast cancer advocacy group, Sheila Swanson, recalled, “They [AIDS activists] showed us how to get through to the Government. They took on an archaic system and turned it around while we have been quietly dying.” Health advocates sought training by AIDS activists and adapted some of their techniques, such as the use of a ribbon worn on the lapel as a sign of solidarity with victims of the disease. AIDS activists forced an overhaul in the way AIDS drugs were tested, released and financed. Activists also successfully lobbied the Government for billions of dollars for research, treatment and education at a time of fiscal restraint.
The lessons women learned from the AIDS movement provided the impetus for the growing activism around breast cancer and other women’s health issues. Until the AIDS epidemic, advocates for people with a certain disease never developed such a broad influence on public policy. AIDS is also a suitable study for the application of Foucault. Foucault spoke of philosophical diagnostics in order to reveal the representations placed upon the body itself. The stigma surrounding AIDS and the initial deficiency of knowledge about the disease made it difficult for patients and society to truly understand the illness. The body with AIDS drew its meanings from already existing social structures. Resultantly, AIDS patients came to embody new beliefs about themselves; while society operated as a system that labeled and defined the AIDS patient.

The general perception that AIDS organizing had been tremendously successful in changing AIDS policies set off a spark in women and triggered organizing and activism around women’s health issues on a national scale. There are many similarities in the terms of political goals of the two movements. At the beginning, emerging AIDS organizations provided services for people with AIDS and pressed for research dollars both to find a cure and to educate citizens on ways to prevent the spread of the disease.38 With women’s health issues, similar goals were put forward: education regarding health concerns pertaining to women, prevention of cancer by finding its causes, and access to health care. In 1990 the modern American woman embodied new beliefs about her own health, one that centered on political rectification and a fear of breast cancer. A woman’s wellbeing was based on the tangible aspects of the body, especially the breasts, which were emphasized much more by female patients and physicians than the reworking of social institutions. From this focus, a certain direction and political strategy emerge concerning the implantation of goals, such as utilizing advocates, the media, and aggressive
political lobbying. Women came to believe that legislation as a result of their collective efforts and newfound political power would finally provide equality in the field of health and health care, and consequently sought to create a new health agenda.
V: MODERN HEALTH POLICY

Since Victorian times, health care decision making in the United States has been largely within the purview of physicians. Additional players include other health care professionals; the government, acting for the uninsured, underinsured, and elderly; and third-party payers. The role of the average female patient has traditionally been limited by supplementary factors, including the system of financing and social status. In recent years female patients have started to question physician autonomy. With greater mass communication patients have evolved into “consumers” and are becoming more knowledgeable about medicine and science. In terms of health research, consumers are less likely to have an impact when they work as individuals than when they lobby as a group. Though women have long been involved with seeking increased research funding as mothers of children with cancer and polio, or as daughters of women with Huntington’s disease, they did not lobby en masse for research related specifically to their own diseases and conditions until recently. Cervical, endometrial, ovarian and breast cancers, endometriosis, conditions related to pregnancy and the menstrual cycle were not taken up as special causes by the public nor championed by the “hidden colleges” in Congress and academia until women sought answers about their health. The flood of information about a woman’s body also altered the manner in which female patients embody beliefs about their own health and what it means to be healthy. With breast cancer being the most publicized disease, women tend to give more attention to their breasts. This adds to the consummate worth of breasts for the woman as both a foundation of health or site for disease. In addition, the clinical gaze shifted from the sole responsibility of the physician to include the patient. Now, with practices like self-breast exams, women are expected to watch over their own bodies alongside their doctors.
The historic trend of health policy defining and prioritizing women’s health based on reproductive biology and motherhood apart from socioeconomic variables while neglecting other basic needs is noticeable throughout the history of American health care. Such cultural biases that dictate the manner in which women are treated by medical professionals and legislators survived through the Twentieth Century due to a lack of female force in key positions of Congress and medicine. The influential National Institutes of Health (NIH), overtly dominated by males for the majority of its existence, grew up in the days that espoused traditional gender roles for men and women. It was an era when society discouraged women from seeking careers as doctors or medical researchers. As a result the NIH consistently set up new studies that followed men in their 20s, 30s, and 40s without any female participants. Led by male physicians, the NIH wanted to prevent their male colleagues from being felled by life threatening illnesses like heart disease. In essence, the NIH funded what they feared.

In the 1970’s a lawsuit filed by Estelle Ramey and a group called American Women in Science made the NIH agree to include women scientists on the review panels that awarded federal research money. Dr. Daniel Steinberg, a noted cardiovascular researcher who was at NIH throughout the 1950’s says that there were “no deep psychological reasons” for concentrating on men. He argued the reasons for excluding women were practical and, if anything, based on preconceptions about age, not gender. Another reason women were routinely left out of studies involving new drugs or therapies was the fear that, if they became pregnant, the fetus could be harmed. Including women in studies also seemed more difficult because of the menstrual cycle. Researchers claimed that monthly hormone cycles, menopause and pregnancy would make the results hard to interpret and greatly increase the cost of studies.
As a result of greater social and professional sovereignty in America, women would not quietly accept the startling information that the media and newspapers conveyed regarding their health and healthcare. On December 12, 1989, the Washington Post ran an article titled “A Look at Research Involving Women – There is Concern that Data From Studies of Males Will Not Apply to Females.” Other national papers picked up articles with similar agendas. “Politics May Hold Cure for Breast Cancer,” followed the earlier study in the Washington Post, and “Working on a Cure for Unequal Medicine” ran in the Los Angeles Times. Each article addressed the dearth of general knowledge and federal support for women’s health. Baby-boomer women took note of the news, and came equipped to political discussions with professional backgrounds – as teachers, doctors, nurses, administrators, accountants, managers, writers, sales persons and business owners. Consequently, this new generation of women already possessed the faculty and resources indispensable for the rapid mobilization of a political advocacy organization.

Women working at the grassroots level also had new political allies in Congress. The Congressional Caucus for Women’s Issues, led by Representatives Patricia Schroeder (D-CO) and Olympia Snowe (R-ME) came to champion women’s health. Schroeder and Snowe reacted to the lack of data that stemmed from a general deficiency of knowledge at the federal government level about women’s health. For example, a 1985 report by the Public Health Service Task Force in Women’s Health Issues found no central inventory of what research, what health services, and what programs involved women’s health.43 In 1989 the Institute of Medicine report highlighted another area where women’s health often falls short: obstetrics and gynecology. The report, written by the planning committee of the IOM’s Division of Health Policy, found inadequate funding for research in this field. The lack of money was attributed to the charged political climate surrounding the abortion issue. The report also faulted the lack of an
organizational focus for reproductive research at the NIH and concluded that there may be too few qualified investigators in obstetrics and gynecology to successfully compete for significant research funds. The absence of an obstetrics and gynecology department in the on-campus research program at the NIH headquarters also results in the relative disregard of ob-gyn research. Meanwhile, the NIH continued to spend disproportionate amounts of money on AIDS research as a result of the successful lobbying efforts by associated activists. In 1989, forty-four times more money was spent on basic AIDS research at NIH than the amount that was spent on breast cancer research.\textsuperscript{44} AIDS research became a popular political cause at about the same time that the public became frightened that the disease was going to spread into the heterosexual community. The epidemic nature of the disease, and its potential for killing ever-increasing numbers, gave immediacy to AIDS research that other diseases lack. During the 1980s about 54,000 persons died of AIDS. In comparison, America lost 430,000 citizens to breast cancer over the same amount of time.\textsuperscript{45} With these statistics it became clear that breast cancer research was comparably under funded. AIDS also served as the political catalyst for women’s health advocates in the early 1990s because the definition of the disease, and early shortcomings to understand the risk and means of prevention, left women’s experiences with the illness invisible. The first definition of AIDS was linked to men because it was viewed as a disease of gay men. The very listing of HIV-related diseases taken to characterize AIDS was a listing based on male experiences of infection. Only much later, after considerable protests by women activists, were female disorders – such as invasive cervical cancer – made part of the definition of the disease.\textsuperscript{46} With data in hand, women and sympathetic congressmen began to rally around the need for increased funding and research in support of women’s health, an issue that grew to become indistinguishable from breast cancer.
VI: LEGISLATION AND FRUSTRATION

Although the NIH had recognized the need to evaluate health issues in women by the 1986, they had failed to apply their own policy. Congresswoman Olympia Snowe criticized the NIH for being lax in their own policy, one that stated grant applications must include women unless there is a substantive rationale for excluding them.\textsuperscript{47} Snowe stated “The NIH in 1985 looked at the research they were doing on women’s health, and realized they were not doing any research on women’s health. So they implemented a new program to say they were going to take into account how these things affected women before they continued allocating grants.”\textsuperscript{48} Snowe also quoted a breakthrough finding of the Physician’s Health Study on heart disease that used 22,071 men and no women. As a result, the study linking aspirin and coronary disease prevention could not be applied to women. Several other studies were mentioned in her address with equally lopsided numbers. Because the NIH had failed to adequately respond to their own 1986 guidelines that cited the need to include women and minorities in federal-sponsored research, Snowe recognized that formal legislation was required to ensure the inclusion of women in clinical trials. Congress felt this was a push in the right direction in order to guarantee that “they [NIH] pay attention to their very own policy that their very own scientists said they should follow.”\textsuperscript{49}

At the onset of the 1990s women collectively flexed their political muscle to address many aspects of women’s health. On July 27, 1990, Patricia Schroeder introduced the start of a series of key pieces of legislation on women’s health. Supported by a group of senior female members of Congress, including Snowe, Mary Rose Oakar and Barbara Mikulski, Schroeder labeled this package of bills as the Women’s Health Equity Act, (WHEA of 1990, H.R. 5397/S. 2961).\textsuperscript{50} The initial group of twenty bills, which would later evolve into more than thirty, called
for more research, services and prevention in such areas as breast cancer and ovarian cancer, sexually transmitted infections, contraceptive research, infertility, osteoporosis, and adolescent pregnancy.

The Women’s Health Equity Act was brought before the House of Representatives to address “the appalling lack of attention given to women’s health care needs.” Schroeder went on to say, “The facts speak for themselves, the death rate from breast cancer increased 24 percent between 1979 and 1986. Women are now the fastest growing group of those infected with AIDS. Heart disease is the number 1 killer of women but virtually all research is conducted on men.”

In the same speech Schroeder highlighted the findings of the General Accounting Office from 1989. The GAO wrote, “The National Institute of Health, the nation’s major source of funding for medical research conducted in the United States, spends only about 13 percent of its budget on women’s health.” Schroeder argued that it was consequently the responsibility of Congress to protect and direct the health of women in America.

An important factor that largely influenced both the women’s health legislation and subsequent provisions that became law was the need to reauthorize the NIH in 1990. The NIH Reauthorization bill provided the congresswomen leading the push for the Women’s Health Equity Act with the vehicle they needed to move their legislation. Sections of the WHEA that would later become law succeeded as part of the NIH Reauthorization Act. A different bill that never made it through the legislative process, the Minority Health Initiative Act, also served as a vehicle for some of the Women’s Health Equity Act provisions that failed to become law. Thus, when studying the congressional hearings surrounding the WHEA, one must also study the NIH Reauthorization bills that absorbed many WHEA stipulations.
The political-medical discourse that encircled the Women’s Health Equity Act and related Congressional hearings are unique within the realm of women’s health policy. This legislation addressed many new topics in women’s health that had not received Government attention prior to 1990. Among the new topics were a new field of medical education on women’s health and the Defense Women’s Health Act. The WHEA’s innovations for women’s health policy certainly deserve recognition. However, it is more important to note which provisions were actually passed and accordingly became law, how quickly certain stipulations passed and with what amount of monetary support. Because the Women’s Health Equity Act was repeatedly introduced before Congress in various sessions, it provides an opportunity to trace debates concerning different aspects of women’s health alongside changes in Congressional leadership and involvement from activists and the media over the years. Sponsors of the bill also wax as the legislation was later detached from the abortion debate following the presidential election of 1992. Indeed, the congressional hearings literally confer social and monetary value to different aspects of women’s bodies and wellbeing. Despite all of its advances for women, the WHEA also contained obvious setbacks. A large section on child welfare prolongs the belief that motherhood is the quintessential function of woman, sometimes at the expense of her own physical condition.54

The most noteworthy section of the first Women’s Health Equity Act, the 1990 bill, included the formation of the Office of Research on Women’s Health. This was an attempt to bridge the gap between men’s health and women’s health by adding a permanent home for women’s health issues at the NIH. In addition, two other initiatives were introduced: a center for women’s health research and development and an intramural program in obstetrics and gynecology to initiate research and conduct clinical trials within the NIH. Only two of the
original twenty bills passed in 1990, both regarding breast cancer. One ensured Medicare coverage for mammograms for women over 65; the other established a $30 million screening program for breast cancer in poor communities, where women die from the disease in disproportionate numbers.55

The remaining pieces of the Women’s Health Equity Act failed to pass in 1990 due to controversy surrounding research into fertility and contraception. The legislation was criticized by abortion opponents, who warned it would open the door to federal funding of research on RU-486, the abortion-inducing drug used in France. This defeat also stalled the creation of an annual report from the NIH director on progress related to women’s health issues. The debate over abortion and fetal tissue had virtually halted federal regulation and funding for most types of fetal research and all other provisions linked with the bill, including numerous women’s health stipulations that did not relate to reproduction. Many politicians argued that scientists had been using fetal research for decades. Cell lines derived from fetuses were instrumental in developing vaccines for polio. Several researchers believed that fetal tissue transplants could treat such diseases as juvenile diabetes and Parkinson’s before the new millennium. In 1990, after stripping out all controversial provisions, Congress late in the session cleared legislation (S.2857/PL 101-613) to authorize certain programs at the National Institutes of Health.56 At this point in the legislative process the majority of the Women’s Health Equity Act fell short of consideration. Also dropped from the NIH Reauthorization Act were provisions intended to eliminate sex and race bias in NIH-funded research and to provide new research on women’s health in hopes of gaining the Administration’s support. President George H.W. Bush claimed, “Great progress is being made in the area of women’s health under the valued leadership of the first female director of the NIH,” and therefore unnecessary to provide federal funding.57 Bush also said that the NIH
Reauthorization provisions regarding the Scientific and Technical Board on Biomedical and Behavioral Research Facilities and the Office of Research on Women’s Health raised Appointments Clause problems. Furthermore, in a detailed letter of criticism, Health and Human Services Secretary Louis W. Sullivan warned that he would recommend a veto of the bill on the grounds that it represented an attempt to micromanage the NIH from Capitol Hill. Sullivan commented that the authorization levels in the bill were too high. Republicans on the committee voiced their objections to the provisions requiring that women be included in clinical trials, arguing that the requirements amounted to quotas for scientific experimentation. Accordingly, efforts to enact a full NIH reauthorization bill along with the complete script of the Women’s Health Equity Act in this congressional term failed.

In the wake of the President’s veto, sponsors worked to push a compromise version of the measure. The new bills (H.R. 5495/S. 2899) took out some provisions the administration objected, left funding levels open-ended and required that researchers first attempt to use the fetal tissue bank proposed by Bush. Language dealing with women’s health issues remained in the legislation. However, the new proposal was still deemed unacceptable by the administration, and the bill went no further.

The response to the presidential veto was mixed. Some congressmen and congresswomen agreed that certain aspects of the bill should not be passed, specifically terms for a fetal tissue bank. Cost was also a concern; the bill exceeded the spending allotment by $3 billion for the President’s fiscal year 1992 request. Louise Slaughter (D-NY), refuted the President’s rejection of the bill by saying our own government was dismissing “American women, whose very own tax dollars pay for the health research undertaken by NIH.” In a similar rebuttal, Patsy Mink (D-HI), declared that the “President vetoed this bill. He said it is not
necessary to increase support for research targeted at women’s health needs. He said those needs are already being met. But the fact is no research initiatives in this area were ever begun before this legislation." James Scheuer (D-NY) agreed that women and minorities must be included in clinical research studies: “History has repeatedly shown that women have been treated as second-class citizens in business, education, and social relations. Health care has proven to be no exception.”

In 1991 the NIH Reauthorization Act, which incorporated pieces of the Women’s Health Equity Act of 1991, was brought back to the floor. During these hearings Bernadine Healy, the new director and first female head of the NIH, addressed the Congressional Biomedical Research Caucus on the topic of women’s health. Healy acknowledged that women’s health was experiencing a “real awakening” in which the field was gaining momentum on a daily basis. This was evident from the activity within Congress, recent NIH activity, and media coverage. Healy recognized that “decades of research exclusively done with male subjects have reinforced the myth that heart disease is uniquely a male affliction, and have generated reams of information and references in which men become the norm or normative standard.” The authority of the NIH epitomizes the power of the clinical gaze discussed by Foucault. Physicians and politicians are able to administer the fitness of its citizens through observations during clinical trials and research. Thus, men and the society at large are taught to fear heart disease in male patients. Meanwhile women spend a great deal of time and energy fretting over the ideal body image crafted by American society without regard for their complete wellbeing. As Foucault reminds us, it is largely through the discipline of our bodies that we are trained, shaped and impressed with the stamp of prevailing forms of selfhood, desire, masculinity and femininity.
Healy went before Congress to declare, “Beginning in February 1991, no proposals before NIH review will ever be recommended for funding if women are not a part of the clinical trial.” Although the NIH had previously established this in 1986 and Congress reiterated the practice through legislation in 1990, Healy was openly recognizing the need to enforce this policy. Healy noted that there were very difficult issues that bear involvement of women in clinical trials, among them legal and ethical considerations of including women of childbearing age in clinical research. The NIH also recognized that many social and economic factors traditionally exclude certain women from participating in trials more often than men, due to lack of transportation, childcare, financial resources and time.

The NIH Reauthorization Act of 1991 incorporated the majority of the Women’s Health Equity Act and funding for diseases that primarily afflicted women. The legislation for the NIH included $225 million for breast cancer research, $100 million for clinical research that included six multidisciplinary breast cancer research centers, $75 million for basic and clinical research on ovarian and other reproductive tract cancers, $40 million for osteoporosis and related bone disorders, $20 million for contraceptive and infertility research, an OB/GYN research program and a National Institute of Aging study on women. However, due to the fetal tissue provisions in the NIH Reauthorization Act of 1991 (H.R. 2507), this legislation did not sustain the presidential veto. Even with Healy’s support, failure to pass the Women’s Health Equity Act kept women from medical opportunity that year. Two provisions from the 1991 Act that did survive the legislative process to become law that year led to the establishment of an associate administrator for women’s health services at the newly created Substance Abuse and Mental Health Services Administration (SAMHSA,) and a new requirement for the NIH Office of
Research on Women’s Health to monitor research on women’s mental health and substance abuse.\textsuperscript{69}

When the Women’s Health Equity Act returned to the floor in 1993 (H.R. 3075), as part of the NIH Reauthorization Act (H.R. 4/S.1), the controversy surrounding fetal tissue research received no mention. President Clinton lifted that ban on his second day in the oval office. Consequently freed from the politics of abortion debate, the NIH bill (S.1) won 16-0 approval from the Senate Labor and Human Resources Committee on January 26, 1993, with none of the Republican dissent that had stalled the measure in past years.\textsuperscript{70} The NIH Reauthorization began moving through the House less than a week after it passed the Senate. On February 24, the House Energy and Commerce Subcommittee on Health and the Environment voted 20-6 to approve H.R. 4, the bill reauthorizing NIH, increasing its funding, streamlining AIDS research and emphasizing research involving women and minorities. Despite some partisan infighting over an effort to channel breast cancer study funds to New York, the House Energy and Commerce Committee approved H.R. 4 by a vote of 34-10 on March 2.\textsuperscript{71} The presidential veto by George H.W. Bush that killed the bill in previous years did not surface in Congressional hearings. With speedy approval by Congress, many of the NIH Reauthorization provisions that included much of the WHEA of 1993 went into effect that year as well as the reauthorization of the Breast and Cervical Cancer Mortality Prevention Act. Provisions from the 1993 bill that almost passed but died in the last days of Congress after the Senate blocked action on the conference report include a study of the adequacy of women’s health curricula in medical schools, a requirement that the Office of Minority Health and the Office of Women’s Health investigate the number of women in the United States who have been subjected to female genital mutilation and conduct outreach activities to educate individuals about the physical and
psychological health risks of FGM, statutory authority for the Office of Women’s Health within the Public Health Service, and a requirement that the NIH establish policies regarding the employment of women scientists with respect to tenure, family leave, and the recruitment of women of color.72

After three years of contention centering on fetal tissue research, Congress successfully reauthorized selected programs at the National Institute of Health that included sections of the original Women’s Health Equity Act. President Clinton signed the three-year, $6.2 billion reauthorization measure (S.1/PL 103-43) into law on June 10, 1993, closing another chapter in the fight over abortion policy that raged between Congress and Clinton’s Republican predecessors, Presidents George H.W. Bush and Ronald Reagan.73 The NIH Reauthorization Act of 1993 required that in most cases women and members of racial and ethnic minority groups be included as subjects in NIH-funded research projects. Exceptions were permitted if, for example, such inclusion would jeopardize the health of research subjects. The bill stipulated that the cost of including women and minorities was not a permissible reason to exclude them from a research project. Women and minorities could be excluded if there were scientific reasons to assume the variables being studied did not affect women and minorities differently than white men. It also codified in statute NIH’s Office of Research on Women’s Health, created in 1990 after women in Congress publicized the systematic way researchers excluded women from research studies and downplayed diseases that primarily afflicted women.74

More specifically, the bill authorized increased funding for research on ovarian and cervical cancer, osteoporosis, reproductive health, and especially, breast cancer. The $325 million authorized in the bill for breast cancer research represented an increase of 160 percent from the fiscal 1993 appropriation. From this amount, $225 million would be dedicated to
research on the causes of and cures for breast cancer and $100 million would go towards prevention, detection and treatment in fiscal 1994 and unspecified sums for fiscal 1995 and 1996. Indeed, over the preceding 5 years, total appropriations for breast cancer had grown 450 percent. No other cancer research received such increases.\textsuperscript{75} This was the first time that the bill earmarked an authorization for a particular cancer.

The infusion of earmarked money gave pause even to some researchers who specialized in breast cancer, not to mention those who worked on other cancers and saw their funding levels remain relatively flat. Not only did scientists worry about politicians making decisions they thought should be left to them, there was concern that breast cancer might not even be the most serious problem afflicting women. More women died annually of lung cancer than breast cancer, for example, and while breast cancer mortality had remained steady for more than a decade, lung cancer mortality rates for women had risen 71.7 percent since 1973.\textsuperscript{76} However, several observers noticed that the coalitions of groups lobbying for the increased breast cancer research funding had been extremely successful in making breast cancer funding a way for members of Congress, especially men, to show their commitment to women’s health even if they opposed abortion.\textsuperscript{77}

The law also stipulated that the NIH director, in consultation with the director of the Office of Research on Women’s Health and the Office of Research on Minority Health, was to create a program to recruit women and minorities as research subjects. In addition a biennial report must be submitted on the progress of women’s health research and treatment conducted or supported by NIH to the President and Congress. PL 103-43, the NIH Reauthorization bill, also required the creation of a single data system to collect and disseminate information regarding research on women’s health conducted or supported by the NIH.
The changing view of participation in clinical trials as a benefit rather than a burden provided the momentum of the movement toward increased inclusion of women in clinical research. Beginning with AIDS research, the focus of public attention regarding clinical trials turned toward access rather than protection. As AIDS activists cried out for improved access, the public began to realize the numerous advantages afforded to research participants. These include possible therapeutic advantages when other treatments are inadequate, close monitoring of the disease, attention for other ailments, superior physicians, labs, and testing, more contact with providers, remunerations and contributions to society. Women ultimately changed the definition of protection by contending that the failure of the medical community to adequately test drugs and research diseases in females undermined the health and health services for their gender.

The ability of women to turn themselves into medical subjects is an action that Foucault would mark as self-diagnosis or self-identification. The subject must possess an ability to determine the presence of disease, something previously described and defined by the medical profession exclusively in men. Women realized that an absence of participation in clinical trials would limit their understanding of health and illness. Yet dividing practices based on gender or race objectifies human subjects for purposes of medical and social identification. This typifies Foucault’s concept of power structures and the strength of the gaze as the subject’s experience during the medical process extends beyond the material boundaries of the clinic. Consequently, the political-medical discourse surrounding health policy increases governance over many personal activities, such as personal identity, notions of healthiness and self-breast-exams.

While the Women’s Health Equity Act struggled to survive the legislative process, advocates for women’s health turned their attention to the Food and Drug Administration. The FDA regulates privately funded human subjects research that is intended to introduce a new drug
or medical device to the market. The FDA’s policy on the inclusion of women in clinical trials is set forth in its guidelines. In the 1977 Guidelines, the FDA largely excluded women of childbearing potential from clinical trials. What is noteworthy about these guidelines is the language used both to protect and exclude women from clinical trials. Women of childbearing potential “may” be included if prior animal studies have been completed. The practical result of the 1977 Guidelines was that drugs could be marketed without ever being tested on women. Ironically, the FDA could approve drugs, the toxicity of which was unknown in women and fetuses, for use on the very populations it sought to protect – pregnant women and women of childbearing potential. Moreover, by following FDA guidelines and attempting to “protect” women of childbearing potential, drug manufacturers could find themselves exposed to even greater potential liability should the adverse effects of a drug be discovered after it was marketed to the general public.

The 1977 Guidelines were considered by many to reflect gender stereotyping more than concerns about good science. In 1992, at the urging of women’s health advocacy groups, the Congressional Caucus for Women’s Issues requested a GAO audit of the FDA. As expected, the GAO found that women were underrepresented in drug trials, especially in the earliest stages of new drug research. As a result of the GAO audit and public pressure, the FDA issued a new guideline in 1993 for the inclusion of women in drug research. Consistent with its historical concern for fetal protection, the FDA also made clear that “appropriate precautions should be taken in clinical studies to guard against inadvertent exposure of fetuses to potentially toxic agents and to inform subjects and patients of potential risk and the need for precautions.” What is new is the FDA’s recognition that women of childbearing potential, “are competent to give informed consent to their participation in research trials, and that this informed consent provides
the necessary insulation to protect researcher and manufacturer from suit by mother or possible child for all but negligent enrollment practices.”

80 The FDA’s 1993 Guideline concluded with the following disclaimer: “This guideline does not bind the agency, and it does not create nor confer any rights, privileges, or benefits for or on any person.”

81 Similar to the WHEA, the new FDA guidelines garnered substantial but limited success for women’s health.

In spite of legislative setbacks notable progress was made between 1990 and 1993 for women’s health and health care in the United States. During a Senate hearing on menopause in 1991, one senator summed up the event’s significance: “I don’t think that word has ever been uttered on the floor of the Senate.”

82 To women’s health care leaders, the hearing was but one landmark in an extraordinary surge in addressing gender inequality. The transformation began in 1990 following the General Accounting Office report that found medical research was mainly being done on males, to the benefit of males only. The resulting cascade of criticism, advocacy, hearings, conferences, and government appointments has led to major changes in the way women’s health issues are regarded by both medical professionals and consumers. Women’s health advocates say more money is going into women’s concerns and more women are being enrolled in clinical trials, entering medical schools and being appointed to senior positions of private and public health institutions. Moreover, between 1990 and 1993: a woman – Dr. Bernadine Healy – was named director of the powerful National Institute of Health.

83 The NIH created its own Office for Research on Women’s Health. The Women’s Health Initiative, the largest clinical trial ever funded by the United States, began. The Society for the Advancement of Women’s Health Research was founded to give women’s health issues greater public visibility, and the Journal of Women’s Health, the first interdisciplinary peer-reviewed medical journal devoted to women’s health, was published. The nation finally sought a more
comprehensive effort to address the treatment and prevention of conditions and diseases that affect primarily women, instead of viewing women’s health as an afterthought or of secondary importance to men’s health. Joanne Howes, a founder of SAWHR, believes that “there’s no question that the leadership in Congress remains an important piece of this, if the congressional interest lessens, then the pressure on NIH is less.” Indeed, even though the Women’s Health Equity Act failed to pass on its own accord, the government did adopt a more involved role in women’s health. Within these three years of political debate the government accumulated authority in aspects of women’s health that allowed them to direct the needs of female patients.
VII: MAKING A SCENE

Women’s health consistently infiltrated political conversations and congressional hearings in the early 1990s. As this topic was brought up in national debate, media coverage began to engage in the issue of women’s health and health care. The mass media worked to inform women about the legislation that concerned the wellbeing of their bodies. In turn, women who wanted to voice their opinions about their health utilized the media and modern technology. In a society whose health care system operates primarily according to market principles the rise of mass media and the Internet profoundly altered the ways in which patients have access to medical care. Patients can access medical information via the web, can fill prescriptions with the click of a button, and can even receive diagnoses through emails. It is not unusual for patients to be well informed on a wide variety of medical conditions and terminology as a result of numerous computer resources. Consequently, female patients learned to monitor their own health with new information at hand. The Internet also aided the way in which the country networks, a vital feature for breast cancer support groups and grassroots activists who live miles apart. Women throughout America could read about happenings in Congress almost immediately after they occurred. This had a profound impact on women’s health advocates and the organizational strategies used by activists, particularly by women and men who campaigned in favor of breast cancer research.

The stunning success of the National Breast Cancer Coalition in its first few years of operation can be attributed in part to a confluence of political and newsworthy events. The year the Coalition was formed, 1991, was followed by the Year of the Woman. In that time, the Congressional Caucus for Women’s Issues submitted the Breast Cancer Challenge to the medical research community and the National Cancer Institute, naming five goals related to prevention
and cure of breast cancer, to be achieved by the year 2000. Also in 1991, in a report cited in headlines by the media, the United States General Accounting Office called attention to the increasing incidence, and unchanged mortality, of breast cancer. The extraordinary proliferation of information concerning breast cancer provides a vivid demonstration of modern knowledge mechanisms discussed by Foucault. An array of cultural institutions effectively joined together in the production and dissemination of material about breast cancer, including medicine, government, media, and education. Vigilance concerning breast cancer seemed guaranteed when individuals believed it to be a disease that was both elusive and locatable. Likewise, women came to embody an acute fear of the disease as a result of the collaborative efforts made by powerful social institutions.

In 1991, breast cancer activists confronted federal policymakers with specific goals at the National Cancer Institute (NCI) and in Congress for the first time. They met with Samuel Broder, then Director of the NCI, to demand that the NCI focus more of its research attention on breast cancer. Dr. Broder acknowledged the need to involve breast cancer patient advocates in the research process and to focus more breast cancer research on postmenopausal women, but he insisted that politics and science would not mix.88 Not dissuaded by Broder’s concerns, the activists met with Ohio Congresswoman Mary Rose Oakar, whose sister died of breast cancer and who was sponsoring a bill authorizing $25 million for NCI to conduct research on breast cancer.89 At a press conference called by Congresswoman Oakar, Ellen Hobbs of Save Our Selves, a formidable breast cancer support group based in Sacramento, removed her wig and held up her prosthesis at the appropriate point in her testimony; Oakar noted that “they [the subcommittee] almost died.”90 Some of the men remarked that they were angry at her theatrics, but Oakar explained that this is what happens to women after chemotherapy, they become very
angry. By drawing attention to the physical depreciation of her feminine attributes, Hobbs made the effects of breast cancer visible in new and dramatic ways in the corridor of federal power. This zealous act recollects Foucault’s notion that conformity with cultural visions of normality are strengthened through institutional participation.

The National Breast Cancer Coalition also achieved a significant victory in 1992 when Congress increased the funding for breast cancer research more than twofold of what it had been the previous year. Another campaign, “Do the Write Thing,” sought the creation of a new panel on breast cancer that unified breast cancer consumers, doctors, policymakers and scientists. The strategy of the coalition was to garner 175,000 letters “to be delivered to Congress and the President – one letter for each projected breast cancer diagnosis.” The final number was 600,000 letters. The following year the NBCC obtained 2.6 million signatures in support of a National Action Plan on Breast Cancer by recruiting representatives throughout the country. During this period NBCC members frequently testified before Congress and worked closely with the media, cementing the organization as a formidable political force on Capitol Hill. “Women had declared war on breast cancer,” NBCC President Fran Visco later recalled, and were insisting that Congress “find a way to fund that war.”

Funding the breast cancer war actually became part of the nation’s defense budget. The Department of Defense was charged with the duty to oversee breast cancer funding as a back door solution to controversy surrounding the 1990 Budget Enforcement Act. Amid allegations of women’s health neglect, members of Congress began to search for ways to remedy the situation during a period of conservative fiscal management. The 1990 act was aimed at holding the line on spending, although health minded senators sought a waiver to transfer money directly from defense to breast cancer. Senator Tom Harkin, a democrat from Iowa whose two sisters
died of breast cancer in their mid-50’s, exposed a small breast cancer program in the Army and proposed a huge funding increase.\textsuperscript{95} Lawmakers ardently supported him, voting 89 to 4 to pass Harkin’s suggestion. In 1992 the Army ran a breast cancer research project to conduct screening and diagnosis for women in the military and its dependents. At the urging of advocates for more breast cancer research, Congress raised the appropriation to $210 million in 1993, and stipulated that the money be used to support a peer-reviewed competitive grants program aimed at reducing the incidence of breast cancer, increasing survival rates, and improving the quality of life for those diagnosed with the disease.\textsuperscript{96} Led by Harkin and Representative John P. Murtha (D-PA), Congress attached more federal money to the military budget for breast cancer research than the NIH had allocated for the disease that same year. In addition, another $196 million was attached to the budget of the Department of Health and Human Services.\textsuperscript{97} Within 12 months breast cancer advocates secured $400 million for research, while also pioneering new methods of conducting scientific studies.

The political strength of the breast cancer movement, though well established by 1993, became abundantly clear when John Hamre, the Pentagon’s chief budget planner, testified to the Senate Budget Committee that the Department of Defense might not spend the money earmarked for breast cancer research since the money was “unrelated to military needs.”\textsuperscript{98} President Bill Clinton, whose mother died of breast cancer, lost his temper when he read Hamre’s testimony and sent a stinging letter to Secretary of Defense William Perry demanding that the money be allocated.\textsuperscript{99} With the support of President Clinton and vocal breast cancer lobbyists throughout the early 1990s, the NBCC and NABCO could measure their success a billion times over, one dollar at a time.
VIII: THE POWER OF PINK

Breast cancer possesses strong political appeal. Unlike abortion or gay rights, breast cancer was a perfect woman’s issue, a “win-win” game for politicians to solicit female votes. While many politicians took the initiative to introduce legislation for breast cancer treatment and funding, many activists gave congressional testimony that allowed elected officials to hear and witness the effects of the disease first hand in record numbers. The act of giving Congressional testimony and giving statements to the media is a highly instrumental activity for raising awareness regarding a particular cause. Activists seized their opportunity and quickly capitalized on the powers of mass communication while noting the influence of their own rhetoric in delineating the breast cancer epidemic.

Breast cancer has received a great deal of attention in American culture. The Government responded with unprecedented amounts of research funding, while several magazines, literature, corporate philanthropies, fashion retailers, and a plethora of Internet sites have devoted immense quantities of time and energy to raising awareness and money for the disease. The market is so saturated with advertisements and campaigns regarding breast cancer that it would be easy to forget that this disease is not the leading killer of women, nor is it the top cause of cancer death in women. Breast cancer remains second to lung cancer for the highest number of cancer deaths in women, and cardiovascular disease continues to consume many more female lives each year than any breast ailment. Yet women themselves are demanding more attention for breast cancer research, and federal funding is being applied specifically toward that disease in greater quantities than many other illnesses. Patients, politicians and physicians are all seeking a cure. Recalling theories of Foucault, the heightened presence of breast cancer in popular culture
influences the embodiment of the female patient. Women fear the disease and demand better attention. The fascination with breast cancer makes the topic an important point for a discussion of biomedical policy and gender in America.

America is one of the only countries in the world that stipulates the collection of medical data by age, gender, race and ethnicity. Our biomedical policy is also routinely sex centric; when biomedical policy becomes focused on sex attributes problems for women emerge. For years, abortion was the only women’s health issue lawmakers pursued. Now, as women’s health issues come into vogue, controversy surrounding the politicizing of the female body is brought into the spotlight. Current and former female members of Congress complain that a sense of paternalism still prevails on the Hill, a sentiment they say becomes evident when women’s health matters, especially those involving reproduction. Patricia Schroeder, reflecting on her time in Congress, remarked “It seems to all go back to our reproductive organs. You know why? We’re just not smart enough to deal with this by ourselves. We need Congress’s help. Now, if we did this with their [men’s] health, they would be nuts.” The tendency to focus on women’s sex related body parts means that women are sexual objects. This is as troublesome in medicine and politics as in the media. To center on female body parts and glorify them as the zenith of sexual allure or degrade them as cancer sites is equally dangerous. In addition, concentrating research on breast cancer alone reduces women’s health to a breast-first view. More than ever breasts have become objects seemingly detached from the female form since the advent of plastic surgery and the birth of the breast cancer “epidemic.” Even now women judge their breasts based on a male ideal. Like Dr. Fugh-Berman’s experience with the female cadaver in medical school, breasts remain objects that can be easily removed or reshaped. In medicine breasts still exist as an expendable site. Consequently a woman’s sense of self is developed not
by the physical qualities of her breasts but by their related social and cultural value, thus they can be discarded or replaced without much hesitation by the patient, physician, or political community. Breast implants, of course, are not the only form of plastic surgery that has gained popularity in recent years. But breasts, more than thin thighs or full lips, are most potent as a symbol of women’s sexual self-worth. More then 2 million women have had breast implants in America, currently the most sought after form of plastic surgery in the country. The social worth of breasts is further inflated by the fact that they are symbols of femininity and motherhood.

Breast cancer eradication is a culturally viable cause to defend in the social realm, and many breast cancer activists have made it their mission to see that the government maintains research and prevention regarding the disease. Nonetheless the success of breast cancer activists cannot be attributed solely to the appeal of the body part that they are trying to preserve. Breast cancer activists have successfully manipulated the language of medical procedures and generated an issue for policymakers to seize and utilize for their benefit. It is important to recall that prior to 1990 it was a radical notion for breast cancer activists to demand that the federal government assume primary responsibility for breast cancer funding – this political response reflected a significant shift in attribution for the problem of breast cancer. The period of funding activism in the 1990s defined governmental neglect of the disease, in the form of research funding, as the central problem associated with breast cancer. In this new context, breast cancer was constructed not as a problem of stigma or access to quality screening and treatment, but as a problem of insufficient scientific knowledge of the disease. This lack of knowledge was credited to the claim that the government had not sufficiently prioritized research on breast cancer, furthering the epidemic of breast cancer through institutional neglect. Activists repeatedly articulated their
grievances to both politicians and the general public through claims making in the form of congressional testimony and through media coverage of movement activities.

Over time, the role of the government as a form of protection for women has evolved from the exclusion of women from medical trials, education, and politics into a new form of paternalism through gender-specific legislation. While it is true that women have historically been excluded from the medical process or relegated to traditional female roles based on motherhood, it is also important to observe the ways in which such legislation reinforces preexisting social constructions of gender. In this case, support and research for breast cancer is held in higher esteem than the overall health and plight of women in society, as demonstrated by the mixed passage of the Women’s Health Equity Act. Although the National Institute of Health Reauthorization Act absorbed pieces of the Women’s Health Equity Act in 1993, by and large the issues surrounding contraception and abortion were turned into a political football that hindered any true progress for women’s health. While breast cancer remains a veritable threat to the health of many American women, it has only become an epidemic as a result of increased media attention and disease specific legislation. Moreover, because breast cancer threatens both life and an organ that is associated with sexuality and motherhood, it is a disease that implies more than mortality. Breast cancer is associated with intimacy, femininity, and sexuality. As a result, it is a disease men and women fear. However, increased funding for research does not equate with a cure.
Diagnoses of breast cancer, the disfiguring disease most dreaded by American women, rose steadily in the 1980s and now appear to have leveled off. But death rates from the disease have changed little since the 1930s. To some experts, the data indicate that modern medicine is conquering the disease through treatments like chemotherapy and regular screening with mammograms, which can catch the disease at an earlier, more curable stage. But to skeptics, the statistics mean that breast cancer remains an intractable disease and that scientists have yet to find a cure for its most virulent forms. As politically savvy breast cancer activists push for increased federal spending to find a cure, they are asking increasingly skeptical questions about how the money should be spent. Likewise, proponents of other diseases are beginning to criticize the breast cancer movement by maintaining that breast cancer activists have effectively utilized publicity tactics to accumulate an unbalanced share of the research pie. That is, the perennial attention to breast cancer has deflected attention from diseases that kill more women, such as lung cancer and heart disease. Barron Lerner summarizes the debate by saying, “although breast cancer activists also advocate funding increases for other serious diseases, as shown by their recent support of cervical cancer legislation, in reality there is no competition for the $18 billion in annual funding from the United States National Institutes of Health, and Congress has allocated money to the groups that most effectively marshal data, visibility, and celebrity spokespeople on their behalf.” The National Cancer Institute now spends more for research on breast cancer than for prostate, ovarian, colo-rectal and liver cancers combined. Given that rates of breast cancer remain high in the United States it is unlikely that activists will broaden their agenda until a cure is found.
Glitzy fund-raisers to raise money for breast cancer research have lured such corporate contributors as J.C. Penney and Pier 1 Imports along with Ralph Lauren and Estee Lauder, and their success keeps the disease in the limelight. By contrast, congressional observers note that prostate cancer, which claims about as many men’s lives each year as breast cancer does women’s, and poses similar risks in detection and treatment, lacks breast cancer’s high-visibility campaigning for funding. Ovarian cancer advocates express similar objections with reference to publicity and funding. Ovarian cancer is not as “fashionable” because it presents no easy symbol of feminine beauty and potential frailty like the breast. Dr. Robert C. Young, president of the Fox Chase Cancer Center in Philadelphia, claims that “about 50,000 women die of breast cancer each year, and 20,000 of ovarian. If you make rough estimates comparing the mortality and the amounts of research funding, the funding falls short.” Yet the number of deaths from a disease is not necessarily the appropriate yardstick for a medical research budget, assert some experts. Some scientists, including NIH Director Harold E. Varmus, argue that earmarking funds for a specific disease is simplistic. Breakthroughs for one disease are often discovered through research in other areas, they say. Sydney Salmon, director of the Arizona Cancer Center in Tucson, has noted that scientists studying retinoblastoma, a seemingly unrelated childhood eye cancer, made the discovery of an important factor in breast cancer - the loss of tumor suppressor genes.

Concerns about disease specific legislation have made their way into recent congressional hearings. Frances Visco, NBCC President, publicly recognized that “disease specific legislation is not the most efficient or productive way to create effective public policy, but until guaranteed access to quality health care coverage and service is available for women and their families, there are some very serious patient concerns that must be met.” Senator D’Amato (R-NY) referred
to this type of policy as legislation “by body part.” Meanwhile the NBCC and other breast cancer groups are now being criticized for their narrow focus on breasts in place of general women’s health. Yet these groups emphasize breast cancer because it was, and remains, the most common non-skin cancer in women, and in 2005 it is expected to kill over 40,000 women in the United States alone.

Other critics have questioned the breast cancer movement’s focus on early detection and treatment as opposed to prevention. Recent controversy over whether screening mammography saves lives are resounded by breast cancer activists wanting to ensure that promises of early detection and treatment are not exaggerated. In general, the NBCC and other breast cancer groups want to make certain that women are entitled to learn about the ambiguities of the data for prevention and treatment. In a statement before Congress, Visco clarified the concern:

We also must be clear about the realities and limitations of the early detection tools that exist today. Currently, there is no truly early detection. Often, by the time a tumor is found, it has been in the breast for 6 to 10 years. The goal must be to detect the tumors at their earliest stage, or prevent them in the first place. Mammography should be accepted for what it is: followed by treatment, it may extend the lives of some women who have breast cancer, but it does not prevent or cure breast cancer, and it has many limitations.

Breast cancer as a cause seems to exist everywhere because it has hit a social nerve, in politics and in the greater American community. Amy Langer, executive director of NABCO, argues that breast cancer is so prevalent in American society because “there’s something different about breast cancer that makes it very different from foot cancer or, for that matter, any other disease. It’s about body image, it’s about nurturing – it is certainly about femininity. It is loaded for women in ways that other health threats are not.” For decades that meant that people talked about it less. But as the world changed around the disease and women’s health became a political quest in the media and Congress, the same things that once made it unspeakable became the very reasons people spoke about it more. Breast cancer is also an
effective marketing ploy, it comes with none of the potential baggage that support for AIDS may bring, and similarly possesses no moral conflicts like those surrounding reproductive rights.

To date, breast cancer activists have repeatedly renewed their contract with federal government officials since 1993 to secure funding of more than $550 million annually for the disease. Whether or not activists will be able to preserve this remarkable achievement remains to be seen as other sponsors of new disease campaigns take notes from the success of the political breast cancer movement. Regardless of future funding allocations, the breast cancer movement has already bequeathed many techniques that may be utilized for capturing the attention of federal officials and the general public to search for a cure. Likewise, breast cancer activists’ authority in the health care system has permanently transformed the landscape of biomedical policy in America. As women continue to improve their social status in the United States, they increasingly demand improvements in all aspects of their life. The breast cancer movement is just one of the many political and social changes in which women are attempting to alter their own jurisdiction.

Breast cancer activism is undoubtedly a great cause. However, there are many debates surrounding the breast cancer movement and its success, including cultural resonances of class, race, sexuality and gender. For example, women whose mothers have died of breast cancer might take on the issue of funding for breast cancer research over some other causes, such as women in prison, the mental health system or women immigrants. Unfortunately women in these latter groups usually lack the resources needed to initiate and sustain a self-help project without considerable outside assistance. This problem is exacerbated by the media’s distortion of women’s health concerns. The mainstream media are increasingly controlled by a very small monopoly, and many pressing concerns simply do not get a platform.\textsuperscript{122} Funding breast cancer
research exists at the expense of other opportunities and gives emphasis to breast health above other aspects of women’s lives. Demanding federal responsibility for breast cancer also strengthens the power of politicians in determining the direction of women’s health needs. Foucault argues that medical practices involve a double-sided process, which combines the “extension of a network of personnel offering qualified support and the consideration of disease as a political and economic problem for social collectives which they must seek to resolve as a matter of overall policy.” Shaping health concerns within the framework of policy is even more difficult when trying to define “disease.” Thus, certain women’s health issues such as domestic violence may not be thought of as a disease and therefore disregarded as a political or economic crisis. With a popular culture that is saturated by breast cancer awareness and increasing political-medical discourse on the topic, female patients that are working to take control of their own wellbeing are relegated to health concerns that focus on feminine features and confined by legislation relating to motherhood.
X: THE LEGACY OF LEGISLATION

Modern medicine now involves a complex array of specialties and new technologies that probe and dissect female patients. As part of the medical transformation in America, the female body begins to have body parts that are valued in different ways by society and politicians. Just as the probes and pieces of the female patient do not produce a complete view of the subject, the acts and bills proposed by Congress do not allow for the complete health of the woman when they are passed in segments without regard to race, socioeconomic status, or even with consideration for the term woman.

Obviously, biological components cannot be ignored in analyses of health policy, but that makes the task of delineating the biology and culture interface even more difficult. Breast cancer is a viable threat to many women, but so are many other diseases, along with various economic and social challenges that impact women’s health as much as physical illness. Creating legislation specifically aimed for the protection and advancement of women holds many promises to improving their wellbeing, especially in previously neglected areas of research and treatment. However, women’s health as an area of public policy presents many fundamental challenges to the idea of gender and womanhood in American culture. The Women’s Health Equity Act aimed to integrate biological, medical, behavioral and social issues that have an overall impact on the totality of women’s health, but the legislation distinctly avoids a definition of what a woman is, what a woman ought to be, and what a woman should therefore be allowed to do. In addition to the conflicting notions of gender raised by health policy, legislation and congressional testimonies repeatedly frame the need for women’s health by stressing their contributions to society as a “mother” or “wife,” thereby valuing their work in the family unit over the need for health as a basic right.124 Furthermore, while women work to empower
themselves by demanding more research and funding for diseases like breast cancer, they are systematically disempowered as the government assumes greater responsibility and secures the role of protector. Many studies have shown that the “personal is political” by linking the actions of legislators to their own experiences and interests. Thus, while the government is still largely male and mostly white, legislation dictating the health and treatment of women is coming from a source that does not adequately represent their needs. This is made evident by the ease of passing breast cancer legislation and increasing funding for that disease between 1990 and 1993, while many other women’s health provisions stalled or died during the same period that were arguably more important for certain populations.

Medical theorizing about differences between men and women has a long history, but only recently has the government been actively controlling the medical policies related to gender. The everyday political relevance of gender and racial identification in our pluralistic society in the United States only increases the likelihood that these categories will be emphasized in biomedical classification. And, despite the recent political agitation on the part of people calling themselves intrasexuals or transgendered, this notion of clear and reliable sex differences endures. While policy makers and the general public realize that sex is only a theoretical ideal of male and female, as long as these classifications exist, the government will continue to exert control over individual identities. Since sexual difference or object is more often female centric, sexual dichotomy is often more detrimental to women, as demonstrated by the medical profession and prioritized treatment of breast cancer over other aspects of women’s health. While it is true that women’s health has evolved to encompass their needs beyond sexuality and reproductive health, there has not been a complete alteration in the agenda. Many women are still uninformed about their health risks and a significant number of women, especially those who are
uninsured, do not have access to quality care. Federal policy makers have expanded the field of women’s health such that research money is now flowing to diseases that specifically affect women. Yet, items relating to women’s reproductive life and sexuality, including breasts, still receive disproportionate attention through federal funding and the print media.

Women’s health legislation also fails to recognize abortion and violence as health issues even though significant health concerns associated with both abortion and violence persist. These two issues have been demedicalized as they have become increasingly politicized. This is clear in the congressional hearings for women’s health between 1990 and 1993, as the overwhelmingly majority of testimonies that were given revolved around the politics of the womb and related moral quandaries rather than the actual content of the bills being proposed. The Women’s Health Equity Act failed not because it wanted to increase funding for breast cancer, ovarian cancer, and osteoporosis research, and create the Office of Research on Women’s Health. Rather, it did not pass because the biology and health of women’s reproductive organs have always been the focus and failure of policymakers and policy. In this sense, abortion is no longer a medical issue, but a political dispute. In contrast, breast cancer is an issue that cuts across the political spectrum and creates a consensus that has never been reached on over abortion, one of the primary women’s health issues of recent decades.

For some legislators and foundations, breast cancer has come to symbolize the bulk of women’s health issues. Many women’s health advocates now argue that this makes it harder to draw their attention to other devastating diseases such as cardiovascular disease or lung cancer, or lesser known female ailments like lupus and multiple sclerosis. While women in Congress and other politically active roles are seeking equality for women and civic responsibility on behalf of their health needs, these efforts frequently result in the augmentation of biological and
social differences concerning gender. For instance, patriarchy, in order to survive as such, must keep women as separate, as other, and the easiest way to achieve this is to emphasize observable differences, particularly those that are biological. Basic to the study of women’s psychological and physical wellbeing is an understanding and appreciation of the powerful and pervasive political motivations underlying the definition and treatment of women’s health concerns. The politics inherent in the medical principle operating in a patriarchal society provide a basic structure by habitually defining a healthy woman as one who fulfills her biological destiny, one who is able and willing to bear children, and by inventing illness and remedy for the woman who is unwilling or unable to conform. Contracting breast cancer is an inhibition for women who want to raise children and possess the feminine qualities associated with healthy breasts, that of sexual allure and motherhood. By supporting breast cancer legislation apart from the entire body of the woman and community needs the Government acknowledges that each body part comes with a disproportionate social value. Similarly, creating institutions for the sole purpose of researching and preserving physical differences between the sexes compounds the efforts feminists make to dissolve gender barriers.

Women’s health policy faces many of the same challenges that women’s studies as an academic field frequently encounters. Creating a new health specialty could actually be detrimental to women’s health, making a few practitioners responsible for knowledge about women’s needs instead of making that knowledge part of mainstream medical education. In many ways, the debate over the new specialty mirrors the academic controversy about women’s studies departments within universities. Some feminists argue that having a separate department adds to the credibility of the subject. Others claim that establishing a separate place for women
makes it easier for the male establishment to continue to exclude women’s concerns from the
general curriculum.

The commercialization of medicine that occurred while women’s health legislation came
to the fore has also led to expanded public attention on women’s health care concerns, some of
which are beneficial, but many of which have contributed to unnecessary mastectomies,
hysterectomies, and cesarean deliveries. Likewise, phallocentric medical and political culture
tends not to think of a woman’s breasts or womb as hers. With woman as a natural and social
territory; her breasts and body belong to others – her husband, her lover, her baby. Abuse and
violence against women as well as reproductive choice are not defined as medical or health
issues by policymakers. Whereas entry into the political arena as a non-health issue has not
forestalled positive policy responses for abused women it has limited reproductive choice and
freedom, a battle that emerged during the hearings for the Women’s Health Equity Act. The
themes of women’s health policy in American history continued to direct legislative issues in the
1990s. The role of women as the primary caretaker dominated Congressional hearings, while
issues involving contraception and fertility determined the outcome of proposed bills. Above all,
it was a result of women’s improved social status and louder political voice that demanded
increased attention for women’s health. Without representatives in Congress, medically
confident women, or aggressive lobbying from breast cancer activists, women’s health would not
have grown into a formidable political cause. This has certain setbacks, however, as most
advocates arguing in favor of breast cancer funding are middle-class, white women. Poor
women, for example, are much more likely to suffer from cervical cancer. On the other hand, at
least among older women, breast cancer is more common among the affluent.
In spite of the improvements that legislation and related media coverage has brought forth on behalf of women’s health, especially by increasing the number of women in medical schools and demanding more funds for research, there are still many obstacles that women face when seeking medical care. On average, women still lack the financial resources to access the best types of medical treatment in America. Existing power configurations also impact the way that physicians and the medical community at large treat women, reflecting cultural values of femininity. Moreover, federal funding in support of breast cancer raises specific questions about the medical and social value of the female body in relation to other diseases. While lung cancer and heart disease have received recent attention as women’s diseases, the birth of women’s health as a policy issue in 1990 furthered Freud’s famous notion that “anatomy is destiny” by focusing primarily on breasts and the female body as a reproductive vessel. Women had limited control over their own bodies because their function in society was politically ordained as a result of the label “woman.” Breast health is one more avenue in which women are cultured to focus on feminine qualities related to motherhood and male definitions of femininity. Similarly, women’s health legislation continues to emphasize social values concerning the female body while upholding gender differences by preserving existing biomedical classifications. Without a doubt, gender-specific medicine is providing new avenues of study and improving health care, but advocates should be wary about the evenhandedness of research, funding and access. Overall, women’s health policy between 1990 and 1993 made great strides in acknowledging the need for better funding for gender-specific diseases like breast cancer, but many socioeconomic variables were left out of the majority of successful legislative measures. By failing to address the needs of women who are unable to pay for cancer treatment following mammograms, or
providing more education regarding access to public health programs, women are still at a social and political disadvantage.
XI: CONCLUSION

Embodiment is defined as being specifically concerned with the lived experience of one’s own body. This lived experience refers explicitly to the way that individuals negotiate their everyday lives via the utility of their bodies, and how they mediate, interpret, and interact with their physical and social environments. Implicit within the concept of embodiment is a sense of dynamism or constantly shifting meanings and understandings. Embodiment is experienced within particular historical, cultural, political, and societal frames, and these experiences are also shaped by gender and race. For example, the way we define disease, a healthy body, and beauty are all changeable and vary depending on gender and ethnic backgrounds. Within medical and sociological theorizing, embodiment has offered an alternative to dualistic theorizing, in which mind and belief are literally embodied and, conversely, the bodies of persons literally mindful. Utilizing theories crafted by Foucault to examine the body in relation to the deployment of power and knowledge in social institutions elucidates the construction of the contemporary female patient.

Foucault instructs us to analyze the ways in which knowledge is sustained by social processes. Power structures that exist in modern society, including the Government, education, and media, affect the kind of knowledge that is produced. Therefore, even scientific knowledge is socially produced and politically maintained. Funding considerations, political and economic constraints, power relations and moral frameworks influence the paradigms of scientific enquiry, knowledge, and ultimately, the embodiment of the contemporary female patient. Historically, women’s health policy in America has taught women to concentrate on motherhood as a necessity for complete health. Recently, this practice of creating a biological certainty from a
social and political system changed to include an emphasis on breast health. Since knowledge and social action work together to alter the ways society may perceive a problem, breast cancer is treated accordingly when the illness is viewed as a medical problem, an epidemic, a threat to our social order or a deforming malady. After politicians identified breast cancer as a principal interest in the field of women’s health, the female patient and the medical community embodied new concern for a woman’s chest. Breast cancer is an illness that has existed for centuries but it acquired additional power once it was identified as a woman’s disease. Without similar titles, disorders like multiple sclerosis and lung cancer lack the political and social potency of breast cancer. Scrutinizing women’s health policy between 1990 and 1993 reveals the political and medical mechanisms that are employed to influence our social beliefs regarding the female body. The political-medical discourse surrounding breast cancer and the WHEA illustrates how bodies are inscribed with meaning through culture by prioritizing the health needs of the female patient. Hence, the work of Foucault with regard to women’s health policy highlights the need to consider the physiological affects of culture on our bodies and the related cultural affects of our bodily experience.

Cultural ideals of sex, gender, race and sexuality masquerade as scientific wisdom or facts of nature that change over time. Stereotypes based on gender, race, and class tend to distort the content of science and medicine in American history and routinely have a negative impact on the most vulnerable members of society. By analyzing the course of medicine over time, it is seemingly impossible to remove political evaluations from the scientific process. Therefore, researchers must remain mindful of the political implications of their scientific practice. The Government, which is acting on this concept of politically motivated science, realizes that medicine is not nearly as objective as some initially hoped. Mandating that researchers address
women’s health issues exemplifies the need for Government intervention and the subjective nature of the medical community. However, controlling the direction of research is a precarious business. Scientific discoveries can be made at unexpected times, from unrelated research. Government intervention also dictates how we may identify ourselves socially. Creating categories of gender or race undermines science as a resource of biological information and instead works to fulfill current political agendas. Moreover, the attempt to evaluate scientific theories and medical advancements in part on the basis of their alleged political progressiveness narrows the hypothesis space that scientists may pursue in their attempts to solve problems.

Today feminists and the Government are asking science to play a larger role in the project of relieving prejudice and oppression. This is a legitimate request, and the very fact that it is being made shows that science is respected for its power to dispel ignorance and to better the human condition. But these requests are still being made with certain social values. Breast cancer research is given more public and political value than lung cancer. Hormones that affect a woman’s menstrual cycle are still avoided as an area of research by the medical profession. Outside of the political arena, breast cancer advocates are still unable to reach a consensus on how to alleviate related women’s health concerns, typically issues that involve race and class. Breast cancer does indeed discriminate; it disparately affects different groups of women, and some it barely affects at all. Advocacy groups, which are unable to envision a non-medicalized way of approaching this public health crisis, are surely a failure of political imagination. Political and social powerlessness to change the national inequalities that force people to inhabit unsafe and unhealthy environments is the leading cause of cancer today. Sponsors of women’s health need to address relocated risk factors away from the particular genetic body, to the political, geographic and economic environments. Because of its unbalanced focus on breast cancer, and
because it makes sweeping claims to unite women under one umbrella, women’s health legislation as it stands needs to change radically if it is going to serve a broader population. Representing the entire range of issues that affect all women seems like a tall order, but it was this notion that the authors of the Women’s Health Equity Act tried to incorporate into their legislation. The very indeterminacy of the category of woman and its conceptual volatility provides the means to reconfigure identity beyond the dualistic model of sex as currently maintained by biomedical policy. In the end, the overall health of women will only improve in conjunction with a corresponding improvement of their social status and political power. Until women achieve equity in all aspects of their lives, diseases that threaten traditional gender roles, such as breast cancer, will receive undue attention and support from politicians and the media. An approach to women’s health policy that does not reside on traditional concepts of femaleness will push for new forms of inquiry, attend to unforeseen lines of research, and seek stimulating engagements with the political, social and medical milieu. When disciplinary practitioners of science, technology, politics and medicine consider the processes of their own production as educators and researches and reevaluate the coincident construction of topics, informants, and patients studied, a more complete form of women’s health policy will arise.
3 U.S. General Accounting Office, National Institutes of Health: Problems Implementing Policy on Women in Study Populations (1990). This does not mean that the remaining 87% of funding went directly to men’s health. Instead this shows that women were not included in studies and therefore excluded from general health research. How illness and medicine works in the female body was never considered. In addition diseases and matters of health that predominantly affect women, including pregnancy and childrearing, only received 13% of Government funding.
7 Association of American Medical Colleges, www.aamc.org/start.htm
8 Barbara Hanson, “The Social Construction of Sex Categories as Problematic to Biomedical Research: Cancer as a Case in Point.” Health Illness and the Use of Care: The Impact of Social Factors, Volume 18, 2000. p. 53-68.
12 Some investigators are beginning to consider how racism shapes people’s environments and, as a result, their health. Several studies now illustrate the link between toxic dumps and poor neighborhoods that are disproportionately located in poor neighborhoods of color. Other researchers are starting to ask how people’s experience of and response to discrimination may influence their health. A recent study of hypertension, for example, found that black women who responded actively to unfair treatment were less likely to report high blood pressure than women who internalized their responses. Interestingly, the black women at highest risk were those who reported no experiences of racial discrimination. (Krieger and Fee, “Health Politics and Power”) Thus racism is a matter of economics, but also a concern for living and working conditions that greatly influences health.
15 Krieger and Fee, “Health Politics and Power”
20 Leder, The Body in Medical Thought and Practice, 6.
22 Ibid., p.15.
23 Spitzack, Body in Medical Thought and Practice, p. 63.
26 Commonwealth Fund, Survey of Women's Health 7 (1993).
28 Association of American Medical Colleges, www.aamc.org/start.htm
29 A dearth of women at the Federal level of Government still exists, but women are closing the gap at the local and state level.
33 Ibid, p. 15.
34 Rogers, Dearing and Chang, “AIDS in the 1990’s”; Dearing and Rogers, “AIDS and the Media Agenda”
36 Wachter, “AIDS Activism and the Politics of Health.”
44 Casamayou, p. 58.
46 Krieger and Fee, “Health Politics and Power”
48 Ibid.
49 Ibid.
51 Ibid.
52 Ibid.
54 A list of the major subtitles of the WHEA can be found in Appendix A.
55 Haseltine and Jacobsen, *Women’s Health Research: A Medical and Policy Primer,* p. 307-313. October 25, 2000, breast cancer activists enjoyed another legislative victory when President Bill Clinton signed into law the Breast and Cervical Cancer Treatment Act. Beginning in 1994, low-income, uninsured women had enjoyed the right to free breast cancer screening, but those diagnosed with malignant disease were not entitled to affordable treatment. Activists, including NBCC leader Visco, made it a top priority to close that cruel gap between diagnosis and treatment, mounting a legislative crusade that stormed its way through Congress before President Clinton left office
64 Ibid, Remarks by Mr. Scheuer.
Dr. Bernadine Healy, National Institutes of Health Revitalization Amendments Conference Report. (Senate - June 04, 1992)

Ibid.

Women’s Health Issues – (Address by Dr. Bernadine Healy, Director of NIH) (Extension of Remarks - July 31, 1991), http://thomas.loc.gov/cgi-bin/query/F?r102:3.:./temp/~r1022PwkZk:e0:


Ibid, p. 312-313.


The NIH Reauthorization Bill (S.1/H.R. 4) did encounter a new controversy before becoming law. The legislation established a permanent ban on foreigners infected with HIV, the AIDS virus. The AIDS immigration issue was the central conflict during the House-Senate negotiations on a final NIH Reauthorization bill.


FDA, U.S. Department of Health, Education and Welfare, General Considerations for the Clinical Evaluation of Drugs 5 (1977). A woman of childbearing potential is defined as a premenopausal female capable of becoming pregnant. This includes women on oral, injectable, or mechanical contraception; women who are single; and women whose husbands have been vasectomized or whose husbands have received or are utilizing mechanical contraceptive devices. Women in certain institutions, e.g. prisons, although of childbearing potential, could be considered as not in the appropriate environment to become pregnant during the administration of an investigational drug.

However, women in mental institutions could become pregnant.


Ibid, p. 203.


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Healy’s term as NIH director ended after Clinton became President in 1993.

The Women’s Health Initiative, which is still producing unprecedented amounts of information and data on the health of American women, skirts the issues of hormones and cyclical fluctuations by choosing to study osteoporosis and the wellbeing of postmenopausal women. Although portions of the study focus on breast cancer and diet, the majority of the initiative does not take young women with childbearing potential into consideration. Sections of the study were also terminated when clinical trials proved to be detrimental to the health of the patient.


Casamayou, *The Politics of Breast Cancer*, p. 112-113. The funding increases for breast cancer during the early 1990’s can be attributed to Oakar’s leadership and the lobbying efforts of many coalitions like the National Breast Cancer Coalition. Thus, Oakar’s bill “passed” because funding levels for breast cancer grew dramatically beyond the initial $25 million request.

Ibid, p. 113-115.


98 Olson, *Bathsheba’s Breast*, p. 204.

99 Ibid, p. 204.


102 Epstein, “Bodily Differences and Collective Identities”

103 Hanson, “The Social Construction of Sex Categories as Problematic to Biomedical Research,” p. 53-68.

104 In 1994 Feminists for Life introduced a collection of studies that hypothesized a link between abortion and breast cancer. The FFLA distributed the material to every member of Congress and much of the press, and they were not the only organization to do so. The politics of the abortion debate seem to preclude the kind of response to this information that would be expected, were this potential cause a relatively non-controversial item. Research is still underway to gather statistics and evidence for this claim.


106 Which raises an interesting point of contention, if breasts are simply objects that can be reshaped or literally removed from a woman’s body, then why is America so determined to eradicate breast cancer? An interesting analogy can be drawn to appendicitis. No patient wants to have their appendix removed unnecessarily, but the appendix has no known purpose. An easy way to prevent appendicitis therefore is to remove the appendix. Of course breasts have a natural and important function for women who are breast-feeding, but for most of their existence the breasts just hang around. Or, for golfers like Jessica Simpson, they get in the way. Yet breasts are an external, visible and real part of a woman. They are feminine, they represent motherhood, and popular culture continues to glorify breasts when any young female enters the spotlight. Women want to keep their breasts just as any person wants to keep their body in tact. Society simply adds pressure for maintaining that idealized female form.

Additionally invasive breast cancer, which can afflict the chest wall, is not necessarily eradicated by a mastectomy. In the end mastectomy treats breasts as disposable, an ideology shared by Fugh-Berman’s anatomy lab instructor; whereas lumpectomy cherishes the breast. Neither option is devoid of cultural implication.


108 There is room for an interesting study between breastfeeding laws and related policy in relation to breast cancer funding and other women’s health concerns. As Yalom suggested, the scarcity of breasts in real life makes them that much more valuable and prized. Examining the objectification of women’s breasts through breastfeeding laws or even documenting the transition of the sacred breast associated with motherhood to that of the eroticized breast denoting sexual pleasure and male desire could be coupled with medical and social policy history for unique research. “Manmade Breast Cancers,” by Zillah Eisenstein mentions that breast milk is now the most contaminated of all human food.


120 Ibid.

Which begs the question, what makes an illness a “woman’s disease?” Although lupus cases can strike men and women of all ages, 90% of individuals diagnosed with the disease are women, and 80% of those afflicted with systemic lupus develop it between the ages of 15 and 45. Lupus is also two to three more times prevalent among people of color, including African Americans, Hispanics, Asians and Native Americans. These statistics can be found on the Lupus Foundation of America, Inc., Education webpage, [www.lupus.org](http://www.lupus.org). Likewise, multiple sclerosis disproportionately affects women. The number of women living with multiple sclerosis jumped by 50% between 1980 and 1990, while the amount of men living with the disease remained constant. This information, combined with the fact that autoimmune diseases such as MS are the fourth leading cause of disability among American women, underscores the need for further research. In fact, for some unknown reason, women make up about 75% of all autoimmune disease sufferers. A slew of other sex differences exist in autoimmunity, including the fact that multiple sclerosis typically progresses more quickly in men than in women. The American Autoimmune and Related Diseases Association has recently brought this issue to light, [www.aarda.org](http://www.aarda.org).
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US Congress. House of Representatives 1161. Committee on Energy and Commerce,


APPENDIX A

Proposed Women’s Health Equity Act, S. 2961 101st Congress
July 10, 1990

Research
- Establishment of offices and programs relating to women’s health
- Inclusion of women and minorities in clinical research conducted by NIH
- Breast Cancer Research
- Grants and contracts for research centers with respect to contraception and infertility
- Establishment of general program of research regarding women with AIDS
- Osteoporosis research

Services
- Requiring information on alternative treatments for breast cancer
- Coverage of OB/GYN and women’s health nurse practitioner services
- Adolescent pregnancy prevention, care and research grants
- Extension of COBRA continuation benefits
- Family-building federal employee benefit

Prevention
- Phased-in coverage of pregnant women and infants up to 185% of poverty level
- Phased-on mandatory coverage of children up to 100% of poverty level
- Optional coverage of children up to age 6 with income below 185% poverty level
- Optional coverage of children to age 18 with income below 100% poverty level
- Establishment of program of grant to states for prevention and control of breast and cervical cancer
- Medicare coverage of annual screening mammography
- Medicare coverage of bone mass measurements
- Establishment of programs of grants regarding prevention of AIDS in women
- Establishment of program for prevention and control of Chlamydia

Proposed Women’s Healthy Equity Act, H.R. 1161/S. 514 102nd Congress
February 27, 1991

Research
- Office of research on women’s health
- Inclusion of women and minorities in clinical research
- Office of research on women’s health and mental health
- Women and alcohol research equity
- Breast cancer research
- Contraceptive and infertility research centers
- Sense of Congress regarding contraceptive and infertility
- Women and AIDS research initiative
Requirement regarding certain categories of basic research on ovarian cancer
Osteoporosis and related bone disorders, research, education and health services

Services
Requiring information on alternative treatments for breast cancer
Coverage of OB/GYN and women’s health nurse practitioner services
Adolescent pregnancy prevention, care, and research grants
Adolescent health demonstration projects
COBRA displaced family and disability amendments
Federal employee family-building

Prevention
Medicaid infant mortality amendments
Breast cancer screening safety
Medicaid coverage for mammography and Pap smear screening
Medicare coverage of bone mass measurements
Women and AIDS outreach and prevention
Prevention of infertility due to sexually transmitted diseases

Proposed Women’s Health Equity Act, H.R. 3075 103rd Congress
September 14, 1993

Research
Women’s scientific employment
Establishment of general program of research regarding women and AIDS
Women and alcohol research equity
National Breast Cancer Strategy Act of 1993
Establishment of Office of breast cancer and national breast cancer commission
Duties of director of breast cancer of the National Cancer Institute relating to breast cancer
Lupus research amendments of 1993
Women’s midlife health research act
Osteoporosis and related bone disorders, research, education and health services
Ovarian cancer research and information amendments of 1993
Antiprogestin testing act of 1993
Women’s health environmental factor research act of 1993
Federal risk assessment in women’s health of 1993
Pharmaceutical interactions safety act
Pharmaceutical testing fairness act
Tobacco advertising and promotion studies act of 1993

Services
Equity in health professions education act
Women’s health office act of 1993
Women’s health information act of 1993
Breast and cervical cancer amendments of 1993
Women’s preventive health amendments of 1993
Postreproductive health care act
Medicare bone mass measurement coverage act of 1993
Mickey Leland Adolescent Pregnancy Prevention and Parenthood Act of 1993
Adolescent health demonstrations project act of 1993
Eating disorders information and education act of 1993
Women and HIV Outreach and Prevention Act
Standby guardianship act
Federal prohibition of female genital mutilation act of 1993
Smoking prevention and cessation in WIC clinics act
Family and medical leave health care reform of resolution of 1993
Veteran women’s health improvement act of 1993
Defense women’s health improvement act of 1993
Defense women’s health research center
Women’s health education and curriculum advisory committee
International population stabilization and reproductive health act

**National Institute of Health Reauthorization Act of 1991 (passed)**

Federal funding
- $225 million for breast cancer research
- $100 million for clinical research, including 6 multidisciplinary breast cancer research centers
- $75 million for basic and clinical research on ovarian and other reproductive tract cancers
- $20 million for contraceptive and infertility research
- $40 million for osteoporosis and related bone disorders
Also included OB/GYN research program
National Institute of Aging study of women
The National Center for Nursing Research was elevated to an institute

**National Institute of Health Reauthorization Act of 1993 (passed)**

Women’s Health Research
- Inclusion of women and minorities in clinical research funded by NIH
- Office of Research on Women’s Health
- Biennial Report
- Data system and clearinghouse on research on women’s health
- $325 million for breast cancer research
- $75 million for female reproductive system cancers