Of histories, hysterias and hysterectomies: Medical discourses and imaginaries on female reproduction

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Sexuality, culture and politics
A South American reader

Although mature and vibrant, Latin American scholarship on sexuality still remains largely invisible to a global readership. In this collection of articles translated from Portuguese and Spanish, South American scholars explore the values, practices, knowledge, moralities and politics of sexuality in a variety of local contexts. While conventionally read as an intellectual legacy of Modernity, Latin American social thinking and research has in fact brought singular forms of engagement with, and new ways of looking at, political processes. Contributors to this reader have produced fresh and situated understandings of the relations between gender, sexuality, culture and society across the region. Topics in this volume include sexual politics and rights, sexual identities and communities, eroticism, pornography and sexual consumerism, sexual health and well-being, intersectional approaches to sexual cultures and behavior, sexual knowledge, and sexuality research methodologies in Latin America.

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Of histories, hysterias and hysterectomies: Medical discourses and imaginaries on female reproduction*

Patricia Tovar**

The history of a hysterectomy serves as a starting point to examine the meanings attached not only to this procedure, but also to female reproductive processes in the perspective of bio-medicine and culture. Critiques of gynecology and obstetrics have motivated the reformulation of several medical practices, research on treatment alternatives, and the empowerment of regarding medical decisions about their bodies. Medical discourse and bio-medical practices on the female body account for complex power hierarchies. An investigation into those must address how the female body is perceived, under a cultural perspective of reproduction; as well as the implications of this and other surgical procedures, public health concerns and medical treatments options from a human rights perspective. Medical discourses and the socio-cultural constructions on reproduction are under constant tension. This tension is compelling because contemporary medicine is at the same time liberating and controlling; both necessary for survival and essentializing of women's lives. This paper is written from the perspectives of medical anthropology and feminist critiques of science, and gynecology in particular. Through my hysterectomy experience I also underscore the presence of cultural stereotypes in scientific discourses related to womanhood, as well as the representations implicit in metaphors on reproduction and their impact on women's lives.

My story begins when I was fourteen years old and suffered from strong colic and bleeding during my first menstruation cycles. The doctors I consulted underestimated these pains, and alleged that I was perhaps making a big deal out of them; they suggested I should not call attention to this, that perhaps it was all in my mind, that I was simply unsatisfied with my own femininity or that, perhaps, my mother wrongly explained how reproduction works. All of this was making me feel restless because none of those explanations applied to my situation. I have had sex education at school. Many f*emale* personal c*are* companies had come to our school to lecture on sex education. I had been prepared at home by my mom, a teacher with five daughters. In fact, I noticed a big contradiction between what the doctors were saying and what I was feeling,

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** PhD. Associate Professor at John Jay College of Criminal Justice, City University of New York.

and so I got used to taking great amounts of painkillers without getting any answers to my questions on the causes and consequences of my problem. The message I was receiving was that I had to accept living with pain as part of being a woman. In a gynecology book published in 1976 I found the following explanation:

> Primary dysmenorrhoea, that is, painful menstrual periods, is usually found in girls who have had a false education during their puberty years. Education should follow the mother's example. If the mother's menstruation goes unnoticed, disregarding eventual discomfort, the daughter will evolve in the same manner. However, if the mother feels compassion towards the daughter, the daughter will fearfully wait for the next menstrual period, and accentuate the potential discomfort her bleeding may cause. The treatment consists on a good psychotherapy that must include the mother. The patient may take spasmolytics, though she should be strongly advised not to take any medication. (Kern, 1976: 99).

This negative or careless description of female biological processes encompasses an idea of women as responsible for the problem, if not an accusation that women are inventing the problem in their minds. Physicians arrive to those conclusions without caring to check for a possible biological cause to the problem. Those representations reflect the tendency to implicitly consider women as incapable of processing their ailments and making decisions about their bodies. Historically, menstruation has been a cause for amazement, fear and angst. It has been endowed with magical qualities, prohibited by religious systems and, more recently, discovered a source of profit by personal c*are* companies that advertise their products' advantages to make women feel "free, clean and safe", so that "its arrival won't ruin our date". Likewise in India, campaigns brought about by modernization opposed the traditional taboo that forced menstruating women to stand aside from their daily chores. Those campaigns were hardly beneficial for the women who no longer practiced the taboo; they lost those few days that allowed them to escape from their hard domestic labor every month.[1]

Menstruation derives from *the Latin* word *mensis* (month), and is also known as "*el menstruo*", "the flow", "the rule", "the month", "the period", "the time", "the habit", "the visit", "the novelty", "the moon", or even "the monstruation".[2] English-speaking countries insult women who escape female imperatives of passivity and softness by saying "she's on the rag". I have also heard that menstrual bleeding is "nature's weeping on a non-fertilized egg"–though others would say "it's the monthly tribute to the joy of non-fertilization."[3]

As years went by, the situation got worse, and I started to suspect I might have fertility problems. I asked the doctor, and he prescribed a set of thorough medical exams,

[1] Joan Mencher, personal communication.

[2] Translator's Note: *Monstruación*, a neologism, merges: menstruación and monstruo, that is, menstruation and monster.

[3] See: http://www.medspain.com/n7_nov99/artic03_1.html

which revealed that I had *fibromyomas, also known as myomas or non-cancerous, that is, "benign" tumors. Before,* I had been told that my uterus was in an odd position called retroflexed uterus, yet the doctors assured me that that was not related to my pains. The aforementioned gynecology book, however, acknowledged that it was one of the few dysmenorrhoea cases admitting the use of spasmolytics.

I did not know exactly what fibromyomas were, or what the implications. At that time, the only female gynecologist that touched me along this long process said that the best thing to do was to be careful and to wait and see how the fibroids evolved. The possibility of performing a myomectomy, that is, the surgical removal of fibroids, was of high risk and was not assured to put an end to the problem, because new fibroids usually developed and a new surgical procedure was needed. Although the doctor did not explain the exact cause for the fibroids, her words reassured me by saying that many other women suffered from fibroids. I followed her advice and waited, but as fibroids evolved and the pain and bleeding increased, I went back to the doctor, and I was told that my uterus was the size of a three and a half month gestation. At least, no one told me at that point that mine was a psychological problem.

This doctor was born in India, a country where due to its cultural and religious constraints and modesty rules, almost no man can practice gynecology. She told me I should consult a breast specialist, because my mammography showed that I had many cysts in my breasts as well. I had never had a mammography performed on me before, and I did not know exactly what to expect. Nothing prepared me for such rough handling of my breasts; in order to take X-rays, a machine squeezed my breasts so hard it took my breath away for several agonizing minutes. As I found out later, this is another controversial diagnosis technique, not only for the amount of X-rays the body is exposed to, but also because of its partial effectiveness: it can only detect tumors once they are at an advanced stage. The critique points at the lack of research on alternatives to this unpleasant exam.

It goes without saying the feeling of aggressiveness and disrespect one is often left with after a visit to a doctor. As an example of common consultation manners, I once visited a recommended breast specialist whom I met only once I was sitting topless on examining chair. He entered the room and began to look at X-rays and feel my breasts, without asking my name or establishing a minimum dialogue about my situation. Since I was feeling uncomfortable, I told him I usually like to introduce myself to anyone who sees me naked and touches my breasts. As many other women who went through unpleasant medical encounters, I find this and other medical office details such as used chairs, stretchers, and empty offices with nothing but coats offensive. My search for answers left me with bluntly said contradictory information, with no space for questions or requests for clarification. In addition to this, the constantly changing medical system forecloses any possibility of treatment continuity or being attended at the same place by the same physician who knows one's medical chart.

Given the vague explanations I was getting, I decided to visit a 'private' gynecologist, i.e., one whose fees were not covered by my health care plan. A friend recommended an eminence in the field of fibromyomas. His office was full of his publications and media appearances, which made sense considering the high cost of the consultation. The publications mentioned his specialties, including procedures which avoided hospitalization, such as what he called "embolization" of the uterine artery, and a treatment based on leuprolide, a drug usually recommended for fibroids reduction, not covered by the *Plan Obligatorio de Salud* (Compulsory Health Plan). According to the brochures, this technique destroyed the tumor through a small cut in the abdominal wall, through which an electric needle was inserted to "coagulate" the blood vessels that feed the fibroids. The doctor arrived when I was at the entrance of the room, and before saying hello, he fixed his hair and tie in front of a mirror. Using fruit metaphors, he explained that I had several tumors: one the size of a grapefruit, another the size of an orange, and a third one the size of a lemon. This meant that his revolutionary techniques were useless for my uterus, and what I needed was a myomectomy performed by him and afforded by me. He explained to me how, through a small cut in the abdominal wall, the fibroids were to be removed preserving the uterus. I left the office lighter on my wallet with the additional feeling that I had just raised someone else's ego.

Myomectomy, a less controversial procedure than hysterectomy because it preserves the uterus, is also an elective surgery. Depending on the fibroids' size and position, and although they may cause severe pain, having fibromyomas is not life-threatening; hence every woman can choose which treatment suits her best. Myomectomy involves the same risks as any other abdominal surgery, in addition to the possibility of the development of new fibroids. This procedure is usually practiced on young women trying to conceive. A caesarean section is also usually scheduled when the women who get pregnant reach their term.

My waiting and consultation of different doctors continued without getting any options other than hysterectomy. As the years went by, my belly grew to the point I could no longer bend over to tie my shoes. I had not turned forty, but during doctors' consultations I have to listen to recommendations such as: "If you haven't given birth by now, you're not going to now, so you better remove that useless uterus". Another doctor told me I should not worry; there was no point in me postponing the decision: a hysterectomy was just like removing a back tooth, because one can live without it easily. Not only I felt insulted, I also felt humiliated for experiencing the potential loss of an organ I considered important and resisted being separated from.

I was recommended to find solutions in acupuncture and homeopathy, which had a perspective on the matter that involved a different understanding of the symptoms without contemplating surgery. In reality, I sensed little improvement in my condition. After this whole process, I was left with a feeling of guilt for having postponed my decision to have children. After a thorough Web-based research, I found a webpage

that explained step by step every surgical procedure, with all kinds of illustrative images. In this research, I also found some discrepancies in the naming of female reproductive organs.

> The womb or uterus is like an animal inside the women, with an appetite for making children; when the womb or uterus remains long enough without a fertilized egg, it gets impatient and can hardly tolerate this emptiness. It wanders through the body, blocking the passages of breath, preventing breathing, feeling extreme anguish and causing all kinds of diseases. (Plato, Timaeus)[4]

Some of the modern definitions of the uterus were:

> The uterus, also known as womb, in a hollow organ, shaped as a pear, [note the fruit metaphors] located at the lower part of the abdominal wall, between the bladder and the rectum. Every month, during the menstrual period, the uterine lining sheds. When an egg is fertilized it attaches to the uterine wall where the embryo develops[5] [emphasis by the author]

> The uterus is a hollow muscular organ located in the female pelvis, between the bladder and the rectum. Ovaries produce eggs, which travel through the fallopian tubes. Once the egg leaves the ovary it can be fertilized, and is later implanted into the uterus.[6]

> The main function of the uterus is to feed the fetus before birth.

The uterus is never defined and appears to exist only upon the possibility of hosting a fetus. None of the found definitions mentioned the very interesting and positive fact that the uterus is the strongest organ of the female body, capable of expanding and contracting to its original size a large number of times.

U*terus* derives from the Greek word *hustera*, also related to the word histeria. As we see, ever since the Classical period, it was assumed that the uterus—either empty or full—, more than any other organ of the body, dominated us completely and was the source of many other female emotional and social problems (Chauvelot, 2001).

The relationship between emotional disorders and women's reproductive functions has been long studied since the Classical period. Gonzalez' book (2004) mentions: "the finding of Egyptian papyrus manuscripts from the year 1900 B.C. where behavioral disorders are described, such as hysteria". The volume also refers to Hypocrites' writings, where "hysteria has been long considered an exclusively female condition,

[4] Cited in: J.D. Nasio, 1990

[5] http://www.martinmemorial.com/clinical/adult/spanish/pregnant/anatomy.htm

[6] http://www.nlm.nih.gov/medlineplus/spanish/ency/esp_imagepages/19263.htm

related to uterine migrations; this perspective existed for several centuries as part of the association between female reproductive physiology and some psychiatric disorders such as PMS, postpartum and menopausal depression" (Gónzalez, 2004:92).

Uterine fibroids are the most common non-cancerous tumors in women of reproductive age, and the cause for at least one third of the hysterectomies performed every year. Hysterectomy is the second most common surgery among women, second only to childbirth by cesarean section delivery.[7] The amount and costs of both these procedures are highly controversial. Women activists have questioned the handling of childbirth and accused gynecologists of profiting out of these procedures.

The causes for fibroids remain unknown. There is a pervading implicit accusation which links fibroids to the postponement of motherhood. In other words, the tumors come as punishment for defying nature, for not assuming motherhood at a younger age, for studying or working instead. Although *fibromyomas* affect a great number of women across the world, it continues to render medicine and science answerless.

More studies on hysterectomy reveal that almost three quarters of the procedures are performed on women aged 30 to 54. Some studies show that around 15% of all performed hysterectomies are unnecessary, and that physicians who have graduated more recently tend to recommend the procedure less.[8] Other motives for uterus removal include endometriosis, chronic pelvic pain, uterine prolapse—commonly referred to as "the fall of the womb"—, as well as uterine and ovarian cancer.

Although the agendas of medical associations such as the American College of Obstetricians and Gynecologists are currently targeting the causes and treatments for uterine fibroids in genetics and endocrinology, the immune system and the environment play important roles in diagnosis as well. Including these two other factors would add to the finding of preventive practices and the possibility of finding a cure without removing the uterus. More is expected to be heard from medical research; however, the expectations are based on less invasive surgeries and the use of hormonal therapies as alternative treatments.[9]

The literature on ovaries, often described as the size of a plum or an almond, provides a different characterization, as this organ contains the eggs for further fertilization and produces the hormones necessary for ovulation and menstruation. As a result, the consequences for the removal of ovaries are very different. These hormones help to protect the heart, bones, bladder and even the brain. As I write these words, I read on

[7] According to the American College of Obstetricians and Gynaecologists, about half million hysterectomies are performed per year only in the United States. Daily News, Now Health, June 1997.

[8] See: http://www.ahcpr.gov/consumer/spanhyst/hster2.htm

[9] See: http://www.nichd.nih.gov/publications/pubs/fibroids/espanol/index.htm

the newspaper that another scientific dogma on women's reproductive system has now fallen. "Apparently, we are not born with a limited number of eggs".[10] Recent research shows that eggs could be transplanted or could grow back. As the research reveals, the amount of eggs rises during the woman's life course. This opens many possibilities for women to ovulate and give birth after their fifties.

Contrary to the scientific dogma that stipulates the uselessness of ovaries after menopause, some research suggests that eggs do play a physiological role in the control of calcium metabolism—a mechanism unknown until today. After observing women who went through bilateral oophorectomy, researchers found that these women were at higher risk of suffering bone fractures (Melton et al., 2003). It is possible that a similar phenomenon may occur in the removal of the uterus, demonstrating that the organ has a specific, yet unknown, role.

These thoughts build on Emily Martin's idea (1996) of a "scientific fairy tale" or "scientific fantasy" on textbook representations on the female reproductive system. Whereas the latter indexes women's reproductive organs as always negative, time-limited, self-destroying and agonizing, the male reproductive system is always regarded quite differently. This process is described as an interesting, fantastic, fascinating celebration of men's capacity to produce millions of spermatozoids destined to "colonize" women's reproductive organs. The verb choice exemplifies the deployment of militaristic metaphors by medical discourse to refer to the male reproductive system.

When I finally confirmed I had no other choice, I decided to undertake a hysterectomy. The myomas kept growing and the bleeding increasing; I was feeling constantly exhausted and weak. One chapter of the gynecology book I picked to learn about the details of the procedure was titled: "Surgical Castration".[11] Until that moment, I had never thought the term "castration" had anything to do with me, yet this is what the procedure now called total hysterectomy was referred to during the 1970's, that is, the surgical procedure where uterus and ovaries are removed.

Hysterectomy is a surgery referred to as "routine procedure," whereby the uterus can be total or partially removed, along with the Fallopian tubes and the ovaries. Partial hysterectomy consists on the removal of the upper part of the uterus without touching the cervix and the lower end of the uterus. Total hysterectomy is the removal of the entire uterus and cervix, and radical hysterectomy is the removal of the uterus, Fallopian tubes, ovaries and the upper part of the vagina.

[10] According to Nathalie Agier (New York Times, March 10, 2004) science has found evidence that ovaries could be refilled with eggs.

[11] See Kern, 1976

The hysterectomy performed on me began through a cut in the lower part of the abdominal wall because my uterus was too big for a vaginal hysterectomy. I asked my physician if I was going to keep my uterus, to which he responded: "What for? It can only get you cancer". This seemed a too radical way of preventing cancer, so I wondered if this was the case for men as well, to remove a healthy organ to prevent a potential cancer in the reproductive system. I was also terrified to find out that uterine cancer was not the first cause of death among Colombian women between the ages of 15-44, but violent assaults resulting in homicides within their homes (15%), followed by accidents, complications at birth and pregnancy, and lastly, malignant uterine tumors (6.39%).

My research on the causes for uterine cancer reveal that the serotype G chlamydia infection, one of the most frequent sexually transmitted diseases, increases the risk of having squamous cells at the cervix, and that, as the literature claimed, women are more likely to have cervix tumors if their husbands have other sexual partners. The human papillomavirus is responsible for an important number of cervical cancers. Since this virus apparently does not affect men, it is also known as a "machista" virus. Every sexually active woman is at risk of developing cervical cancer, hence cytology is recommended as a preventive measure. Likewise, research points out that this problem is most common among young women of low-income households who become sexually active at young age, or have multiple sexual partners, or have one partner with multiple other sexual partners.[12] Chastity, sexual activity, and even virginity—as addressed in gynecology textbooks—must be read under a critical lens that visualizes gender prejudice. For example, a 1925 gynecology dissertation equates virginity with nulliparous women, a word that resonates to something like null uterus, a medical term used for women who have never given birth to a viable, or live, infant:

> The [vertex] of the cervix is rounded, and has a central hole (circular in virgins) in the shape of a crack of one centimeter, and it turns into a more irregular shape in the case of multiparous woman. According to several authors, uterine capacity outside of gestation is of 4 cc in virgins and 6 cc. in multiparous women (Ospina, 1925: 15-16).

The eminent Spanish physician Gregorio Marañón (1940) claimed that "chaste women intensify their masculine tendencies and frequently presents fibroids, polycystic ovary syndrome and fibrocystic breast changes". This statement had me wonder if the real cause for my *fibromyomas* was that I had been too chaste. Dr. Marañón expresses another common thread of thinking found in gynecology, which stresses that women's problems can be solved through early motherhood. These date from earlier times in the history of gynecology; in time they have obviously changed.

[12] Information found at the web page of the Catalan Oncology Institute (Instituto Catalán de Oncología), directed by Dr. Xavier Bosch: http://www.enel.net/mujer/82_clamidia.asp

As for my case, aware potential complications and side effects, I felt I was choosing the lesser of two evils. Finally, once on the operating table, I felt like I was lying on the sacrificial stone, ready to offer one of my organs to the Gods of medicine. I had my uterus removed while a vallenato sounded: the anesthesiologist was from the Caribbean region of Colombia and he liked that musical genre. While the doctors applied antiseptics, epidural anesthesia and painkillers, I was once again reprehended for letting my uterus grow to such an extent that my stomach had lost its shape. I lost track of everything until I opened my eyes to see what the doctor was showing me in his hands: I thought it was my torn, bleeding heart, but instead, it was something like a pumpkin the color of an eggplant (to go on with the fruit images).

After a while he called me to say how difficult the surgery had been. He showed me something resembling a giant purple spider: it was in fact my right ovary. The ovary was attached to my bowel due to endometriosis. That was why the surgery had been so difficult and risky. Unable to move or speak, I thought that neither of the doctors I consulted mentioned endometriosis, nor noticed its presence in the multiple tests they had performed on me. I was surprised, and, again, I thought about castration.

It was so cold when I woke up, and I was in so much pain that when the vomiting began, I completely regretted having the surgery done. The next day I was already feeling better and the nurse asked me why I was there. When I answered, she said: “Such a pity, so young!” She told me I should not worry and that I should never tell anyone what had happened. She argued that from that moment on, every time I would be too happy, or too mad, or get into an argument or anything at all, people were going to blame my mood to “the surgery”, that is, to the fact that I no longer had an uterus.

That was the beginning of a series of unrequired comments and opinions given to me by both men and women. The hardest ones argued that it had all been my fault, for being a careless woman. Others felt sorry for me, for seeing me so “incomplete”; I no longer had a uterus, what was then left of me as a person? I realize how little women know—and men even less—about the meaning of hysterectomy. The questions were on whether I still menstruated or not, if I was menopausal, if I could no longer give birth and if the uterus was the same thing as the womb. As a childless person, this last question had a special meaning to it; whenever people made it, there was always pity in their tone. So bored I was about this question, that I once answered someone that yes, technically I was able to have children, all I needed was to get an in vitro fertilized egg implanted into a surrogate mother, like the ones advertising in the Colombian newspaper. I also mentioned I have already experimented with uterus transplant in Muslim women and artificial uterus in Japan, made not necessarily for women like me, but for other ends not so clear for science—the implications of these artificial uteri were yet to be seen.

I was concerned about the lack of information and the pervasiveness of stereotypes not only related to reproductive health, but also circulating in regular conversations: a

woman once told me that ever since she got her uterus removed, she felt "clean", and another one said she suffered distress when told that her husband was going to find a new wife because she no longer was as "useful" as she used to be.

A few words on menopause

Hysterectomy refers inevitably to the subject of menopause, where once again we find all kinds of negative images that feed on the hormone replacement therapy (HRT) controversy. Without getting into any further detail, I will limit my account to some key issues on menopause:

There are several medical perspectives on menopause. Highlighted are those which describe it as a "flaw", "deficiency," or "loss". Menopause or climacteric is defined as "the abrupt low in the production of estrogen that causes the end of menstruation and the loss of the capacity to conceive" (Gómez, 2004). This definition of "the loss of the capacity to conceive" is most influential in the cultural ideology whereby women's roles are determined by its reproductive functions.

> Women who presented menstrual periods of 4-5 days during their reproductive years consider it an insult to their femininity that their menstrual cycles last only 1-2 days. They are right: their ovaries are losing vitality, the production of estrogen and progesterone diminishes and the possibility to conceive is almost null. Finally, the ovaries lose their main goal: to ovulate. (Kistner, 1982: 656)

Biologically, the female body is defined as deteriorated, useless to the end it was originally created for, which is reproduction. This definition resembles the social one, because a woman is no longer "useful" the moment she loses her reproductive capacities. Similar to the arguments used against contraception, which renders these efforts as "anti-natural," there is a perception of menopause as a deficiency, as a lack of capability, opposed to men's ability to procreate until the end of their lives. Menopause is never shown as something positive, as the liberation from all the health risks derived from gestation, from the domestic obligations and the social restrictions which are harder on women at reproductive age in patriarchal systems like ours. Not to have a uterus or to have a useless one means the same in cultural terms. Women entering menopause are usually seen as "castrated" and their bodies are described in not very flattering ways. "The decrease of cervical and vaginal secretions results in a vagina that is nothing more than a dry and rigid tube" (Kistner, 1982: 657-658).

Menopause is always represented in association with "symptoms" or "syndromes", that is, with a pathologizing vocabulary. Likewise, this perspective describes women's behavior as determined by biology. Women's hormonal change during this stage of their lives is seen as a disaster, framed in the idea of deficiency that should be treated like, for example, diabetes is.

Facing such perspective, women fell trapped in the dilemma of undertaking a series of risks due to hormonal replacement therapy or thinking that if they do not, their bones will dissolve and their health, sexuality, and femininity, will go into crisis:

> The pre-menopausal decade (40-50 years old) is a difficult time in many women's lives. The symptoms in this time of life involve a deterioration of the female physical characteristics along with an intense, unpleasant sensation of adding years to their lives (Kistner, 1982: 655).

I made a list with the variety of symptoms associated to menopause in the works cited: hot flashes, sleep disorders, depression, urinal syndrome, sexual dysfunction, obesity, hypertension, osteoporosis and heart disease risk. I wonder to what extent these symptoms actually reflect other medical conditions apart from menopause. Remarkably, in spite of the number of opinions and of medical interventions, "the estimated percentage of women with mood swings during the menopause is 10%" (Kistner, 1982: 657).

Within this perspective we find another medicalizing disposition towards menopause, producing a specific idea of what it means to be a woman, while claiming that hormonal replacement therapy is the solution to their problems and to all the negative symptoms that go along this biological process: The pre-menopausal patient should be convinced that she has not reached the end of her life, but the beginning of a new stage. She now has new liberties; she can expand her range of activities inside and outside the household, revive postponed interests and achieve unfulfilled desires and ambitions. Equally important is to receive a symptomatic therapy. She should be prescribed with appropriate medicine to relief her from short-term symptoms on a psychic and somatic level (fenobarbital- 30 mg, combined with - 0.75 mg, 3 or 4 times a day). Some patients are also prescribed with spasmolytic agents and sedative infusions for the autonomic nervous system (Onatra, 2004: 280).

With a notably condescending tone, these medical texts locate the root of the problem in women's "psychic tension" and attempt to solve all their problems, including those subject to social causality, through the use of external estrogen for the rest of their lives: "If women consumed external estrogen not only during menopause and post-menopause, but also during the rest of their lives, they would take over the world" (Davis, quoted by Kistner, 1982).

The human female is the only animal that goes through menopause. In many other species, females are able to reproduce throughout their lifetime. Recent social and cultural changes in the history of humanity reflect in biology. On the one hand, menstruation is a biological process interrupted only once or twice due to pregnancy. In comparison to this, in other times and places of human history, women were constantly either pregnant or lactating. Women's longevity has dramatically increased; during the times where birth was associated with health risks, a woman's life expectancy was

lower. Basic health indicators in Colombia (Health Ministry, 2002) show a current fertility rate of 2.6, which means that the average of children per woman is less than three, and that life expectancy at birth is of 75.3 for women and 69.2 for men—as long as they stay away from armed conflict.

Menopause is always described in negative terms, and the assumption is that the problem lays in the patient's imagination: "It is very important that the doctor can tell the difference between real facts and fantasy, because the symptoms that take place during menopause vary greatly, and how they express depends on the patient's social context, marriage, genetics and medical history" (Kistner, 1982: 655). The author recommends caution, because ovarian failure and the low in estrogen mix with anxiety, marriage problems and boredom. He also suggests that "these symptoms must be treated not through the incorporation of estrogen, but through the limiting of diuretic agents and sodium, in addition to some tranquilizer, and, in particular cases, psychotherapy" (Kistner, 1982: 656).

To sum up, these definitions reveal the controversies within gynecology that confuse, inside and outside the medical office, physical with emotional and even social problems. Menopause takes place at a time of women's lives which coincides with other significant events: retirement, working through children's emancipation (resulting in the so called "empty nest" syndrome), widowhood. These events impact differently in men and women, and are not always object of pharmacological concern. On the other hand, we need more information and education to understand and support this very normal stage of transition in life.

In conclusion, I must add that we are far from understanding menopause in particular, and human reproduction from an anthropological instead of a medical viewpoint. We are still ignorant about how indigenous and rural women experiment menopause in our country, as well as the perceptions that women have about their own bodies and the processes they experience.

Conclusion

My hysterectomy experience, with its vicissitudes and the questions it raised, exposes the contradictions of this particular medical practice. In my case, it involved complications and life-threatening circumstances. I regret that medicine did not offer me any alternatives, confusing and blaming me for all the gynecological problems I had from the moment I started menstruating. At least now, information and outreach increased and there is new research on the causes and cure of this condition.

I presented the hysterectomy case to illustrate the problematic encounter between science and the representation of female reproductive processes. Such event is

conceived within a framework where medicine constructs and intervenes on the body in different ways, thus reflecting cultural images held on women and the corporate interest of drug companies that profit out of health.

The birth control pill exemplifies these controversies; this pill is now prescribed for 15 years old girls for skin care and acne prevention. It is also of public knowledge that not all women can take estrogen, and that there are several risks—listed in small print on the package leaflet (cervical and breast cancer, heart attacks, just to name a few). Birth control pills and hormones are promoted, in general, as a panacea for women. Yet there is another great inconvenience to the pill has: it does not protect women from sexually transmitted disease. Other problematic examples are hormone replacement therapy and diagnosis processes like the mammography.

I frame this work within feminist critiques on science, in this particular case, on gynecology, a specialty characterized by the exclusion of women—a fact which seems to be under transformation. The practice of gynecology echoes patriarchal attitudes and a gaze pervaded by unequal power relationships on women's bodies. Likewise, it regards a female wisdom that passes from generation to generation as fantasy, myth, and old women's stories. In my research, I noticed the absence of women's perspective in gynecology. I bring to attention a particular compilation with 32 authors, of which only two were women. One of them at least had a critical gender perspective, with interesting proposals that emphasized, above all, social aspects that impact on adult women.

Women's risk factors related to disease, especially during menopause, are particularly linked with psychosocial factors (gender) more than biological aspects, that is, those of neurological and hormonal nature. Culture allocates in women the power of affection and in men the power of rationality and economy. It identifies women with various roles: the mother, which demands love, selflessness and capacity for emotional support; the housewife, obediently willing to serve, to be receptive and to expressed herself in a contained, controlled, and passive manner to coordinate domestic life; and the wife, docile, comprehensive and generous (González, 2004: 93).

Gynecology on the other hand is a profession that mostly depends on the literature published in the global north, where drug research, production and profiting also comes from, exposing thus a conflict of interest. In addition to this, what is regarded as adequate and effective for industrialized populations is not necessarily so for countries like ours, with a deficient health care system.

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