The Swedish medical discourse: Impotence, erectile dysfunction and Viagra in *Läkartidningen*

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4 The Swedish medical discourse

Impotence, erectile dysfunction and Viagra in *Läkartidningen*[1]

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Medicalizing the ageing male

The inability to achieve and maintain an erection has had many causes and many cures. Ancient Greeks attributed it to a diet of dry, cooling foods. During the European Middle Ages, impotency could be the result of a curse – dealt out by one's enemies, a witch or a slighted lover who tied knots in a string. Later, sexual excess, youthful indulgences and masturbation were blamed. During the nineteenth century both a wife's aversion to sex and her desire for it could cause impotence, as well as a glimpse of her 'unattractive' female genitals. The stress of modern, urban living was (and still is) made a culprit. Then, of course, comes the litany of Oedipal urges, domineering mothers, incestuous fixations and the Freudian analysts needed to cure these. In the mid twentieth century, especially in the United States, therapists looked to relationship issues for a cause and the point of treatment, while in a wider arena impotence was variously attributed to feminism, the sexual revolution and the contraceptive pill. And most recently, impotence has become a vascular issue (for a cultural history of impotence, see McLaren 2007).

Tracing the changing expectations of men's potency and vitality in Europe and North America shows how male sexuality has, with time, become more and more medicalized. This is true of sexuality in general. It has slowly gained recognition as a field in medicine: conferences are being held about various aspects of sexuality; medical journals on the subject are sprouting up; medical schools are offering courses in sexuality and some are even opening entire departments in the field; doctors are being encouraged to speak with their patients about sexual histories during routine medical exams; and pharmaceutical solutions to sexual 'problems' help define these problems as medical (Fishman and Mamo 2001, 181; Tiefer 2006, 274f). At the same time, non-medical experts are flourishing, offering sexual advice on the Internet, radio talk shows and TV, in magazines and newspapers (Tiefer 2006, 275). But while female reproductive health has traditionally been a focus of medical intervention (see Martin 1992; Oudshoorn 1994; Dugdale 2000), for men it has been virility, with strength and vitality instead of reproductive capacity, that has long attracted medical attention (Sengoopta 2006; McLaren 2007).

Sexuality is not the only area of life to be medicalized and later pharmaceuticalized with the development of pharmaceutical solutions to health 'problems'. The processes of medicalization and pharmaceuticalization depend on the social and technical networks within which people and diseases are placed. As Oudshoorn states, 'health problems can only be classified as illness and be medicalized if there exists a cultural climate and a medical infrastructure that actively transforms health complaints into diseases' (Oudshoorn 1997, 143). Thus, solutions to problems like depression, anxiety, obesity, hair loss and ageing can become medical solutions when both the medical community and general population recognize them as such. This process is not uncontroversial, however, and the pharmaceutical solutions to obesity, hair loss and ageing can be grouped together with the treatment for erectile dysfunction in the category of drugs sometimes called lifestyle drugs (Mamo and Fishman 2001, 16; Elliott 2003; Loe 2004a; Moynihan and Cassels 2005; Williams *et al.* 2011a). While some of these cures address problems that most people would at least nowadays call diseases (like depression), the disease status of others is more contested and their development has spawned the term *disease mongering* to denote the process of medicalization that uses medical practice and medical technologies to promote a concept of improvement unto perfection and the idea of medication for instant, scientific solutions for physiological and psychological distress (see Fishman 2004, 193; Tiefer 2006, 274). Disease mongering not only serves the purposes of pharmaceutical companies looking for conditions that can fit their pharmaceutical cures, it also expands the areas of life that doctors can claim as their territory – and for which they can charge consultation fees and sell drugs (Elliott 2003).

Some of these lifestyle drugs and diseases are related to a change in attitudes towards activity, sexual and otherwise, in older age. The concept of successful ageing allows the medical community to offer medical solutions to health problems traditionally associated with ageing, problems like hair loss, menopause and, as will be discussed in this chapter, erectile dysfunction. As the medical community claims these areas as its domain (rather than the domain of diet, witchcraft, antisocial behaviour or psychoanalysis, for example), the problems become diseases and the solutions are often decidedly medical, in the form of surgeries, drugs and physiological treatments. Because these solutions to ageing are creating diseases out of changes during the life span, the idea of getting older successfully has been critiqued for promoting an idea of ageing that really means not ageing at all (Marshall 2006, 350). Viagra and its promise of returning male sexual performance to a youthful, erection-on-demand state so that anyone can have sexual intercourse at any time and any age is currently one of the most talked about treatments for successful ageing.

This development should be placed in the history of medicalized male vitality. In the early part of the twentieth century, it was thought that the secret to masculine vitality was found in the sex glands, and much research about these glands, in both people and animals, was conducted (see Oudshoorn 1994; Marshall 2006; Sengoopta 2006). One of the medical treatments developed during the 1920s (sometimes called the decade of the testicle because of the intensity of

research into testicles during this time) to treat a loss of vitality in ageing men was the Steinach operation. Developed by Austrian Eugen Steinach, and said to have been performed on both Freud and Yeats, the operation redirected fluid from the testicles to be reabsorbed into the body rather than released outside. This fluid was then thought to help revitalize the patients (Marshall 2006, 347; Sengoopta 2006; McLaren 2007). In the 1930s and 1940s, male rejuvenation treatments moved into more mainstream medical practices and began to reflect new knowledge about testosterone. Hormone therapy, that is testosterone treatment, was developed as a treatment for the 'male climacteric'. But again, the goal of treatment was general male vitality as displayed through physical and mental, but not necessarily sexual, prowess. In fact, increased sexual function was sometimes seen almost as an undesired and slightly embarrassing side effect of treatments (Marshall 2006, 347–8).

In the middle of the twentieth century, new research into sexuality and sexual behaviour changed the way sex and sexual dysfunction was perceived and treated. No longer was sexual decline in the male thought to be a natural part of ageing. Experts asserted that sexual activity and sexual intercourse were important parts of healthy ageing (Marshall 2006, 349). Impotence was thought to be caused by a fear of impotence. It was perceived as something that could be avoided and treated through therapy, often involving the partner, rather than through biomedical interventions (Tiefer 2006, 283). During the middle of the century and up into at least the 1980s, it was generally agreed that in 80% of impotence cases the problem was psychological and therapy was the best treatment.

According to feminist sex therapist Tiefer (2006), the psychology-based approach to sexuality in general and sexual dysfunction in particular changed during the 1980s. She notes that in the United States, several different factors contributed to a shift. For one thing, the American Psychiatric Association (APA) decided to define sexual problems as disorders in performing a sequence of genital functions, which coincided with a broader acceptance of a biomedical and psychopharmacological model of mental health. At the same time, the health industry began to use the *Diagnostic and Statistical Manual of Mental Disorders* and its definition of sexual (dys)function when determining which diseases would be eligible for reimbursement (Tiefer 2006, 283). Shortly thereafter, urology specialists began to take on more sexual dysfunction cases, which served to cement the idea that impotence was a biophysical issue of the penis, and led to examinations and treatments for sexual dysfunction that did not include the involvement of wives or partners (Tiefer 2006, 285).

Thus, impotence, which only a decade before had been called a psychological problem with physiological results, began to be seen as a physiological problem that could lead to psychological suffering (Marshall 2006, 350). The 1990s also saw other changes in the view of sexual dysfunction. Impotence became known as erectile dysfunction (ED), specifically located in the penis. By the late 1990s, largely thanks to research and advertising funded by Viagra's maker, Pfizer, the new reigning explanation for impotence stated that 70–80% of cases stemmed from physical causes, a direct reversal of the earlier ideas and one which supported

medical consultations and prescription-based solutions rather than behavioural therapy or couples counselling (Plante 2006, 379). Sexual function was no longer seen as a controversial side effect of anti-ageing treatments; it was now the main goal.

The narrative of impotence and ED within the US context is also relevant to what has happened in Sweden, although with a bit of delay on some points. To examine the pharmaceuticalization of erectile dysfunction in this discourse in Sweden, I have analyzed articles dealing with impotence and erectile dysfunction in the generalist medical journal *Läkartidningen*.[2] I have looked at the articles published between 1990 and 2015, starting eight years before Viagra's introduction in 1998. Doing so shows that the construction of impotence, erectile dysfunction and male sexuality in *Läkartidningen* in some ways follows very closely with how these ideas have been framed in the international medical community, despite the framework of socialized medicine within which *Läkartidningen* publishes and the debates about subsidies of Viagra which have surrounded its introduction to the Swedish market. For example, in *Läkartidningen* the discourse has moved from social causes of impotence to a focus on mechanical and molecular aspects of ED, as has also happened in English-language journals. Reports in *Läkartidningen* from studies about impotence are also frequently linked to pharmaceutical funding after the introduction of Viagra, and there seems to be more column space granted to these discussions than there was before Viagra. In 2006, a study was published in *Läkartidningen* which reaffirmed that social aspects of ED contribute to individuals' treatment options. This suggests that a broader definition and re-evaluation of male sexuality could have appeared in the Swedish discourse. But it is rather unique. The local structures of health care provision also influenced the Viagra discourse in Sweden, framing it in debates about chronic medical conditions that produce 'legitimate' and severe ED. These debates are particularly Swedish in that they stem from questions about subsidizing Viagra with tax money.

Later I will present my analysis drawn from a careful reading of the *Läkartidningen* articles. In examining the articles, I have looked at the construction of patients and symptoms associated with impotence, as well as how the authors define and propose impotence and its cure(s). I have then contextualized this against results of similar analysis of the international discourse on impotence and ED. The articles studied have been found using the search words: impotence, impotence treatment, penis erection, erectile dysfunction, erectile difficulties, potency treatment, Viagra and Sildenafil.[3] A total of fifty-three articles was sourced for the years 1990–2015. Forty-five of these were published after Viagra was introduced.

Impotent patients before and after Viagra

Prior to Viagra, impotence was presented in *Läkartidningen* as a combination of psychological and physiological conditions. It was also something 'natural'. This understanding of the condition is reflected in a 1993 book review which asserts: 'Approximately ten percent of western men suffer from sexual difficulties

associated with impotence, and if men can stay healthy and live long enough, they all become old-age-impotent'[4] (Mellgren 1993, 984). Old-age impotence, my translation for *åldersimpotent*, can be read as a specific type of impotence, and one that seems to disappear from the discourse after the arrival of Viagra and the presentation of the term *erectile dysfunction*. Also of note is that this number, 10%, is very low compared to Pfizer statistics that began to appear with the introduction of Viagra. (On the Viagra website,[5] ED is said to afflict more than half of men over fifty.)

Impotence, if natural, was, however, already a medicalized condition before Viagra arrived, although for fewer people. Pre-Viagra, impotence was also very complex in *Läkartidningen*. In an article about the causes of impotence from 1990, the authors spend an entire section speaking about feelings. They discuss the way men, particularly after not engaging in sex for a longer period of time, can want to have sex, but still not have sexual urges. They explain this by stating that 'many people interpret desire as the same thing as libido. But desire and libido are not the same thing' (Olsson *et al*. 1990, 4456). Five years later, in an article written by two of the same authors, the pre-Viagra discourse denied the feasibility and benefit of distinguishing between physical and emotional causes of impotence, something Viagra relies on. 'To create a distinction between somatic and psychological cases of impotence has been shown to match poorly with reality. Instead, one must for every patient evaluate biological factors and his feelings, his relationship to his partner, his family and work' (Olsson *et al.* 1995, 313). Thus, pre-Viagra, impotence is a result of a combination of (mostly social and emotional) factors.

It is not just the number of impotent patients and the emotional causes of impotence that change through the 1990s in *Läkartidningen*; the definition of an impotent patient also proves flexible. In the 1995 pre-Viagra article about impotence (Olsson *et al.*), impotent patients are constructed as a heterogeneous group, within which one finds some patients easier to treat than others. Those most likely to respond successfully to treatments are men in long-term relationships, and when discussing them, this 'patient' is frequently spoken about as the couple. More difficult to treat are single men, of which the authors identify three types: the young, shy man; the older man who has been sexually inactive for a while; and the loner carrying a secret. Of these, the older, sexually inactive man is seen as the easiest to treat (Olsson *et al.* 1995, 314). This typology of patients is based on social factors, and focuses on the men's relationships with others, not on the biological or mechanical causes of impotence. Respect for the social aspects of impotence also appears when, in the same article, the authors discuss reasons it can be difficult to treat impotent patients: because some impotent men can have rigid stereotypes about normal sexuality; they can find intimacy threatening; they think sex is about performance and thus develop performance anxiety; they are unable to recognize their own emotional signals; they see the ability to have intercourse as a sign of power; and/or because some of them experience impotence as shameful (Olsson *et al.* 1995, 314). And, as the authors later go on to say, the most difficult thing to deal with as a doctor is the rage that some patients feel and can at times project upon the doctor when treating impotence.

After the appearance of Viagra, types or groups of patients are still discussed in association with ED in *Läkartidningen*, but usually these are connected to individuals who have diseases whose symptoms can include, or whose treatments can induce, impotence, that is diabetes, multiple sclerosis, anxiety attacks and heart disease. Thus patients are distinguished into categories based on medical diseases rather than social factors. This later discussion of the types of ED patients in *Läkartidningen* was probably triggered by the debates raging after the introduction of Viagra over who should receive subsidies for the prescriptions of Viagra (see Landtblom and Ertzgaard 2000; Örn 2001). Using Viagra in these cases is presented as a solution to ED for patients with a legitimate need for the drug. I use the word *legitimate* because it is in these cases that the Swedish courts have heard arguments for and against the subsidized use of Viagra as a treatment for severe ED (see Chapter 2).

Sexual problems and pharmaceuticals

From their studies of US cases, sociologists Mamo and Fishman note that prescribing drugs like Viagra can, in some cases, lead to and justify polypharmica (Mamo and Fishman 2001, 27). *Läkartidningen* takes up the occurrence of polypharmica as well. Three years before the introduction of Viagra, the discussion of sexual difficulties and pharmaceuticals was raised in *Läkartidningen* in an article called 'Sex life and pharmaceuticals' (Lundberg 1995). In it, Lundberg discusses both how pharmaceuticals have been developed to treat sexual problems, and how pharmaceuticals taken for other reasons can influence one's sex life. Thus, by 1995, pharmacological sources of, and solutions to, sexual problems were gaining acceptance within the Swedish medical community. But it also shows that the understanding of the concept of sexual problems was very broad before Viagra. In this article, a great deal of time is spent discussing the influence of other drugs (i.e. dopamine and serotonin blockers) on desire rather than on the mechanical ability to have sex, for both men and women. Most interesting, however, is the way sex is defined more widely than it often is in post-Viagra discussions. For example, sex is presented as involving not just intercourse but also orgasms, even for women. And after noting that serotonin blockers can make orgasm difficult for women, the author states, 'There are, however, few reports of orgasm difficulties in men using this type of antidepressant. We do not know if there is a sex-specific difference or if the problem is hidden in men because of the difficulties in differentiating between ejaculation and orgasm' (Lundberg 1995, 2745). The idea that men could experience ejaculation without orgasm is completely absent from any later discussions of Viagra, as is the possibility of having an erection without ejaculation. But in the 1995 article, a nuanced way of discussing pharmaceuticals and sexual health is presented, one that involves desire, ability and pleasure. Much of this nuance is lost with the arrival of Viagra, and discussions about libido and desire also tend to disappear in the literature about ED, in *Läkartidningen* and other medical journals, despite the fact that the makers of Viagra insist that it will not produce an erection without sexual stimulation. But, as many social scientists and critics have

noted about Viagra in general, it relies on the traditional understanding of male sexuality, that men *always* want sex (see Fishman and Mamo 2001, 183; Mamo and Fishman 2001, 23; Marshall 2002, 2006; Loe 2004b; Tiefer 2006).

Returning to the discourse in *Läkartidningen*, libido appears only in connection with impotence post-Viagra in two articles. One is the 2004 column 'Pharmaceutical questions' (Kimland and Ståhle 2004), which is a brief compilation of topics discussed at regional pharmaceutical information centres. There, in 2004, the terms *libido* and *impotence* appear together when reporting a study that examined these in connection with the use of lithium (as the 1995 Lundberg article did when talking about sexual problems and pharmaceuticals). The other is a 2008 article that discusses the benefits of off-label use of Sildenafil for women suffering from sexual dysfunction as a result of antidepressants (Bodlund 2008). But these two articles can be read as special cases dealing with the effects of psycho-pharmaceuticals rather than the use of Viagra for a wider population.

Pharmaceuticals and erectile dysfunction

Pharmaceutical solutions for impotence existed prior to Viagra's arrival in 1998, although most of these involved needles or pellets inserted directly into the penis and were therefore not as easy to administer as a pill. However, in a *Läkartidningen* article from 1997 (Hedelin and Abramsson), the use of orally ingested medicines for erectile dysfunction is discussed and their pending introduction to the market predicted. In this article, the term *erectile dysfunction*,[6] rather than *impotence*, is first used in *Läkartidningen*.[7] With this term, the discussion is shifted to the mechanical aspects of blood flow, vascular systems and muscle cells. Men have 'erectile difficulties' and these can be treated. The authors start the article with the statement, 'The ability for a man to have an erection that facilitates intercourse and insemination is a prerequisite for the continuation of the human race' (Hedelin and Abramsson 1997, 2548), and then go on to discuss various possibilities for treatment to be subsidized by the Swedish state, a discussion that later takes on enormous proportions in *Läkartidningen* (Hedelin 1998; Sjöstrand 1998; Beerman 2000; Byström 2000a, 2000b; Landtblom and Ertzgaard 2000; Landtblom 2004; Ströberg *et al.* 2006).

In 1998, Viagra appears in *Läkartidningen*, with articles about the drug itself and about the way it is being received in the United States (Bergström 1998; Branke 1998), its introduction to Sweden, specifics of its use, questions of its costs to the individual and society (Hedelin 1998) and warnings that it is being sold illegally through the mail (Aldstedt 1998). It is at this point that impotence, which in the 1990 and 1995 articles was broadly defined, often with social causes, and which occurred in many different types of patients, including couples, is now directly equated with ED. In the introduction to his 1998 article 'New treatment for impotence', aforementioned urologist Hans Hedelin articulates this discursive coupling: 'Erectile dysfunction (impotence), that is the inability to achieve and maintain an erection for a sufficiently long period for sexual activity, is the most common form of sexual functioning problems' (Hedelin 1998, 4558).

To better contextualize his use of the term *erectile dysfunction*, it is important to note that the discursive sliding between, and in some cases conflation of, impotence and ED has a history outside of the Swedish context, largely in the field of urology and closely connected to the development of pharmaceutical therapies. Social scientist Barbara Marshall, in her work on Viagra, relays the story of how Dr Giles Brindley in 1983, in front of an audience of medical peers, injected his penis with phenoxybenzamine and obtained an erection, essentially removing the connection between emotional or tactile stimulation and erection. Ten years later, in 1993, the US National Institute of Health created consensus around the use of the term *erectile dysfunction* (Marshall 2002, 136). In Sweden, in the 1998 Hedelin article, erectile dysfunction becomes equated with impotence in *Läkartidningen*.

Susan Bordo claims that impotence as a term reflects a characteristic of the person, not a disease – one says of a man, 'he is impotent' while one would not say 'he is a headache' (Bordo 1998, 87). And, as Loe (2004a) has noted, the shift in English from impotence to ED can be quite comfortable for the individual. ED allows the man to maintain his identity and self untainted, and treat only the penis. Potts notes this as well: 'This term [impotence] infers that a man loses power through his "failure" to achieve an erection, and demonstrates how important a notion of "potency" is in constructions of conventional masculine sexuality. Consequently, an inability to produce erections may be perceived as tantamount to a destruction of the male self' (Potts 2004, 23). With the introduction of ED and Viagra, a medical term and a pill exist that can prevent damage to the individual and erase blame for the failure to produce an erection on demand. These comments on terminology are also applicable to the Swedish usages of *impotence* and *erectile dysfunction*.

Another interesting observation in connection with the use of the term *erectile dysfunction* is that, in the 1998 *Läkartidningen* article, Hedelin asserts that ED is 'the most common form of sexual function problems' around the world. This statement was very common in 1998, internationally. That ED became the most common form of sexual function problem just when a medicine to cure it was introduced has been discussed elsewhere in relation to medicalization, biomedicalization and pharmaceuticalization (Mamo and Fishman 2001, 16; Elliott 2003; Loe 2004a; Moynihan and Cassels 2005; Williams *et al.* 2011a). In *Läkartidningen*, articles after 1998 spend a great deal of time talking about the physiology of erections and their molecular and biological aspects, and very little, if any time discussing counselling, couples therapy and the social or relationship issues related to impotence.

Perhaps most indicative of the direction articles about impotence and ED in *Läkartidningen* took after the introduction of Viagra is the 2000 article 'Viagra is the first option for treating erectile dysfunction,' co-authored by urologist Hans Hedelin (who defined erectile dysfunction as impotence) and Pfizer employee Lena Jacobsson. In this article they discuss a study which compared treatments for ED in Sweden. Gone from this study are all questions about the emotional or social aspects of impotence, or even the fact that sexual problems can take other forms than ED. Instead the study only focuses on how ED can be treated pharmacologically. The authors start their article by stating, 'In the last few years different methods to successfully treat erectile dysfunction (ED) have appeared,

methods which work largely unrelated to the cause of the erectile problems and which demand a minimum of evaluation before the treatment can be initiated' (Hedelin and Jacobsson 2000, 2616). Thus, the treatment for ED (which impotence had become) is suddenly a relatively simple procedure, rather than one which, as suggested in a 1995 article, demands an empathetic doctor who can give hope and understanding, and who can spend sufficient time with the patient to discuss his/their problems, often over a period of several consultations (Olsson *et al*. 1995, 313). Likewise, in articles appearing prior to Viagra, references to alternative treatments like self-injections to the penis and the use of penis pumps and surgical implants appear, often as later-stage complements to couples therapy (see Olsson *et al.* 1995). This is particularly true with the penis implant, which is discussed with the warning:

> Those patients who expect that an implant will not only create erections but also improve their relationship with their partner and bring them closer to a harmonic life are often disappointed.
>
> (Olsson *et al.* 1995, 316)

However, this is exactly what Viagra promises, as noted in a 1998 *Läkartidningen* article, which argues for subsidies for Viagra because its use cures two patients, not just one, that is also the partner of the man suffering from ED (Sjöstrand 1998). Potts and colleagues (2006) have shown how this idea is also prevalent in English-language commercials for Viagra, and the partner in the Swedish commercial discourse is discussed in Chapter 6.

The shift in the use of the term *impotence* to *erectile dysfunction* occurs in *Läkartidningen* and the post-Viagra articles written largely by urologists, and is not unique to the Swedish discourse. It is in line with what has occurred in other journals and media outlets internationally. As Tiefer notes in her critique of the English-language use of the term, 'erectile dysfunction, a condition in the man's genitalia, has become the only acknowledged focus of interest, focus of evaluation, and focus of treatment. This represents a substantial narrowing from sex therapy – erasing the partner, erasing subjective meaning, and, ironically, perpetuating the obsession with penile hardness, which many sex therapists have argued is itself a primary cause of sexual unhappiness' (Tiefer 2000, 278).

Examples of the same refocusing of the discourse in Sweden can be seen in *Läkartidningen*. Prior to Viagra, mention is made of another closely related sexual problem: premature ejaculation (Olsson *et al.* 1990). But after Viagra, this problem is not discussed again in connection with sexual difficulties until 2006, when a notice about a new drug treatment is presented (Hansen 2006) which mentions that 20–30% of men suffer from premature ejaculation. (Compare with the pre-Viagra book review that states an estimated 10% of men suffer from impotence (Mellgren 1993).) This seems to confirm Marshall's assertion, drawn from her analysis of English-language articles about Viagra, that 'even though premature ejaculation (an "orgasmic disorder") has higher prevalence rates than "erectile dysfunction" in many studies, we do not hear of an "epidemic" of premature ejaculation' (Marshall 2002, 137). Viagra has shifted the focus onto ED, and redirected

attention away from other sexual difficulties, including early ejaculation and a lack of libido, internationally and also in the Swedish medical discourse.

The impotent man, the partner patient and a woman's responsibility

Before Viagra, in several of the *Läkartidningen* articles about impotence, the patient is presented as the partner unit. For example, in an article from 1995, the roles of each partner in dealing with impotence are narrowly defined. 'Conversation with the couple is the most important diagnostic and therapeutic instrument. One should strive to work with the couple rather than the man alone, though one should never try to force the partner's cooperation. Men and women have different ways of expressing themselves and therefore misunderstandings can easily arise. Women must learn to be clearer and men to be more receptive' (Olsson *et al.* 1995, 313). In addition to charging each partner with a specific way of communicating and the responsibility to change this, the article notes: 'The best help for a man with disappointing erections is, besides his own courage to speak about it, an understanding and sensual partner who is sexually keen but not demanding' (Olsson *et al.* 1995, 314). Although, as the authors go on to say, 'of course, this isn't always enough' (Olsson *et al.* 1995, 314).

The couple-patient is also present when talking about other sexual problems pre-Viagra, as here, when discussing early ejaculation: 'Naturally, the sexual act can easily be a failure in these situations unless the female partner is wise and possibly experienced, and can focus primary attention on physical contact and intimacy, and reduce the importance of genital contact' (Olsson *et al*. 1990, 4456). The woman is charged with responsibility for ensuring that the sexual act is a success, despite the man's sexual problems. This is slightly different than when speaking about impotence as a partner issue or presenting the impotent patient as a partner constellation. Instead, the solution to the sexual problem is in the hands of the female partner. This same shift of responsibility for curing the patient occurs in the discussion about (male) libido. When expanding on the difference between desire and libido, and their relationship to impotence, the authors state that, 'Naturally, even here the female partner's behaviour is very important' (Olsson *et al*. 1990, 4456). Also of note is the distinct sense that impotence occurs only in heterosexual relations. And, as the earlier discussion about men and women's communication issues implies, not only is the patient a heterosexual couple, it is a couple with very stereotypical, gender-specific interaction patterns.

In 1998, after the introduction of Viagra, the definition of the patient with ED shifts from the couple to the man in *Läkartidningen*. The only articles which suggest the presence of a female Viagra patient is the aforementioned 1998 article which argues that the debate about whether to subsidize Viagra should take into consideration that the pill helps two patients, not one (Sjöstrand 1998) and the 2008 article about using Viagra for women on antidepressants (Bodlund 2008).[8] Other than these, however, the post-Viagra ED patient is primarily the man prescribed the pills, and often only the genitals of that man.

The assumption of heterosexual patients in the Swedish case is not unique and mirrors a wider heteronormativity in the English-language discussions about Viagra and impotence, this despite the widespread use of Viagra within homosexual communities, and despite the use of the gender-neutral term *partner* in Pfizer advertising (see Chapter 6). For further discussion, see McLaren (2007) and Vares and Braun (2006).

Reopening the debate

Not until 2006 does the partner-patient unit of ED appear again in the post-Viagra *Läkartidningen*. In this year the partner becomes one of the people who should be asked about evaluation of the treatment and one of the reasons patients chose to discontinue treatment (Ströberg *et al.* 2006, 1107). While the integration of the partner in the discourse can be related to his/her presence in the pre-Viagra articles, this is a somewhat new role for the partner. Rather than being part of the cure, as in the articles from the early 1990s, now the partner is part of the wider context that influences a patient's decision to follow a medical cure. It is also in this 2006 article that the social factors behind ED are finally reintroduced to the discourse, after having been absent for eight years. In the discussion about the discontinuation of pharmaceutical treatments for ED, the results of the Pfizer-funded study showed that more than half of the patients prescribed Sildenafil stopped using it within two years. To explain this, the authors report that 'Often the reasons are multi-factoral and factors like increasing age, diminished libido, relationship problems, health problems, social and cultural background all together can influence the decision to stop treatment' (Ströberg *et al.* 2006, 2866). Issues concerning the physiology of ED were not the only, or even primary, answers they received from patients. This article in *Läkartidningen* shows that when a study is conducted which actually asks Viagra patients about their experiences and the reasons for their use or disuse of the drug, a disjuncture of the drug's patients and their medically prescribed sexual identities and practices begins to (re)appear.

That international medical research about the use of pharmaceutical treatments for ED is focused on biological, mechanical or molecular aspects of erections has been noted. As Tiefer wrote in 2000, 'There's little attention to the person or couple attached to the penis, or recognition that relational factors might modify the meaning or importance of penile rigidity or sexual intercourse in a couple's sexual script. It would appear that industry-sponsored research wishes simply to wave away the complexities introduced by the psychosocial context of sexuality' (Tiefer 2000, 278). As an example of pharmaceuticalization, the case of Viagra in Sweden before the 2006 study complicates the medicalization hypothesis that general medicine is trying to constantly expand the domain over which it reigns. The examples of medical intervention for impotence in the pre-Viagra articles in *Läkartidningen* suggest that doctors were willing to intervene in the biomedical and social aspects of their patients' sexuality, but that after Viagra's appearance, medical intervention is narrowed to the biomechanical functions of a man's penis. This narrowing runs counter to some expected processes of medicalization, but

shows how pharmaceuticalization tries to confine the condition of impotence to one disease (ED) with a universal, pharmaceutical treatment.

This tendency makes the Pfizer-funded Ströberg, Hedelin and Bergström (2006) study in *Läkartidningen* even more noteworthy, as it perhaps suggests that Viagra has not successfully reduced impotence to ED. Their article reopens the discussion of factors that can influence sexual health and simultaneously remedicalizes the larger context of patients' sexual health. One could have hoped that this signalled a return to a more nuanced discussion of sexual problems and their treatments within *Läkartidningen* and that acknowledging that there may be diverse reasons for patients to discontinue treatment with Viagra and similar medications may lead the medical discourse to include aspects from the early 1990s, that is recognition that there are different types of patients who have different reasons for and understandings of their impotence, along with the existence of a pill. By comparison, it is relatively uncomplicated to assert that women's sexualities are complex and context dependent, and that they are influenced by feelings and emotions, even with older women (see, for example, Loe's (2004b) study). One could have hoped that the 2006 article in *Läkartidningen* was a sign that soon Swedish men, too, would be granted the right to (once again) own a complicated and context-dependent sexuality influenced by feelings, emotions and social situations, not just kicked into action with a drug. But in the years that followed, little seemed to change. Viagra continued to be discussed in articles about subsidies and in relation to other medical conditions, like cardiovascular and prostate problems. Thus, in the Swedish medical discourse, the local structures doctors and health care providers worked in combined with Viagra's global traits to create a glocal Viagra in *Läkartidningen*, one which presented and maintained a pharmaceutical solution to erectile dysfunction.

Notes

1 An earlier version of this chapter has been published as Johnson, E. (2008). Chemistries of Love: Impotence, Erectile Dysfunction and Viagra in *Läkartidningen*, *NORMA, 3* (1), 31–47.
2 *Läkartidningen* is the trade journal of the Swedish Medical Association (*Läkarförbund*). It is published about once a week and covers international and Swedish developments in medicine and medical care.
3 In Swedish: *Impotens, impotensmedel, peniserektion, erektil dysfunktion, erektil svårigheter, potensmedel, Viagra, Sildenafil*.
4 All translations are the author's.
5 www.viagra.se (October 2015).
6 Much later, in 2005, an interesting shift is made when erectile dysfunction, which had been a side effect of some diseases, also becomes a symptom. *Läkartidningen* reported that erectile dysfunction may be a symptom of undiagnosed heart disease and encouraged doctors who have a patient with ED to find out if that patient actually has heart disease (Gunnarsdottar 2005).
7 Masters and Johnson used the term *erectile dysfunction* in the 1950s (McLaren 2007, 221). However, it was generally not taken up by the medical community until adopted by urologists and popularized by Pfizer (see Marshall 2002; Loe 2004a).
8 See Loe (2004b) for an analysis of senior women in the United States and the drug.