Enrolling Men, their Doctors, and Partners: Individual and Collective Responses to Erectile Dysfunction

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Using the Pfizer funded Swedish informational site about erectile dysfunction (ED), www.potenslinjen.se, we examine how potential users, their partners, and medical doctors are enrolled in the process of creating the Swedish Viagra user. Contextualized against other critical work on Viagra, our analysis shows how the commercial discourse embeds the ED patient into a network of actors. Three separate actors are co-constituted and enrolled by this erectile dysfunction information discourse, comprising Viagra marketing material in a country which forbids direct to consumer advertising of prescription medication. Doctors are enrolled to produce the cultural authority of expert medical knowledge, whereas partners are given responsibility for the emotional aspects of a man's sexuality and encouraged to direct the man toward the relationship-saving Viagra. Throughout, though, the man is the patient responsible for taking Viagra to fix his dysfunctioning penis. We problematize this individualised solution by contrasting it with the social aspects of the discourse and examining other qualitative and historical studies of impotence. We then ask if the enrolment presented by the Swedish Viagra website could be (mis)used to expand the circle of actors involved in ED, redefining the 'problem' and opening for a wider variety of treatments.

Keywords: Viagra, enrolment, Erectile Dysfunction

Introduction

This article examines how men, their doctors, and partners are enrolled by the Pfizer sponsored web site for potential Swedish Viagra customers. The Swedish language site www.potenslinjen.se[1] (in English, 'potency hot-line') is framed as a source of information for lay people concerned about erectile dysfunction.[2] We have examined how the site's text and imagery address different audiences in the construction of the Swedish Viagra man. Our analysis builds upon existing literature about the promotion of Viagra which addresses the construction of erectile dysfunction (ED) and masculinity in other national contexts, and we therefore make mention of alternative images and readings in other contexts throughout our analysis. Like previous critical studies of Viagra (Fishman & Mamo, 2001; Marshall, 2006; Tiefer, 2006; Vares & Braun, 2006), we are examining the construction of an ideal user of Viagra, but we also discuss the

way the enrolment of doctors and partners serves to position ED in the man and define its treatment as a solitary act of taking a pill while simultaneously involving the other actors to help the medicine function. Our contribution delineates the specific roles the various subjects are granted, in particular by looking at the invisible work the "passive" female partner is tasked with as she is told to actively guide and support her partner in the Viagra trajectory. To do this, we use the Actor Network Theory (ANT) concept of enrolment, which articulates the roles given to various actants as they are enrolled into a network that discursively constructs ED as an illness and Viagra as a cure.

Our research can be read against the framework of regulations regarding direct to consumer (DTC) marketing of pharmaceuticals. The legality of DTC advertising of prescription pharmaceuticals in the USA and New Zealand has spawned much of the critical research about Viagra and its role in the media climate (see Elliot, 2003; Loe, 2004b; Mamo & Fishman, 2001; Moynihan & Cassels, 2005, Potts & Tiefer, 2006). Our study, looking at Viagra in the Swedish context which bans DTC advertising for prescription drugs, confirms the results of much of this work but contributes an important insight to the strength and flexibility of Viagra marketing in a globalized pharmaceutical market. There is a good deal of harmonization between the Swedish site and other Viagra sites, yet also local adaptation (see Åsberg & Johnson, 2009). And as we show here, the local adaptation of Viagra marketing that is not considered DTC advertising relies on the construction of subjectivities for the man, his doctor, and his partner. The Swedish site is "purely informational" about erectile dysfunction (though it is obviously advertising Viagra) and therefore has information explaining what sex therapy can offer men suffering from impotence in addition to pharmaceutical solutions to ED, and lists the telephone number to a sexual medicine centre at a large hospital in Stockholm that receives undirected funds from Pfizer. Yet, despite the DTC ban, Viagra figures largely on the website and has figured largely in the 'collective psyche' in Sweden both as a subject of newspaper articles (some reading as if they have been taken directly from drug company PR sheets) and of public debate, thanks in large part to the drawn out discussions and court cases about whether or not Viagra would be subsidized by the Swedish health care system (Johnson, 2008; Sjögren & Johnson, 2012). Likewise, Viagra is available in Sweden, but falls outside of the state subsidized pharmaceutical scheme, which means patients must pay for the drug themselves, creating challenges for marketing the drug. We argue that this challenge has been met in part by enrolling the man, his doctors and partner in the ways we detail below.

In our final discussion, we ask what this enrolment says about social, rather than individual, aspects of ED, drawing inspiration from early medical sociology work on community responses to mental health (Eaton & Weil, 1955) and recent qualitative studies of men's responses to ED (Oliffe, 2005; 2006). By exploring alternative narratives of illness, we suggest that an alternative reading of erectile dysfunction and its subjects could be told.

Below, we delineate the interdisciplinary conjunctions that shape our approach and provide an overview of previous critical Viagra studies[3] before detailing the enrolled subjects we have identified in our material.

Background

Science and Technology Studies use the term enrolment within ANT to denote how human and non-human agents are called upon and woven into complicated networks

(Latour, 1993; 1998). Though it has been rightly criticised for implying a heroic, entrepreneurial actor in the process of enrolment (Star, 1991), the concept is useful for our study because it articulates the sense that there are actors with specific interests (here, the pharmaceutical company Pfizer and its marketing experts) who use specific methods (those described in this article are discursive strategies) to involve heterogeneous constellations of human and non-human actants in the construction of a Swedish Viagra man. We will be using the concept of enrolment to examine how a specific web of actants – potential users, medical doctors, and their partners – are woven together by a discrete discourse to construct an identity and agenda for the Swedish Viagra man.

In Sweden, Viagra has been available by prescription since its approval in 1998, but, like the similar drugs Cialis and Levitra, it is not covered by the national subsidy programme for medicines. Thus, men are able to get a prescription for the drug, but they must pay for it out of their own pockets, which is unusual for the Swedish consumer. Produced and sold by the pharmaceutical company Pfizer, Viagra works physically in some men and in some situations by blocking the return of blood flowing out of the penis. Thus, if a man becomes aroused and blood flow to the penis increases, Viagra will help keep it there and produce an erection.

Discursively, however, Viagra does many other things. Viagra has, for example, changed our language about impotence (in both English and Swedish). The marketing around Viagra has helped to introduce the term ED (erectile dysfunction) to the general public, replacing the more negative term 'impotence' (Bordo, 1998: 90; Potts, 2004: 23). The term erectile dysfunction was used by Masters and Johnson in the 1950s (McLaren, 2007: 221). In psychiatric discourse, erectile dysfunction has been articulated as a problem of arousal since the 1970s, where ED is defined as a problem of attaining and maintaining an erection sufficient for intercourse (APA, 2000). Sexual response models within sex therapy have taken foremost physiology, but also behaviour (penetration) into account in defining healthy or non-healthy sex, which coloured the term impotence pejoratively, and later replaced it with the term erectile dysfunction. However, it was not generally taken up by the medical community until adopted by urologists and popularized by Pfizer (see Marshall & Katz, 2002; Loe, 2004b; Bordo, 1998; see Johnson, 2008 for the Swedish example). This rhetorical shift narrows the definition of what impotence is from a condition of the psyche, the emotions, or the relationship, to a biomedical complaint (Marshall & Katz, 2002; Tiefer, 2006; McLaren, 2007; Johnson, 2008). Pfizer marketing has also introduced the concept of EQ (erectile quality) to expand the market to include younger men (Fishman & Mamo, 2001: 181; Marshall, 2002: 139) playing on 'erectile insecurity' (Tiefer, 2006: 279). And, importantly, Viagra has been a phenomenon around which multiple different vested interests have gathered to sell it and construct the disease of ED, as Loe articulately shows in her examination of the US case (Loe, 2004b).

As has been noted widely, Viagra has reinforced the definition of sex as penetration, and masculinity as the ability to achieve penetration, relying on a reworked version of the notion Sigmund Freud previously had reserved for the female mind: the "anatomy is destiny" determinism of the naturalized body in the construction of the late modern male identity. The physicality of male embodiment boils down to the sexual (and not necessarily reproductive) performativity[4] of the visible sexual organ. Thus, within the Viagra discourse, as

Baglia's (2005) study of Pfizer promotional material in the USA has shown, sexual performance is defined by a narrow sexual function model starting with arousal and progressing through erection, penetration and ejaculation. As long as a man can perform this penetrative sex, his masculinity is intact. The idea that penetration produces (or at least proves) masculinity reinforces the importance of penetration for both the sex act itself and the concept of sex-life expectancy. As sociologist Barbara Marshall notes, this concept of sex-life expectancy, with its calls to vigilant self-monitoring of healthy practices and appropriate sexual behaviour, relies on the disciplined individual taking responsibility for managing the risks of lost masculinity (i.e. lost ability to penetrate) even before 'old age' (Marshall, 2006: 335). Viagra connects this individual responsibility to the medical and pharmaceutical networks within which Viagra is active, which also reinforces the scientism of sex and the naturalized body, attaching both to systems of expertise while simultaneously assigning responsibility for functionality to the man.

The Viagra discourse of sex relies on a three step paradigm of arousal, penetration, and ejaculation, and then demands Viagra as a solution to (age, stress or illness related) declining sexual performance (Plante, 2006: 380). According to this discourse, a person (or couple) can maintain a successful sex life as long penetration is possible, i.e. with the help of Viagra, an idea which ignores, and tends to silence, suggestions of alternative sexual practices and a sex life that is not dependent on penetration (Tiefer, 2006). In this narrative, emotions all but disappear. And where they do play a role, responsibility for them is given to the partner, as we will discuss below.

Materials and Methods

Despite the ban on direct to consumer adverting, there is a wide range of commercially produced informational material about Viagra available in Sweden: free pamphlets and booklets which can be ordered by men or their partners from Pfizer; literature for doctors and other medical professionals; press coverage in local and national newspapers; informational material on publicly funded web pages about men's health. We have, for this paper, focused on the website www.potenslinjen.se for a number of reasons: it is produced by Pfizer for a Swedish audience in the Swedish language; it is easily accessible to anyone with an Internet connection and does not require interfacing with a medical practitioner; it focuses on impotence and erectile dysfunction rather than men's health in general; it can be accessed by and addresses individuals not facing impotence personally, like partners and friends. Additionally, the web site is a good example of how Pfizer tweaks its material to localize a global message for its global product.

In analyzing the text and images on this site, we have been inspired by the critical studies of Viagra mentioned above as well as Foucault's idea of an economy of discourses about sexuality. We are looking at the material presented on the website as an example of an economy of discourses in an attempt to articulate "the necessities of their operation, the tactics they employ [and] the effects of power which underlie them and which they transmit" (Foucault, 1987 [1976]: 68f). We also draw inspiration from studies of scientific discourse and naturalized embodiment that feminist scholars have produced since the late 1970s on powerful ideological processes (cf. Merchant, 1980; Haraway, 1989; Butler, 1990; Martin, 1991; Fox Keller, 1992; McClintock, 1995; Bryld & Lykke, 2000; Franklin, Lury & Stacey,

2000; Braidotti, 2006). These researchers have used feminist critiques to investigate how science as a discourse and notions of the natural are used to support dominant ideologies.

Enrolling Participants in the Viagra Discourse

Examining the Swedish website it becomes apparent that three different groups of human participants are enrolled by Pfizer to assist in constructing a subject position for men as potential consumers of Viagra: the men themselves; medical doctors; and the men's partners. Throughout the discourse, the Viagra pill is also enrolled as a non-human actor, nearly given a hero's identity.

Enrolling Men

Men are enrolled through the information on the pages that constructs them as potential patients with ED. They are welcomed on the first page in what could be considered a respectful and tactful manner: "Potency problems can be a sensitive issue in spite of the fact that many men – and their partners – are affected"[5], they are told. The first picture attached to the welcome sentence, a photo of a tanned, grey-haired man in his fifties on his back with hands behind his head, smiling as he looks up into a blue sky that matches his blue t-shirt, suggests a relaxed, "laid-back", attitude. The blue colours of clothing and sky seem to allude to the iconic colour of Viagra and to Pfizer's logotype, and are a common feature of Viagra ads, as has been discussed by Loe (2004b) and Baglia (2005). In the image and text, the cultural stigma of ED is mitigated by such a respectful yet relaxed approach. Further, the mode of address to the large number of men and their partners who suffer from ED normalizes the prevalence of the problem and works to alleviate the concern the visitor to this site may be experiencing. Highlighted on the welcoming first page is also the accessibility of an easy and comforting solution to erectile problems, in the form of the drug.

Aside from the overwhelming discourse of disease associated with erectile difficulties (including mention of cardiovascular disease, which will be discussed below), one of the primary tools used to enrol the men is an interactive quiz in which they are asked to first rate their sexual health (by answering a series of five questions), then encouraged to talk to their doctor. Unlike much of the other text on this site, the quiz is a short version of the International Index of Erectile Function (IIEF), and is directly translated from the US Viagra site[6]. As Marshall has discussed, this process of inviting quizzes, generous medical advice, and sexual education effectively creates an ostensibly benevolent regime of self-surveillance on the website for the individual through assisted self-monitoring and remedial action (Marshall, 2006: 356; see also Mamo & Fishman, 2001; Baglia, 2005). Such a mode of address, and ways of enticing and enrolling potential consumers of Viagra, can be read as part of a larger discourse, a sexual regimen of the individual. This sexual self-governance and monitoring, to borrow ideas from Foucault, is centred on male penetration at the Viagra website. Given the flourishing market for self-health guides, books, and websites, etc., this mode of address is hardly surprising. This website merges the commercial aims of a product-selling site with sexual education and health advice in a manner characteristic of the rather recent new media genre of "edutainment" where entertaining features such as quizzes and educational imagery blend for accessible, online display (Åsberg, 2005). Health matters are, in such genres, firmly placed within the world of consumerism, as detailed in Stacey's description of self-help literature in her cultural study of cancer (Stacey, 1997). The

Viagra consumer is enrolled into a mode of being sustained by the ideal of the self-caring subject position of a health consumer. In line with Stacey's work on health consumerism, this also resonates with what Rose and Novas termed 'biological citizenship' (Rose & Novas, 2004: 14). The biological citizen invests heavily in self-education on health matters and develops the medical literacy needed to pursue a high-quality, self-sufficient, personally and socially 'responsible' lifestyle (Rose & Novas, 2004: 14). Through the quiz on sexual health, the self-surveillance discourse redefines sexual health in a very specific, determinist way: sexual health for men is the achievement and maintenance of an erection and ability to complete intercourse. Their anatomy (particularly the functioning of certain parts of their anatomy) becomes their destiny.

The website does not only encourage self-surveillance and individual responsibility, it also provides the tools for individuals to take on the task of monitoring and disciplining their erections:

> If you are being treated with potency medicine from Pfizer, you can receive support and encouragement for your treatment through the web.[7]

> Do you lack the time, desire or opportunity to pick up your medicine from the drugstore? Now you can have your impotence medicine delivered to your home by mail.

Similarly, in a special section called the Potency Coach, illustrated by an animated cartoon figure with a megaphone:

> The Potency Coach is an easy to use, interactive patient support that will help you achieve the expected and pre-determined results with your treatment. Here you can also find information about the underlying causes of potency problems and about other patients' experiences.

Working within a benevolent discursive frame to help him help himself, the website also reveals the implicit assumption of a shy Swedish man of few words inferred by such a mode of address. The targeted subject is one who does not easily confide in his physician, especially not regarding sexually related matters, and must be reassured and coaxed to bring up the topic during a health care visit:

> Unfortunately, it is common that men hesitate before seeking help. This is a shame, since the vast majority of those who seek help can be successfully treated for their problems.

Perhaps surprisingly, it is not a sexually liberated or out-spoken subject that is addressed, but someone rather inhibited when it comes to articulating sexual problems. From this arises a Swedish man who is non-articulate with respect to his own malleable body and sexual health, a man who might need encouragement when asking for a Viagra prescription at the doctor's office since doing so could be interpreted as a defeat in the masculinized struggle to control the body. Importantly, this can be read as a remarkable hands-on approach of Pfizer in facilitating the individual and his care of the self.

Enrolling Doctors

Medical doctors are also enrolled through Pfizer efforts on the Swedish www.potenslinjen.se website (beyond the infamous drug rep sales techniques (see Reidy, 2005)). Part way down on the very first page, an anatomical sketch of a heart accompanies a text that reads "Potency problems – an important warning sign" and delineates how potency problems might

be the first "useful" sign of cardio-vascular diseases. It becomes clear that Viagra is not merely a matter of fleshy pleasures and an improved sex life, but that it relates to serious health issues and even has a function as a first warning sign. Such medical appeals to cardiovascular health issues as linked to ED both play to the scientism of the naturalized body and work to medically legitimize Viagra. Swedish men seeking medical attention for ED are addressed as upstanding citizens taking responsibility for their personal overall-health, and doctors are encouraged to help them with that. This use of medical complaints other than ED to legitimate Viagra can be read against the efforts in Sweden to associate Viagra with specific diseases rather than lifestyle choices as part of the debate over state subsidies (Sjögren & Johnson, 2012).

The medical dimension of Viagra is further enhanced with a figure of authority that confirms both the relaxed personal tone and the urgency of the matter, namely a headshot of a physician in scrubs with a hint of a smile on the first page. The photo of the doctor creates a close proximity between medical authority and the potential Viagra consumer in another sense: the ambivalence of the picture in this setting suggests that even a medical doctor can have a use for Viagra. Most importantly, however, this small photo, emitting medical confidence and trust-worthiness, serves a particular function within the website: to illustrate a search engine for finding a local, Viagra-friendly doctor. In addition to encouraging doctors to be 'pro-active' in asking their patients about sexual function during routine exams and when taking medical histories[8], Pfizer has included a national database of 'ED aware' doctors, or 'affiliated experts' as Loe (2004b) calls them, which lets visitors to the website submit a query and generates a list of doctors near them who can be consulted for information about erectile dysfunction (and, presumably, for prescriptions of Viagra).

The same type of database can be found on other national Viagra sites, also paired with suggested phrases that men can use when speaking to their doctors, addressing the fact that some men may find it difficult to bring up the subject of sexual dysfunction during an exam. On the Swedish site, men are told, "When you meet your doctor, she or he will probably interview you and ask you questions about previous illnesses and if you are currently taking any medications. Try to provide as accurate information as possible, including if you still have early morning erections or if your erectile ability has disappeared suddenly or gradually. It may feel difficult to speak about these issues, but it is completely OK to be embarrassed. Remember that doctors are used to speaking about these things and their job is to help you." In this way the men and doctors are also *positioned to enrol each other* and maintain each others' investment in the Viagra-discourse. We suggest that this part of the Viagra website seems to connect biological citizenship with medical literacy and affiliated experts, to thus secure the commercial success of the drug.

Enrolling Partners

On the Swedish site partners are also enrolled in the process of positioning men as subjects for whom Viagra is the solution to a waning sex life and/or issues of sexual dysfunction. Potency issues are continuously addressed as a joint problem, for the female partner as well as for the man. In a special section of the Swedish web pages, partners are told about the ways ED can affect a relationship, above all by letting coldness, distance and worry creep in and replace the sensitivity, nearness and trust that had been in the relationship before. On the connecting pages, partners are encouraged to be supportive of their

partner, and then to let their partner know that there are treatments available for the problem:

> Today there are many different treatment methods. There are medicines that are prescribed in connection with a doctor's visit. Apart from medical treatment, sometimes sexual therapy can be the most appropriate approach. It is good for you as a relative to know about this and to be able to support and encourage your partner to seek help.

The partners are also encouraged to order the free brochure, "A man's best support is by his side", published by Pfizer with a smiling, heterosexual couple on its front page. The way partners are enrolled to support the men experiencing ED plays strongly on the assumption that the partner is steadfastly (unreflectively?) consenting to reproduce certain practices and maintain a supportive position within a relationship with the man (cf. Potts et. al., 2003). There is also information about how ED makes a man feel and what sorts of 'normal' behaviour it can evoke in one's partner. "Many [men with ED] distance themselves from their partners simply to avoid conflict and to avoid situations which can lead to sex. Many develop a new hobby, immerse themselves in their work, or make sure they don't go to bed at the same time as their partner in the evening. Many consciously or subconsciously even create conflicts to avoid being close to their partner." As implied by this quote, sexual intercourse seems to be an active achievement, where 'success' needs to be granted. Moreover, the female partner has a supportive rather than a leading role in this sexual achievement which combines the traditional, passive recipient of penetration (waiting in the bed for her partner with the new hobby) with an active subject tasked with leading and directing the men to Viagra and/or sexual therapy. She can guide him on his way, yet he is the doer behind the deed. This reverberates with the traditional assumption about heterosexual femininity as sexual passivity and masculinity as sexual activity, but more importantly it also points to the enormous effort by the woman that in reality lies behind achieving the "passivity" which can confirm his active and valuable status as a heterosexual male. There are many subtle manoeuvres, enticing practices and persuasive, yet-necessarily non-direct rhetorical moves a woman must master in order to achieve the right amount of sex-inspiring passivity. There is a lot of hard work behind her 'passive' affirmation of his masculinity.

A specific section of the Swedish website is dedicated to the prescriptive discursive patterns available to the partner. As the main heading on the partners' page suggests, she should ask herself how "Can I help?" to receive the answer, "Speak to and encourage":

> It is best to speak openly with your partner; support each other.

In this section of the Swedish web page one finds a discussion about how ED and the normal behaviour it evokes in men can make the partner feel. These partner-responses build on feelings of guilt and inadequacy. However, the partners are encouraged to persevere and help their men seek help because "When one has received help and solved the problem, many discover that their relationship has in fact become stronger." Again, the partner's discursive work is one of maintaining a seemingly effortless and natural attitude that avoids putting pressure on her partner and is achieved by another rhetorical strategy here provided by the Viagra site text, namely the 'we'. She can address her sexual needs and

his sexual problems if they are addressed as a 'we' issue, enrolling a sexual dyad, a figure of heterosexual complementarity.

Within the Swedish context, it is worth noting that pre-Viagra (prior to 1998) medical advice about impotence underlined how important it was for doctors to warn their patients that merely solving a man's ability to produce an erection would not necessarily solve relationship problems (Olsson et al., 1995), something the Pfizer information seems to be belying. Internationally, this assertion can be read in light of a Japanese study where a survey on the level of satisfaction derived from using Viagra indicated that while the male patient was extremely satisfied, his partner was not satisfied at all. Women reported their husband's erections as troublesome, that they had to use supplements to increase vaginal lubrication and in some cases even take hormones (Nagao, 2000 in Castro-Vázquez, 2006: 123). Loe (2004a) and Potts et al. (2003) also provide examples of women's responses to and concerns about Viagra use in the US, demonstrating a wide diversity in opinions and practices. Additional studies on Swedish women's accounts of Viagra would here be needed, but looking at the website it is clear that the female partner, since heterosexuality becomes further implied in the illustrative photos of both older and younger heterosexual couples that frame the text, is enrolled as responsible for the man's health and for their relationship; she can help him help himself to become the Viagra-empowered, potent man. At the website, her task becomes one of ensuring that penetrative intercourse can occur, since sexual intercourse is what consolidates the relationship and makes it strong. Through the figure of the sympathetic partner conjured up on the website, the responsibility not only for the general health and well-being of the man but also for the emotional health of the couple is presented as a feminized task.

It is here, in the partner section, that emotions and feelings are mentioned on the website with the references to coldness, distance, worry, sensitivity, nearness, trust, guilt and encouragement. Physiologically, Viagra only works if a man is sexually aroused in the first place, so partners are encouraged to help achieve Viagra's success by ensuring the necessary feelings are in place. Thus responsibility for the emotional aspects of sex, not just the relationship, is also effectively given to the partner. Partners are reminded that ED is "the man's symptom, the couple's shared problem" so the partner is directed to "speak to and encourage" the man. She is the one that in practice can confirm his potency. Her assignment within the Viagra discourse is to manage this talk as she takes the emotional responsibility for discussing and reflecting over the role of sex for their relationship. Here, too, emotions come into the discourse but so do the co-constitutive agencies of medical expertise, female partners, and Viagra as embodied, chemical effect as well as an expectation on virile manhood giving shape to the ideal Viagra-man. Partners are encouraged to learn about ED because, "with knowledge in hand, you will find it easier to speak with your partner. Together you can discuss your feelings and thoughts, and give each other support, and in the end, solve your relationship problems."

We suggest that this assignment of emotions and responsibility for the relationship's well being to the female partner enables her to legitimately address the problem of ED as a shared issue. Within the discourse on the Viagra pages, the tool she is often given to solve the problem is the little blue pill, but because of the particularly Swedish, legally dictated, 'informational' role of the website, the partner is also provided with information about alternative

treatments like sexual therapy (even if this information is sparse and even as the site is branded in a very Viagra-blue). But as we will discuss below, enrolling the partner in the ED discourse this way could also open for alternative solutions and alternative definitions of the problem.

Discussion

In our analysis, we have identified three enrolled participants who are addressed by the website to help create a subject position for the consuming Viagra man. The first of these is the male patient, for whom anatomy becomes his destiny, but who can consume Viagra to control that destiny and discipline it in line with youthful expectations. The second is the doctor, enrolled both to help ensure the male patient is able to access Viagra and used to represent scientism, which legitimates the use of Viagra by associating it with networks of scientific expertise. And thirdly, the partner of the patient is also enrolled in the process of creating a subject position for the Viagra consuming man. Responsibility for his emotions is given to his partner, who simultaneously consents to supporting a pharmaceutical solution for the man and the relationship.

The enrolment of these three participants in the commercial discourse creates a network of actors who can perform the desire for, distribution of, and context to contribute to successful use of a pharmaceutical as a solution to impotence. Their presence in the Viagra discourse is particularly striking when one considers that they all but disappeared from the medical discourse around Viagra when it was introduced in 1998. As Johnson (2008) has examined, the Swedish medical journal *Läkartidningen* supported a very heterogeneous definition of impotence and impotent patients in the early 1990s, one which recognized many different types of men with different reasons behind their impotence, and which encouraged the involvement of partners during treatment, enrolling the partner in much the same way as the Viagra web site does (Olsson et al., 1995: 313). This approach was not necessarily benign; the imagined partner was a woman in this (also) very heterosexual discourse, and she was ascribed a narrow position in the discourse: "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). Her ideal sexuality was also limited: unthreatening, dependent upon and receptive to her male partner's desires. "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). However, with the 1998 advent of Viagra, the medical discourse in *Läkartidningen* narrowed the definition of an impotent patient to the male penis and removed the varied social and sexual backgrounds, and actors, which had previously been present. Yet, in the commercial discourse, the partner and factors like stress and tiredness are present alongside Viagra.

Despite the stigma attached to impotence and the common assumption that men would not want to talk about ED (as the nudging encouragement provided by www.potenslinjen.se implies), qualitative research (primarily interview studies) on men who are dealing with erectile dysfunction shows that not all men deal with their ED problems alone and in silence. Many men are already enrolling medical professionals and partners in their quest for a solution (Grace et al., 2006; Oliffe, 2005; 2006). These men engage medical professionals to procure treatments for their impotence (Viagra and similar drugs,

but also injections and vacuum pump treatments) and some men enrol their partners in both treatment therapies and as discussion partners with whom they can talk about their difficulties and explore alternative sexual practices (Oliffe, 2005). As much current research within masculinities studies supports, men's experience of illness, especially a condition as related to masculinity as erectile dysfunction, is influenced by how the men and those around them, i.e. the network of actors enrolled in definition and solution work, think about and practice masculinity (cf. Marshal & Katz, 2002; Aucoin & Wessersug, 2006; Sandberg, 2011). These studies also suggest that some men who experience sexual dysfunction are already comfortable using a network of actors to help them both define their problem and seek treatment options.

We ask, then, how this practice and these enrolled actors (patients, doctors and partners) differ from the enrolment we have observed on the Swedish webpage. The obvious answer, of course, is that in the conversations detailed in Oliffe (2005) the partner-pair can explore non-pharmaceutical solutions. But we would like to suggest that the type of 'enrolment' that the men are displaying is also different in another way. Their enrolment is an activity which creates a community of people, all of whom can help to define the medical problem as medical *or not* and as a problem *or not*. And, importantly, it is also a community that seems to at least tacitly recognize that the solution, when there is one, is one that needs to be acted on and participated in by more than just the man. In particular, these interview studies would seem to highlight the partner's need to be active in defining the problem, and also the solution, as co-produced and as something that both parts of the couple are actively participating in. This is in contrast to perceiving ED as a disease of the penis and the penis alone, and for which responsibility to enact a solution (take a pill which will maintain an erection) is the man's. As we have shown, in the Viagra discourse, the partner is enrolled to help the man see how important it is for him to take Viagra. This demands a significant amount of work on her part, actively enabling the man to recognize the problem as ED and the solution as Viagra. An alternative would be for partners to be enrolled as participants who can also define alternative sexual practices and solutions.

Thinking about the enrolment of not only new, male patients, but also their doctors and their partners, we were reminded of an early study of mental health by Eaton & Weil (1955), which found that relatively isolated, Anabaptist communities' responses to patients who developed mental illness were very different than the response to mental illness found in the wider American society at the time. Rather than isolating the individual, institutionalizing him or her, and stigmatizing the patient, the Hutterite communities tried to help the individual continue to play a role in the community, contributing and working as best they could, and being cared for by their family during the course of the illness (Eaton & Weil, 1955: 212). Reading this study today, it is obvious that it was written before the pharmaceutical industry had colonized the discourse of mental illness, and illness in general. Rather than talking about patient-centred, individualized cures to illness, the study relied on concepts of social cohesion, social structures and group expectations as explanatory models and as treatment options. It pays special attention to sociological variables, the cultural and social dimensions of health (Eaton & Weil, 1955: 25).

We are not suggesting that a theory of social cohesion and mental health from

1955 may be a good way to reinterpret erectile dysfunction. But as a reminder that our research material, our observations, and our interpretations are influenced by the paradigm within which we are working, it is very useful. Going back to the material we have discussed in this paper, and looking at the way patients, doctors, partners and pills are enrolled in the production of Viagra consumers, we see first that these actors are enrolled to produce consumption as a treatment option. Secondly, the men and their partners are not discussed as explanatory factors. Though it may seem unnecessary to reintroduce the partner as the source of impotence (for a discussion of historical, cultural and social explanations of impotence see McLaren (2007)), this enrolment can explain what other critical research on Viagra has shown; that its existence and doctors' participation in its prescription practices have created ED. Social structures (the medicalised framework) and group expectations (of lifelong sexual activity and successful aging) have contributed to the 'epidemic' of erectile dysfunction. The illness, itself, is constructed by the enrolled actors. Only then can they be engaged as a network to (help the man) find a solution. Starting from this insight, we ask: how these same human actors could be enrolled into creating a different solution? If Viagra was not available, what solutions could this cast of characters work together to find? Who/what else could possibly be enrolled? And how would the concept of ED change?

Like mental illness, impotence has traditionally been a situation that is not generally flouted or discussed publically. Therefore we find it interesting that the Viagra solution suddenly enrols a wider group of actors to help the man find a solution. The Viagra solution demands these other actors; the regulatory framework means that doctors are a gatekeeper to the drug, and Viagra's reliance on sexual desire means that the sexual partner can be important to initiate, develop or maintain arousal. What we are asking is: If these three groups of actors (men, their doctors and their partners) can be enrolled to address ED through Viagra, how could they be enrolled to address ED without Viagra? How would a distributed response to ED place responsibility for dealing with the problem at the family and community level rather than only by individual?

We suggest that these examples, both Oliffe's qualitative research on men with impotence (Oliffe, 2005; 2006) and the pre-Viagra treatment advice for doctors, show that enrolling a wider community to respond to a health issue does not necessarily mean that the solution needs to be given to the individual, especially as a pill to be swallowed. Rather, enrolling a larger network of actors can involve finding and supporting alternative behaviours, alternative demands, and alternative expectations, both by and of the 'individual' with a condition, such as erectile dysfunction, and by the people around him who are also affected by it.

Notes

1 Accessed in October 2007, February and April 2008, and November 2009.
2 This is in contrast to another Pfizer sponsored website, www.viagra.se, which is framed as an informational site for medical professionals. The different readership is constructed to legally avoid direct to consumer advertising of Viagra.
3 See the special issue of Sexualities: Sexualities 9(3), 2006.
4 We would like to point out that this performativity is more directly connected to specific physical actions than the discursive performativity often found in gender studies, i.e. Butler's (1990) work.

5 www.potenslinjen.se, accessed 4 November 2009.
6 www.viagra.com
7 The below quotes are (unless otherwise mentioned) taken from www.potenslinjen.se, accessed 5 November 2009.
8 This encouragement and advice in how to meet and speak with patients with ED is presented on the website http://viagra.se, which is directed solely to health professionals (Accessed 28 October 2007).

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