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Gender, older female bodies and autoethnography: Finding my feminist voice by telling my illness story

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Synopsis

This article focuses on my experience of thyrotoxicosis and is rooted in the tradition of medical sociologists reflecting upon their own illnesses. I use the method of autoethnography to contribute to broader academic debates on acute illness as a neglected research area and embed my reflections in feminist work which makes connections between bodies, gender, illness, health and healing. Autoethnography, as an autobiographical research genre, displays multiple layers of consciousness, connecting the personal to cultural. My article aims to reveal how acute illness can be (1) viewed critically from the perspective of menopausal bodies, constructed by biomedics and (2) benefit from theoretical explorations of Foucault's concept, technologies of the self and Braidotti's feminist notions, nomadic flexibility and identifications. Given that I illustrate these aims through the methodology of autoethnography, my article has both theoretical and methodological implications.

> Illness has always been of enormous benefit to me. It might even be said that I have learned little from anything that did not in some way make me sick (Alice Walker, 1979: 370).

Beginning on a personal note

It's been a long time since I have written an academic paper because I suffered with an acute thyroid problem for two years. This sickness robbed me of a vibrant feminist voice. When I got sick, I was on sabbatical leave, writing two books. My partner and I were recovering from the death of her father and sister. Soon after, my partner experienced a health crisis which was at first thought to be fatal. Illness and death were all around me. I felt as if I had no space and I was afraid of life. My emotional pain was almost unbearable. But, I coped—not noticing subtle bodily changes, creeping up on me.[1] When I did, I thought 'menopause', reflecting how medical interpretations percolate into lay ones and how older women find it difficult to offer their own understanding of their condition or ask questions about its treatment (Lewis, 1993).

This article emerges from the tradition of medical sociologists reflecting upon their own illness experiences (Adamson, 1997; Davis & Horobin, 1977; Frank, 1991, 1995; Rier, 2000; Roth, 1963; Zola, 1982). It provides a way of introducing autoethnography as a methodological tool for speaking and writing reflexively about my own illness experience of thyrotoxicosis. I embed my reflections in feminist work, making connections between bodies, gender, illness, health and healing (Clarke & Olesen, 1999). In the tradition of feminist autobiography (see Radstone, 2000), I am involved in the production of embodied subjectivity, bounded by a fragile temporality (Mattingly, 1994) and intersected by the impermanence of health and illness. Here, chronic illness has a major impact on identity (Charmaz, 1983, 1990, 1991, 1999), is a radical intrusion into embodied selfhood (Turner, 1992) and is a

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well-researched area. But, acute illness, such as thyrotoxicosis, is a neglected one.

The aim of my article is to reveal how this disused research area (1) can be viewed critically from the perspective of menopausal bodies, constructed by biomedics and (2) benefit from theoretical explorations of Foucault's (1984) concept, technologies of the self and Braidotti's (1994) feminist notions, nomadic flexibility and identifications. Given that I illustrate this through the methodology of autoethnography, my paper has both theoretical and methodological implications. Overall, it is a shared journey with the reader.

Setting the context: what is autoethnography?

Autoethnography is an autobiographical research genre, displaying multiple layers of consciousness, connecting the personal to cultural. Writing in the first-person, auto-ethnographers look through an ethnographic wide-angle lens, focusing outward on social aspects of personal experience; then inward, exposing a vulnerable self, refracting cultural interpretations (Ellis & Bochner, 2000, p. 739). The leading proponents of autoethnography, Ellis (1991, 1995, 1999, 2000), Richardson (2000a, 2000b, 2000c, 2003) and Bochner (2000, 2001, 2003) share a consensus: autoethnography should be evaluated through two lenses, science and art. Autoethnography makes a substantive, aesthetic contribution to understanding social life; demonstrates reflexivity and has an impact on the reader (Richardson, 2000a). 'Conversations' should 'feel' real to life and have the power to stimulate social action (Ellis, 2000, p. 274). The writer extracts meaning from experience rather than depict experience as it was lived (Bochner, 2000). The intention, shape and rapport of the artistic piece should emulate the emotional and scientific commitment of a triumvirate: author, story and reader.

In translating these criteria to medical sociology, I follow Ellis and Boucher (1999). There are many authors, stories and readers. No conventional canons determine how illness stories should be constructed. But, I must be thoughtful, reflexive, ethically self-aware, gender, class and ethnicity sensitive in portraying others and evidence emotional reliability. My portrayals should depict the contours of the patient's sphere and the status of illness and health within that sphere. My stories should be flexible, in enough detail to express the realities of life and aesthetically alluring. I need to ensure explication of what is going on with others, even if their actions and perceptions of events, risks, infirmity, well being, etc. differ dramatically from my own.

Autoethnographies augment empathy on multiple levels including interactions between author and participants as well as reader and story (Bochner & Ellis, 2002). In a health and illness context, they present particular embodied events with people in time, their social shaping and how these are representative of wider cultural meanings and social trends. Through its empathic form, autoethnography provides a tool to fashion a 'non-dualistic ontology' of the mindful body in which emotions play a central role in human experience and cultural scripts of health and sickness (Williams & Bendelow, 1996, p. 47).

Autoethnographies should allow both reader and author to enter into various textual strati and phases of illness understandings concerning what illness is and does as well as what making meaning of illness involves. Do I dare contemplate risk, stigma and suffering alongside control, acceptance and victory? Do I interrogate myself as 'witness and doer' (Chawla, 2003)? Do I consider how the various people I encounter come to treat me in the way they do? What constrains them? What allows us to feel empowered as patients, physicians, nurses, etc.? 'Am I willing to include details that might reflect badly on me' (Berger' 2001, p. 514)—that might show me as an intransigent patient as well as stubborn? Similar to Frank (1995), Ellis's (2000, p. 273) optimal concern is, 'I want to think and feel with my story'. While thinking and feeling with my illness story may be a novel challenge, autoethnography can help me to achieve this aim.

Methods and data: ruminations of the 'healthy' once 'sick subject'

My autoethnography draws on data and analysis from diaries over two years when I suffered from thyrotoxicosis. They include records of key events with times, places and people as well as feelings, emotions and bodily states (e.g. pulse rates, blood pressure and weight). Relevant articles, letters and blood tests are attached to them. Before writing, I do an intensive study of my diaries. After my fourth reading and before data analyses, I write down all key events in a chronological order. This is difficult because remembering is painful and I feel desperate and lost. But, I want 'to write from the heart, bring the first person in my work and merge art and science' (Ellis & Bochner, 2000, p. 761).

As I write, I stroke my neck and remember the thyroid pain and my fear of dying. I look out the window and stop stroking my neck. I have the feeling that as I remember key events, I am processing data through me as the now 'healthy' once 'sick body'.

While reading, remembering, writing and processing these data bring me emotional pain, I revisit my past by moving in and out of sad, painful experiences. I am moved to work harder. I begin to recall conversations and interactions that I had with 'significant others' such as my partner, friends, colleagues and doctors. I am excited because I am able to think and write clearly. But, I feel vulnerable and alone. I am acutely aware that I interpret past events from my current position. I will not get it entirely right nor will I be able to represent these 'significant others' totally (Pyett, 2003). Ley and Spelman's (1968) classic work, demonstrating that the amount of information patients' recall in communications with doctors is limited, looms in my memory. I am afraid, but I reassure myself, there is no such thing as getting it totally right. Seek verisimilitude. 'Evoke in your readers a feeling that your experience is described as lifelike, believable and possible' (Ellis, 1999, p. 674). I feel relieved. My story is about the past, constructed in the present. I confront specific biographical events, placing me in shifting relations of power with myself on the healing trajectory and others who provide different levels of care. I become aware that I am using the method of autoethnography to make sense of my illness experiences.

I do emotional recall in which I imagine being back in these experiences emotionally and physically (Ellis, 1999, p. 675). Emotional recall is embedded in sociological introspection, a process accomplished in dialogue with the self and represented in the form of narratives (Ellis, 1991). It feels good—healing. Sociological introspection allows me to study my lived experiences not 'as an internal state but an emotional process which I recognise internally and construct externally' (Ellis, 1991, p. 32). This is bound up with my emotions and visceral reactions to others in specific sites and social exchanges. While emotion work can be a way of reaffirming one's identity and managing the disruption of illness to one's biography (Exley & Letherby, 2001), I construct scenes and dialogue from partial descriptions in my diaries. I analyse them according to what each story says. I place them in a time line. I know my story is not totally accurate and certain events may be out of place. But, I press on. I know this work will take time but I feel satisfied. I am curious as to what I will find and how I will feel. I write and write and write. I have not only events before me but also situated settings, sites and conversations. I finish. I notice in my writing and analysing a sense of triumph prevails. I have survived death. I beat this punishing illness. I feel overwhelmed with tenderness. I have suffered. I want to learn from my illness and explore the multiple subject positions experienced through my destabilised now stabilised and transformed healthy body. Yes, I am healthy now but a different 'healthy Betsy' than before I became ill. The cartography of acute illness has brought me 'health' but via a circuitous route, one that included choices to take an alternative path, leave my doctor and from the viewpoint of contemporary biomedicine, put myself at risk of more physical harm or even death.

Perhaps, in being focused on what my story is saying, I misrepresented what is going on for significant others. I found some of their behaviour difficult. My story is no less true than theirs. But it does provide comfort from my suffering in a way that differs from their biomedical way of expressing it (Ahlberg & Gibson, 2003). It gives me access to my experience of an unwelcome and painful process, while allowing me to look more critically than these significant others at biomedical conventions and norms.

I need to be ethically accountable to methodological principles of how I portray others. The source of data is personal diaries. There are no research participants as outlined by the remit of Research Ethics Committees (Beyleveld, Brownsword, & Wallace, 2002) nor anyone identified as a conventional respondent from whom gaining informed consent is required (Crow, Charles, Heath, & Wiles, 2004). Thus, seeking ethical approval is not necessary. Nevertheless, I inform all significant others with one exception (I could not find a current address) of my account either in writing or verbally. I protect the anonymity of all as names of people and places are changed. With three significant others, I discuss what I plan to do. They give support and encouragement. I feel relieved. One agrees to read the first draft and finds it 'realistic' and 'riveting'. Talking to others who are involved in my story is important. I gain self-assurance, while they gain important information as well as the opportunity to consider that understanding an older female patient's experience of an acute illness may enrich their own practice. I feel as if I am beginning to find my voice. Maybe it will come as I write my social science prose. Now, I will go on to my story.

My illness journey from thyrotoxicosis to health

The beginning of symptoms: the body 'at war with itself'

Mid February 2001, I sit in my study asking myself, 'Why am I so floppy? I fall on the stairs. I've had terrible diarrhoea. Maybe it's food poisoning but, I never had diarrhoea like this. It's probably because I am working too hard ... Maybe it's menopause. I get palpitations and hot flashes ...' I am frightened of what is happening to my body. I am becoming not well and resisting this change. 'I don't want to die. Too many people around me just have.'

Thirteen days later I sit in a consultation room in front of Dr. Walsh, my NHS[2] GP (General Practitioner), a portly woman in her 40s with a kind face. 'Dr. Walsh, I have been having bad diarrhoea for the past two weeks. I don't know what it is which is why I came to see you,' I say hesitantly. 'Could it have been something you ate?', she asks looking up from her notes. 'Well, perhaps. It did start after I had a spicy pasta', I say. She continues to write and says, 'Sometimes, food poisoning takes a while – weeks – to get out of your system. It's probably that'. I add in a worried voice, 'Also, I sometimes get these horrible hot flashes and palpitations too.' I notice that my right hand starts to shake violently. I quickly sit on it hoping that Dr. Walsh doesn't see. 'Well, that could just be menopause. Would you like something for it?', she looks at me with pen in hand. 'No, I'd rather try control it through my diet', I respond.

For the next three weeks I am on a work visit to Helsinki, Finland. My diarrhoea subsides for the first few days and comes back with a vengeance. I walk through the Helsinki streets, after presenting a University seminar, thinking, 'I wonder why I am so breathless all of the time. Must be the cold ... I didn't feel nervous when I gave my paper, but I saw my hands shake. Strange really ... I wish this diarrhoea hadn't come back. I need a loo wherever I go. I can't believe the hot flashes and palpitations. I hate this menopause feeling.'

Three weeks later I sit in front of Dr. Walsh who appears to take a good look at me in between writing her notes. I try to make eye contact, 'I was away since the last time I saw you. For most of that that time, I had diarrhoea, but not for the past two days.'

'Have you been stressed lately?', she asks with concern. 'Not particularly'. I pause, 'Well yes, I am writing two books, why?' I ask quietly, returning the concern. 'Well, it could be psychosomatic—you could have the beginnings of irritable bowel syndrome', she says in an authoritative tone. 'Oh, I know that. My mother suffered from it for years', I say.

'Ah here it is,' she says as she takes a small cylindrical container from her desk. 'I want you to take a stool sample to be sure you don't have an infection. 'Take this', she says as she hands me the container 'and bring it back tomorrow. We'll get it analysed. If it's clear, that's fine. Ring the surgery to find out. If it continues, we should get a blood test for you. Make an appointment with the nurse for that. 'Thanks, doctor', I say as I stand at the door eager for this new plan of action.

Four days later I am ringing the surgery about the results of my stool test. 'The doctor says your stools are all clear', the receptionist responds ... 'Thank you', I say as I hang up the phone. I think to myself, 'What a relief!'

Two weeks pass...

The 'long in coming' diagnosis: 'your thyroid's packed in'

'Dr. Walsh said to see you for a blood test if my diarrhoea continues. My stools tested clear, but my diarrhoea has continued on and off. This week it's off', I say closing the door to the nurse's room. A short, young woman in a blue nurse's uniform stands with her elbows resting on a sink full of plastic bags and says, 'Well, you don't need a blood test'. 'I wouldn't be so sure of that. This has been going on for some time', I say trying to disguise my surprise at her abruptness. I feel that I have to go to the loo. 'Let me go speak to the doctor', she says as she leaves the room. I wait quietly feeling nervous, but at least my bowels calm down. She returns. 'Dr. Walsh says that you don't need the blood test.' 'OK, that is that', I say in a resigned voice.

Over the next six weeks, I loose weight even though I am eating like a pig. I should be relaxed because my writing is nearly finished, but I am not. I am nervous all of the time. My partner is beginning to notice. 'It feels as if a river is running through my body', I tell her one evening at dinner. I decide to go back to the nurse for a blood test. I know there is something wrong with me. 'I have come to get a blood test. My diarrhoea has not stopped', I say as I come into her room. 'So how long has this been going on for?' she asks. 'A few months now. I came here about five weeks ago. Then, Dr. Walsh said that I didn't need a blood test. Don't you remember?', I ask feeling frustrated. The nurse opens the cabinet door above the sink. 'OK I'll get the syringe', she says.

Soon after, I receive a phone call from the receptionist telling me to see Dr. Walsh. I sit in front of Dr. Walsh whose manner seems rather upbeat when she comes smiling to fetch me from the waiting room. I say, 'You wanted to see me about...' Before I am able to finish my sentence, she says, 'Yes, your thyroid has packed in'. 'What does that mean?' I say feeling immediately confused. She continues in a reassuring voice, 'Your thyroid is overactive. Your antibodies are attacking and destroying it. You are the second person today that has been diagnosed with this condition. The other is my father-in-law.' Sensing that she is in her element, I see her as the knowledgeable doctor. I think, 'She is trying to be friendly but at this moment I don't want to share my consultation with her father-in-law.' She continues, 'There are three options. We can cut the thyroid out. You can swallow radioactive iodine which kills it. Or you can take anti-thyroid tablets. I usually recommend the latter, carbimazole, which is perfectly harmless. What do you want?' I am confused and angry; I don't want to become chronically ill. I say, 'Well, I don't want surgery. The radioactive iodine doesn't sound too good. My mother has had cancer and I'd be afraid of taking any thing if I am susceptible.' 'Oh there is no connection with cancer. Radioactive iodine is perfectly safe', she retorts. A nervous laugh comes out of me and I say, 'I am not sure. I'll take the pills.' The prescription is handed to me as she moves her swivel chair towards me. 'I wonder when she wrote this', I think. She takes my wrist, 'Your pulse is 126, a little high[3] but this is to be expected. Just take the pills. Come in a month's time for a blood test and we'll review your dosage.'

Thirty minutes later I phone my partner. I tell her about my encounter with Dr. Walsh, the diagnosis and prescription. I am worried and remember that my mother had the same condition. I decide to ring an alternative physician, Dr. Fish, who my osteopath recommended once when I had hot flashes. My partner says reassuringly, 'That sounds like a good idea if you are afraid.' And I was.

Five minutes later I ring Dr. Fish. I say that I received a diagnosis of overactive thyroid. I am afraid to take the pills my NHS doctor prescribed. I mention that I would like to explore the possibility of taking alternative medicine and to discuss this with her as soon as possible. Luckily, she has a time later in the day.

Six hours pass . . .

Uncertainty, risk and stopping orthodox treatment: taking the alternative path

I am at Dr. Fish's private clinic. A stately looking woman enters, her right arm extended to shake my hand. She gives a penetrating look and guides me to her office. I feel her warmth immediately. 'Nice to meet you Professor Ettorre. Describe how you are feeling. I am sure we can sort something out, she says'. 'Not too well really. I feel as if a river is running through my body. I have terrible palpitations and diarrhoea. I am irritable. I can't sleep', I respond. She turns toward me and says, 'Tell me if you have had any poisoning recently.' 'No, I don't think so', I say with interest. In our conversation, she says that poisoning can cause thyrotoxicosis and if a patient's pulse goes too high, it can be life-threatening, causing cardiac arrest. I find myself shuttering with fear but speak about the history of my diarrhoea, my other symptoms and my visit to Dr. Walsh. She takes my pulse which is 120 and says that it is usual under these circumstances, but a normal pulse is around 60–70. She speaks about a patient who had the same condition and got better by taking a herbal remedy which she prescribed. She says that thyroid sufferers often feel as if they have no space to speak and asks if I feel that? I feel immediately very vulnerable and start crying softly. Tears run down my cheeks.

I respond, 'Yes, in a way.' I speak about recent grieving and sadness and say, 'You say a normal pulse is 60–70, well I am sure I have not had a normal pulse for some time'.

She looks quietly then says, 'I am going to prescribe you both homeopathic pills and a herbal remedy for the thyrotoxicosis. You have to slow down and take time for yourself. Can you do that?' 'Yes, I am off on holiday in two days time', I say. She asks to see me within three weeks. I tell her that is impossible because as soon as I come back from my holiday, I go to the US to attend some conferences. Looking horrified she says, 'Well, that doesn't sound like a rest. You need to make sure you slow down. I would like your NHS GP's name. Also, you need to ring me while you are away to tell me how you are doing. I'll see you soon after you get back. You'll need to find out your blood test results. I am sure your NHS doctor will give them to you.' We agree that I'll ring her from my holiday.

While away, I take my pulse everyday and the range is from 81–124. I ring Dr. Fish three times to say I am resting and feeling better. In Anaheim California, I present papers at the Annual Conferences of the Society for the Study of Social Problems and American Sociological Association. I also attend the Annual Conference of Sociologists for Women in Society. Besides giving papers, I rest in the shade by the hotel swimming pool and dip in the cool water to relieve my symptoms. I see my colleagues walk past and greet me. I feel ashamed because I think they may see me as lazy.

On my return, I have a blood test taken by Dr. Walsh's nurse. I ask her to give me the results of my first blood test. I say nothing about Dr. Fish who I see soon after. When I meet Dr. Fish, I give her my blood test results.[4] The values are for free thyroxine,[5] 71.2 and TSH,[6] 0.01. Dr. Fish says, 'You need to remember that herbal medication works slowly. If you take an anti-thyroid drug like carbimazole, it's like taking a sledgehammer to your thyroid. Herbal medication won't kill your thyroid. It works gradually but you need to slow down. Tell your NHS doctor that you have come to see me and that you are taking the herbal medicine. It is in your best interest to do that because if anything happens she is the one legally responsible. It is only fair that she knows.' I find myself becoming anxious but say quickly in response, 'OK, I'll do that.' Dr. Fish notices my anxiety, 'You are a professional woman—a professor. I am sure you can talk with her'. I don't feel reassured but say, 'Yes, I am sure it will be fine'. We arrange another consultation in three weeks time. When alone, I think, 'I'm an educated competent women whose afraid of her GP—a first for me. When I read the next day that extreme nervousness and jangled emotions trouble 99% of Grave's sufferers (Gomez, 1994:48), I understand.

A week later, I go to see Dr. Walsh. I am anxious and hope she doesn't ask me about carbimazole. I can't bear to tell her about the herbal medication—jangled emotions again! I am shaking and feeling desperate. Looking at her notes, she says, 'We have the results of your blood test. Your free thyroxine is 55. It has gone down. Your TSH is the same. You don't need to see me anymore. Take the medication and go to the nurse for blood tests and we'll monitor you that way.' I think, 'How different her consultations are from Dr. Fish's'. I say, 'Thank you very much doctor. I am glad I am improving.'

The next week I meet with my Dean of Studies and say I am being treated for an overactive thyroid and want less work. He agrees, is very sympathetic and tells me his wife had the same condition. I am grateful for the understanding.

Five days later, I see Dr. Fish. Tell her that my blood values are down. She says this is good news. Knowing that I start teaching, she says I need to pace myself because the herbal medication works slowly. She wants to know if I told Dr. Walsh about taking it. Reluctantly, I say no because I was too frightened. Dr. Fish volunteers to tell her but I say I'll do it. I am so scared about telling Dr. Walsh about the herbal medication that I take carbimazole for a few days—these jangled emotions. I don't want to lie. I am sitting uncomfortably quiet with Dr. Walsh's nurse in her treatment room a week later and say I've come for my blood test. Immediately she remembers. She gets the needle and starts taking blood from my arm. As she does, I say bracing myself, 'I am improving, uum I was taking herbal medication but now I am taking what Dr. Walsh prescribed'. She finishes taking blood and looks up at me, ' Did I hear correctly? Why did you do that? Was it homeopathic medication? Let me hear your heart.' She puts the stethoscope on her neck to my chest and is visibly panicking. 'Your pulse is racing. I need to speak to Dr. Walsh', she says rushing out of the room. I feel abandoned and a bad patient. Five minutes later, the nurse is standing in front of me, 'Dr. Walsh is unhappy about your not telling her that you were taking herbal medication.' 'But, I have improved, I. . . ', I begin to say. She cuts in with a scolding voice, 'It doesn't matter. You must go to the hospital and get an ECT. You have bad palpitations and these need to get seen to. You need to take beta blockers. You'll get a letter from the hospital. Promise you'll go this week'. Feeling demoralised, I say, 'Yes, I suppose', but I think to myself, 'Not on your life. I am never stepping foot in here again'. In my parked car, I ring Dr. Fish. I ask to come to see her soon because I want her to help me to find a sympathetic NHS GP. We make an appointment in two days time. When we meet she tells me that what is happening is very stressful for me. She is concerned to get my pulse down and warns that I could have major health problems, if it doesn't. I tell her about the nurse and how I took the carbimazole temporarily so as not to lie. She reassures me by saying that of course I can take it, if I choose to and she asks how it feels. I say I stopped and that for the first few days, it was OK. But soon after I got terrible headaches, my pulse and my blood pressure shot up and the palpitations were violent. She suggests that she take my next blood test and she'll sort me out for a sympathetic GP. On her desk is a book of registered physicians who are trained in homeopathy. She looks through it and gives me a list of names.

That same evening I ring the names on the list. One doctor is unable to help because I am outside of his catchment area, but he gives me the phone number of Dr. Edwards, a trained homeopath as well as an NHS GP in my area. The next day I ring Dr. Edwards's surgery, find out the address and go personally to register. I make an appointment to see him after he returns from his holiday.

Sometimes, I feel like I want to die.

A month passes . . .

Increasing pulse rates and heightening work pace: the 'inflexible body'

My blood test from Dr. Fish shows my values going down. I see Dr. Edwards and tell him about my overactive thyroid, my herbal medication from Dr. Fish who he knows of and about leaving Dr. Walsh because she wants me to take carbimazole. Dr. Edwards is a man in his mid 40s whose weathered and open face I am immediately drawn to. Looking at me directly, he says in a soft voice, 'To be honest, carbimazole is not pleasant and can have dangerous side effects. Unfortunately, it's the most common drug we use for overactive thyroid. If a patient does not want to take a drug, she shouldn't. It's your body, not mine. You shouldn't feel forced to take a drug. But, one thing we were told is that homeopathic medicine doesn't work for thyroid conditions.' I breathe a sigh of relief. I feel comfortable with this man. 'I am using homeopathic remedy but mainly a herbal medication and I am taking 15 drops three times a day,' I say. He begins to write and looks up asking, 'How are your blood values? Are they improving?' 'Yes. I feel better than when I was first diagnosed. He continues, 'I am a little unclear. Did you ever take carbimazole?' 'Yes, for a few days but I felt sick with it. I felt as if my eyes were popping out', I say. Our conversation continues in a calm manner. Dr. Edwards suggests that I continue to take my herbal medication, have my blood tests with his phlebotomist and copy my results to Dr. Fish. He agrees to monitor my progress and asks me to consider sick leave and he will sign me on.[7] He asks to see me in a few weeks and thanks me for coming. I leave feeling elated because he is empathetic. 'Just what I need', I think.

A month later I go to the phlebotomist who is a young nurse with a professional manner. She explains what she will do and shares that she has an under active thyroid. After she takes my blood, she asks me to ring the receptionist for my results. When I leave, I notice how calm I feel as well as satisfied.

A week later, I receive my results which show an improvement. My free thyroxine is 24.9, but the TSH is the same. I see Dr. Fish and tell her the news and about meeting Dr. Edwards. She notices my tremor and my right eye is slightly bulging, a classic sign of overactive thyroid. She asks me if I want an eye specialist and I say I am trying to avoid traditional doctors. She laughs and says, 'You must be relieved now that you met Dr. Edwards. I was concerned because just going to a doctor can cause stress and this is what we want to avoid.'

Two months pass . . .

The decision to take the healing journey: skis, yoga and sick leave

My free thyroxine levels go up while the TSH remains the same. I go on a trip to Lapland for Christmas with friends and feel well enough to ski. On my return, I have a blood test and see Dr. Edwards. He tells me that I am not yet normal. I mention that I'd like to take sick leave for three weeks and he agrees saying, 'That is fine. I'll sign you on.' While I am on sick leave I go to see my Osteopath who suggests that I try yoga because I have a frozen shoulder which is common in thyrotoxicosis. I phone the yoga teacher and tell her that I have an overactive thyroid and I think yoga would help. Immediately she tells me that her sister had the same problem and yoga helped. She asks me to come this evening and I agree. Immediately after class, I notice my pulse goes down.

I want to do everything I can do to get better. Dr Fish suggests that I have my amalgam fillings in my teeth removed. I have them replaced, a process which takes six months. I eat organic food, do yoga regularly, drink very little alcohol, take my pulse daily and 'pace' myself. I renew an old activity—'doing nothing'. This involves me sitting and literally doing nothing. That is how I used to calm myself when I was younger. Perhaps, as I become older and busier, I become ill because I forgot how to calm myself. I find 'doing nothing' healing. I am able to sit back and think about my life. It is a 'reflective' luxury for me. I become an advocate of 'looking after oneself' and talk with colleagues about how all of us in the academy need to slow down in our stress filled lives.

Almost a year passes . . .

Avoiding the thyroid storm through normal hormones: 're-embodying' health

I am feeling much better. The palpitations stop. My pulse is down. In January, I go for a blood test. By this time, I agree that I ring the phlebotomist directly for my results. In mid February, I am abroad at a meeting and during a short break; I ring the phlebotomist. After I hear her voice I say, 'Hi it's me Elizabeth. Do you have my results?'

She responds quickly saying, 'Yes, let me find them.' There is a long pause and shuffling of paper. 'OK Elizabeth, here they are—15.2 your free thyroxine and 0.46 your TSH. They are normal'. 'That is great', I say with joy. 'Do you know this is the first time my TSH is normal since I started having my blood tests almost 18 months ago?' 'No, Elizabeth I didn't. That is very nice to hear,' she responds excitedly. 'Congratulations', she adds. I feel full of delight. 'OK, I'll see you at my next blood test and thanks', I say before I hang up.

Eight days later I am with Dr. Fish who wears a lovely floral dress with a matching scarf. The sun is shining through the window onto her desk. I am smiling. 'Good news, Dr. Fish I am finally 'normal', I say. She smiles too. 'Well done. I knew you would do it. So all of your discipline has paid off. 'I must tell you', she says as she looks over my notes. There is a long but pleasant pause. 'I am just looking at your notes from our first consultation'. She looks up, 'When you first came to see me, you had all the symptoms of acute thyrotoxicosis. I was very worried about you. You could have easily gone into what we call 'thyroid storm',[8] had a cardiac arrest or even died. I just kept my fingers crossed that you would pace yourself so you would go slower. I am very pleased for you ... ' I smile and feel deep joy ...

'Doing thyrotoxicosis'

Hopefully, you the reader will have seen from the above that autoethnography is a useful method of making sense of an acute illness experience. In the following discussions, we turn our attention to more theoretical concerns. For example, accounts of acute illness which are shaped by biomedical constructions of gendered bodies and rely on notions of a unitary illness identity, mastered if not tyrannised by health are challenged by deconstructing 'gendered thyroids' and introducing the notions, technologies of the self, nomadic flexibility and identifications.

Gendered thyroids, emotions and menopause

In Britain, hyperthyroidism (another name for thyrotoxicosis) affects 2% of women and 0.2% of men (Gittoes & Franklyn, 1998). In the US, the ratio of female to male is 4 to 8.1 (Ansar et al., 1985 quoted in Martin, 1999, p. 102). While more women than men are affected by thyroid disorders, experts perpetuate misconceptions about women's thyroid glands as being more vulnerable to the vagaries of their emotions than men's. A physician writing on thyroid disorders says that women's emotional system is more susceptible to upset than men's and that there are two periods when a woman is particularly vulnerable to this kind of upset: after giving birth and during menopause (Gomez, 1994, p. 10). This reveals the subtle gendering of susceptibility to thyroid disorders within the medical profession. The belief is that anybody's (i.e. a man's or woman's) thyroid interacts with stress hormones, but women's have a greater propensity to disorders. This 'essentialist' viewpoint is based on the assumption that women's metabolism is more complex and delicate than a man's and women are more responsive to the effects of their emotions than men (Gomez, 1994, p. 10).

Also, this essentialist viewpoint is consistent with the mind body dualism of Western biomedicine. Regarded by physicians as ruled by her emotions, the female body becomes a metaphor for the body pole of this dualism, 'representing nature, irrationality and sensuality', in contrast to the male body, the mind or normalised position of 'social power, rationality and self-control' (Davis, 1997, p. 5). In the binary narrative of biomedicine, physicians perpetuate gender stereotypes about emotions and label hormones as if they were intrinsically gendered (Birke, 2000, p. 592). The health effects of these misconceptions are clear: women's health takes second place in toxicological studies (Birke, 2000, p. 594) or when their illnesses are purported to be linked with emotions, for example when a woman suffers from hyperthyroidism during menopause.

In my autoethnography, these misconceptions came to life when my thyroid symptoms were dismissed by my physician as 'psychosomatic' and/or 'menopausal'. While these dismissals did not benefit my state of health, I want to take a wider perspective and consider the social implications of them. 'Why should a physician take seriously an older woman patient's complaints and uncertainty about her ageing body?' Giving adequate, if not appropriate, treatment implies not only making proper clinical judgements but also listening to a woman's interpretations of what is happening to her own body. As we saw, when diagnosing my troubling symptoms, Dr. Walsh's reliance upon biomedical prejudices about menopausal women (See Caplan, 2001) was unhelpful, if not dangerous. Recent research (Ballard, Kuh, & Wadsworth, 2001) has shown that while menopause may be experienced as a status passage for older women, medicalising this transition or viewing it as a pathological state (Lyons & Griffin, 2000) allows its social context to be ignored and is disempowering for these women (Wray, 2004). Indeed seeing older women almost exclusively through the lens of menopause creates a distinctly oppressive space for their bodies to be blamed, managed or improved and their health to be politicised (Goldstein, 2000). Yet, even now with developments in modern medicine, experts do not have ways of knowing which of women's symptoms such as palpitations, joint pains, sleeplessness, numbness, dizziness and weakness are 'unavoidable concomitants of ageing' and which signify ill health (Greer, 1991, p. 146–8). The problem with physicians active attribution of a deficiency disease to ageing female bodies (Woods, 1999) is that bona fide diseases may be overlooked in the process, as what happened to me.

Technologies of the self, nomadic flexibility and identifications

In the beginning of my story, I experience classic thyrotoxicosis symptoms. Gradually, the symptoms become worse. My routine narrative about the status of my own health is being disrupted as I move increasingly into reconstruction mode (Williams, 1984). I attribute my symptoms to the stress of writing two books on sabbatical but I also clock up difficult life experiences. I am in grief. While there are alterations in my thyroid, I am myself 'alterative'; these minute bodily movements hint at embodied adjustments in my appearance, physical tenacity and psyche. My right eye bulges out. I feel weak. I eat like a horse. I loose weight. I can't think.

By way of these alterations, the small butterfly shaped gland in my neck draws my body silently into organic degeneration. The process of losing myself (Charmaz, 1983), the workings of my discursive consciousness and most importantly, hegemononic views and images of myself as an ill, menopausal woman are set into motion. I must lack discipline or did not give my immune system enough training to be rewarded in the currency of health (Martin, 1994, p. 327). My female body is obstinate. If I don't slow down, I won't get better. It is as simple as that. I have to learn how to 'pace' myself.

By the time my thyroid's 'packs in', I am in the process of losing the body I know. At the same time, I entertain an imaginary relationship to my once healthy body. 'She' is still here as my partner, my friends, my work colleagues, my doctors, etc. are. To change embodiment is to change identity (Turner, 1992, p. 256). I am unsure. The difficulty I have with this and other 'identity notions' in the 'masculinist' dominated field of medical sociology is that there is little, if any, room for technologies of the self (Foucault, 1984) where gendered individuals create their own identities through ethics and forms of self-constitution (Best & Kellner, 1991, p. 61).

For example, if as I am turning out to be unhealthy, my identity is an identity of a sick person, an identity which becomes threatened (Coyle, 1999), has a disrupted biography (Bury, 1982) and a reconstituted narrative (Williams, 1984), needs identity work (Strauss, Fagerhaugh, Suczek, & Weiner, 1982) and has a restricted life (Charmaz, 1983), my identity appears as somewhat fixed. More importantly, it is judged against exclusionary standards of normativity (including gender) in everyday life. Within these 'problematizations of illness identities', chronicity is prioritised over acuteness as well as health over illness. As an overarching regime, medicine as a voluntary and rational structure of conduct (Foucault, 1984, p. 100) takes control of my gendered illness existence. What specific disciplinary practices besides being categorised as infirm are available to me for transformation to a healthy, desiring female body? How do I approach the moral problem of my body that I have to address (Frank, 1995)? What technologies of self are at work in my desire if not passion towards health?

In my autoethnography, I effect sometimes by my own means and sometimes with the help of others a certain number of technologies or embodied practices. I visit doctors. I have my blood taken. I take advice. I don't take advice. I rest. I take herbal medication. I learn yoga. I have jangled emotions. I express anger. I express joy. I do nothing. All of these I do in order to attain a state of health which I seemingly have lost. If Charmaz (1983) is able to transform a restricted medicalised view of the chronically ill person's pain into a broader view of suffering, sociologists in a quest for a greater understanding of health and illness should create wider, more stylised 'infirmity identities' and gendered embodiments that defy closure, while resisting scopic regimes (such as medicine) which authorise and legitimate a morality of health.

For example, aware of my triumph (i.e. I had survived) as well as tenderness (i.e. I had suffered), I wanted to learn from my illness experience and explore the multiple selves experienced through my destabilised, infirmity identity[9] which I embodied. Disenchantment with the dominant Cartesian paradigm of rationality at the heart of modern medicine (as well as the social sciences) led me to narrative because 'narrative emphasises plurality of truths' that subcultures and cultures claim about themselves (Bell, 2000, p. 132). We have moved far away from notions that a single cultural perspective, revealing an irrefutable set of truths to be known or told exists and that any scholar is able to achieve an understanding of illness experiences outside of specific historical contexts or without recognition of shifting relations of power and inequalities. In this way, my autoethnography generates useful ways of creating knowledge about infirmity identities—identities suffering and grappling with the intricate, interior language of wounding, despair and moral pain as well as the victory of living an illness.

Thus, if I abide by narrow conceptions of myself as 'ill', how am I able to embrace new forms of embodiment, pleasure, pain and desire in my illness experience? In asking this question, I challenge sociologists to take up the feminist position of 'nomadic flexibility', embedding us in a critical consciousness that resists settling into socially coded modes of thought and behaviour and which relinquishes all idea, desire or nostalgia for fixity (Braidotti, 1994, p. 22). This position emphasises identifications more than identity.

Braidotti (1994, p. 166) contends that 'Identity is a play of multiplicity, fractured aspects of the self; it is relational, in that it requires a bond to the other; it is retrospective, in that it is fixed through memories and recollections, in a genealogical process.' Identity is related to the unconscious and differs from wilful choice. How conceptions of myself and my 'identifications' are produced is key here (Scott, 1991). If my conceptions are made up of successful identifications of myself as ill or healthy, I am primarily the one who makes these identifications in relationship to significant others. But most importantly, these identifications are unconscious internalised images that escape rational control. If my body, ill or healthy, can't really be fully apprehended, how can my 'identity'? One way I survive is to use technologies of self in my attempt to constantly adjust notions of my own embodiment to the internalised images of the whole female body that I am. In this context, my autoethnography hints at my own internal contradictions, confusions and uncertainties when I pay attention to the level of identity as complexity and multiplicity (Braidotti, 1994, p. 166). I feel like I want to die; I feel like I want to live. I am able to do nothing, to do something, be well while feeling ill, be ill while feeling well, be the object of my 'identity' and the subject of my unconscious. On the one hand, I resist pathologisation. On the other hand, I embrace wholeheartedly regularised blood tests for corporeal assessments, assigning me specific pathological values, providing others with standards for biomedical normalisation.

As a practice, holding on to identifications not identity was strategic for me as evidenced in my story. That finally somebody, first Dr Fish and then Dr. Edwards, sees the entirety of my symptoms – not merely the diagnostic entity – (See Frank, 2002) is crucial in my journey. I am a multiple, fractured body, even though I am a whole 'sick body'. My bodily changes lead to a thematization of my corporeality, a visceral sense of embodiment in which bodily strangeness becomes a part of my life (Kvinge & Kirkevold, 2003). In this process, embodied adjustments are made for me. Doctors tell me what to ingest. My yoga teacher tells me how to breathe. A nurse extracts blood from my veins. I make embodied adjustments for myself. I nourish my illness as 'acute' by rejecting carbimazole; I 'stave off' chronic illness. When I do nothing, I feel something different than before when I did nothing. I increase herbal medication to decrease the size of my thyroid. My wounded gendered body becomes a reflexive body 'capable of ruminating, deliberating, cogitating, studying and thinking carefully' (Martin, 2003, p. 356). The dominant 'identity' of 'healthy body', no longer as important as earlier, recedes in my consciousness. Yet, my embodied identifications become those of liminality, in betweeness and are flawlessly cultural.

In conclusion, this paper began with the premise that autoethnography is a helpful method of telling illness stories as well as creating sociological insights into patienthood, in particular older female patienthood. Like other autoethnographers (Tedlock, 2000, p. 468), I have attempted to clarify and authenticate my self-image and feelings. As a researcher, I have become the epistemological and ontological nexus upon which the research process turns (Spry, 2001, p. 711). Conceptualising uncertainty and at times conflict between an older female patient and her health professionals within autoethnography can bring new insights to understanding and explaining this type of uncertainty and these conflicts. What happens when acute illness strikes a menopausal body unfolds. In learning about the multiple contours of embodied illness and health, let us open wide the door to those who want to think and feel with their stories. For me, attempting 'to write from the heart' has been one small step towards opening that door and finding my lost feminist voice.

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Endnotes

[1] These symptoms included palpitations, joint pains, general muscle weakness, falling, sleeplessness, weight loss, shaking (tremor), 'gritty' eyes, discolouration of the skin on my neck (vitiligo), diarrhoea, irritability, high pulse, damp skin, brittle nails, dull hair, hair loss, swollen neck and difficulty in swallowing.

[2] NHS = National Health Service, the British state funded health service.

[3] This is my resting pulse. I am twice the normal rate.

[4] Blood values vary between laboratories. At mine, the normal range for free thyroxine is between 2.8 and 23.1 and for TSH, 0.35 and 5.5. (I am 3 times the normal value.)

[5] This is the tiny but significant part of the main thyroid hormone. Its level in the blood is useful in assessing whether the thyroid is functioning properly (Gomez, 1994, p. 119).

[6] TSH or thyroid stimulating hormone is produced in the pituitary gland and directs the thyroid to produce hormones. TSH goes up when the thyroid is not providing enough . . . and down when there is a surplus (Gomez, 1994, p. 119).

[7] In order to get statutory sick pay in Britain, it is a requirement that your NHS GP 'signs you off work'.

[8] This is overactivity of the thyroid that has run out of control. With it, one becomes critically ill.

[9] See Clarke and Olesen (1999, p. 10) for a discussion on how there are 'multiple selves' and 'multiple subject positionings in the heterogeneous cartographies of contemporary life'. While Clarke and Olsen refer mainly to the dynamics of race, gender and class, I extend their analyses to include the cartography of 'sick/healthy bodies'.

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