



**Intersections of Feminist and Medical  
Constructions of Menopause in Primary  
Medical Care and Mass Media:  
Risk, Choice and Agency**

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## Abstract

In this thesis I critically examine the intersection of feminist and medical constructions of menopause. I examine language used by general practitioners and in mass media to ask 'what are the implications of constructions of menopause for health care practice and public health for women at menopause?' I present the findings of qualitative analysis of semi-structured interviews with nine general practitioners' working in rural South Australia and qualitative and quantitative analyses of 345 South Australian newspaper articles from 1986 to 1998.

Women's 'choice', 'informed decision-making' and 'empowerment' are key ways in which menopause is described in the general practitioner interviews and newspaper articles. I argue that an 'ethic of autonomy' is constructed in these general practitioner and media accounts and that an 'offer of choice' in relation to health care for women at menopause, far from being emancipatory, serves to intensify power relations. The singularity of choice, to take or not to take hormone replacement therapy, is *required to be* a choice and is embedded in relations of power and knowledge that produce menopause in medical and popular discourse.

While this 'offer of choice' is problematic, I nevertheless argue that in the discursive shift towards women as active decision-makers there has evolved the potential for reconceptualising health care practice for women at menopause by medicine. I argue that conceptions of agency provide a framework for such a reconfiguration. 'Choice' based on agency is not an individual act of the woman pursuing her rights and using her will but is a choice predicated on an active engagement with the relations of power that hitherto were integral to the limitation of her choice. Hormone replacement therapy is not excluded but is no longer the primary issue around which choice is exercised.



A reconfigured health care for women at menopause and beyond would, therefore, see health care practitioners, public health researchers and policy makers actively engage with the multiplicity of menopause, negotiating health care beyond narrowly physiological parameters of traditional discursive constructions of menopause: it would see health policy regarding women's long term health take account of power relations, and the social and discursive context of health.

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent for this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

**Madeleine Josephine Murtagh**

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# Chapter 1: Introduction

## 1.1 Introduction and Background

In this thesis I critically examine feminist critiques of 'the medicalisation of menopause' and analyse language use by general practitioners and in mass media to ask 'what are the implications of these for health care practice for women at menopause?'

Since the mid 1980's and the association of menopause with the long term health risks, issues of health care and disease prevention for women at menopause have become key medical and public health concerns. These preventive health concerns emerged in a context where critiques of medical treatment of menopause, in particular the use of the drug commonly called hormone replacement therapy, were being raised by a range of feminist and social science academics, women's health practitioners and other commentators in popular feminist literature. Debate about the relative medical or social nature of menopause is evident in medical, sociological, anthropological, feminist and epidemiological research about 'menopause' in the past two decades. In medical literature about menopause as well as in the literature critical of contemporary constructions of menopause a key issue revolves around what menopause is and if indeed menopause exists at all. A key collection of essays published in 1997 discussing a range of 'reinterpretations' of menopause begins with the rhetorical question Does 'the menopause' exist? (Komesaroff et al, 1997: 3). This question is

asked in the context of critical debates, particularly feminist, which emerged largely in the 1980s in response to medical constructions of menopause. While there is variety within the largely medical and the largely feminist constructions of menopause a dichotomy appears to exist between medical and non-medical descriptions of and responses to menopause. Nevertheless, medical and feminist constructions of menopause and the debates they prompt form the boundaries for understandings of menopause and consequent health care practices about menopause. Medicine is the dominant discipline informing health care practice about women's health in general and health care at menopause in particular. As feminist writers provide the dominant critique and alternative to medical descriptions of menopause, in this thesis I take, as a starting point, feminist critiques of medical constructions of menopause to examine debates about menopause and health care at menopause. While the perspective taken in this thesis is a feminist one, in that it takes account of the structuring effects of gender, it is an unremittingly critical approach. In addition the thesis takes a postmodern position that assumes knowledge is always already constructed. Both medical and feminist knowledges are considered within these parameters.

I critically examine medical, feminist and other critical literature about menopause in Chapters 2 and 3 of this thesis. I outline feminist critiques of historical and contemporary medical practice relating to menopause. An apparent dichotomy has developed over the past two decades as medical, sociological, anthropological, feminist and epidemiological research about 'menopause' have vied for recognition in debates about the 'true' nature of menopause and the relative contribution of the physiological or the social to the experience of menopause. I question the assumptions vested in these arguments and examine the

implications of an intersection of preventive medicine and public health for women's health care at menopause. In referring to medicine of the late 20<sup>th</sup> century in this thesis I assume a modernist and positivist biomedical science. Any deviations from the positivist paradigm in this literature, for example postmodern interpretations of public health (cf. Bunton et.al., 1992, 1995; Petersen and Lupton, 1996), or standpoints that are expressly critical of medicine or medical constructions of menopause (cf. McKinlay, 1985; Rosenburg, 1993) are explicitly identified. Medical literature, therefore, is defined here as generalist medical, epidemiological and public health literature (cf. American Journal of Preventive Medicine, American Journal of Public Health, Australian and New Zealand Journal of Public Health, British Medical Journal, Epidemiology, Lancet, Medical Journal of Australia and New England Journal of Medicine,), and specialist medical and epidemiological literature regarding menopause and women's health (cf. American Journal of Obstetrics and Gynecology, European Journal of Obstetrics Gynecology, Maturitas, and Reproductive Biology, Journal of Women's Health,). By 'feminist' I refer in this thesis to academic and popular writing that maintains a focus on the structuring effects of gender on social and power relations. There are, however, many feminisms. In recent years a blurring of traditional distinctions between liberal, Marxist and radical feminisms has occurred as these theoretical positions develop and evolve. In this thesis I distinguish between modern and postmodern feminisms, regarding the epistemological and ontological differences between these broad theoretical positions as more adequately able to differentiate the arguments I consider here. Nevertheless I recognise and acknowledge limitations inherent in this dichotomy; there are indeed many modernisms and many postmodernisms. I also refer here to other critical writers, by which I mean authors and researchers whose work, though not necessarily identifying as feminist follows from, supports

or otherwise engages a critique of medicine's response to menopause made by feminists. Throughout this thesis I deliberately use the term 'hormone replacement therapy', not the acronym HRT, to highlight the reference to 'replacement' which represents one of the predominant constructions of menopause as a deficiency of hormones in the common term used to describe the drug.

Many authors trace the dominant contemporary medical constructions of menopause to the popular and popularising writings of Robert Wilson in the late 1960's. In critical feminist and sociological literature it is this man who is credited with the feminisation of menopause and its construction as an endocrine deficiency disease resulting in the end of femininity for women (Coney, 1993). Wilson is noted for his misogynist statements about the fate of the "untreated" menopausal woman. By engaging existing discourses of women's precarious physiological and psychological constitution, Wilson promised to protect women from what he described as the 'ravages' and 'vagaries', of the female body by providing '*Hormones from Puberty to the Grave*' (Wilson and Wilson, 1963). Wilson promised women that hormone therapy would be the 'elixir of youth', which would keep them '*Feminine Forever*' (Wilson, 1966). In this way, hormones defined femininity and, what have come to be known as symptoms of menopause became synonymous with symptoms of a lost femininity. Hormone replacement therapy, which had first been made available in commercial quantities some thirty years before Wilson was writing, became part of contemporary prescribing practices in the 1960's (Bell, 1987).

From Wilson's ((Wilson and Wilson, 1963; Wilson, 1966) attribution of a myriad of symptoms and the loss of femininity to menopause to contemporary associations of menopause with future disease, feminists (cf. Klein, 1992; Coney, 1993) have argued that the concept of menopause as an 'endocrine deficiency disease' has formed a key framework for medical practice and a rationale for the development and application of hormone replacement therapy. Feminist in the late 1980's and early 1990's criticised what they characterise as the dominant medical construction of menopause as a universal experience of women (cf. Bell, 1987; Greer, 1991; Coney, 1993). This is problematic, they say, because medical constructions are defined by a pathological understanding of menopause which produces representations of women as biologically weak and vulnerable, and draws on discourses of a femininity that emphasized popular ideals about beauty and youth and thereby devalues older women (cf. Bell, 1987; Greer, 1991; Coney, 1993). Moreover, they argue that this description of menopause as hormonal provides a scientific rationale for the mass prescription of hormone replacement therapy to potentially all women at menopause and beyond. In response to these medical constructions of menopause feminist critics have, therefore, directly engaged arguments in relation to the use of hormone replacement therapy.

Since the concept of symptoms of menopause was crucial in arguments about the universality of menopause, and since it was precisely the attribution of these so-called symptoms to an exclusively female condition which defined the post-menopausal woman as 'mad, bad and ugly', research demonstrating variability predominated. Epidemiologists such as McKinlay et al. (1987) demonstrated the diversity of women's experiences of menopausal symptoms across North America. Anthropologists demonstrated variation in the manifestations of



menopause in cross cultural studies of women at menopause (Beyene, 1986; Avis et al., 1993; Kaufert, 1996; Lock, 1998). Feminists, particularly nursing researchers using a phenomenological perspective, looked to the lived experience of women at menopause to describe this diversity. Sociologists described the relationship between the experiences of menopausal symptoms and social inequalities, particularly in relation to class and ethnicity.

The overarching argument about women's diverse experiences in these studies countered the dominant medical perspective that menopause was a monolithic physiological phenomenon which was invariably accompanied by devastating symptoms. While this research produced a critique of the medicalisation of menopause, privileged women's accounts of experience, and undermined the symptoms thesis, it risked denying the unpleasant experiences of a small number of women at menopause (cf. Daly, 1995, 1997). In demonstrating the sexist antecedents of medical conceptions of menopause and diversity of experience these feminists refute the logic and disrupt the link between loss of hormones, experience of symptoms and loss of femininity. Feminist authors pursued the agenda of the women's health movement calling for respect for women's autonomy, the provision of information and the right to choose. This key response to the medical construction of menopause is evident in the health information literature emanating from women's health and community health services in Australia, New Zealand, UK, and the US. throughout the 1990's.

Feminist criticisms have not gone unheeded in the medical literature. In the early 1990's a new, if tentative, collaboration between medicine and social scientists appears to have been

attempted. Arguing the poverty and narrow thinking of uni-disciplinary research Kaufert in 1990 called for multidisciplinary in menopause research. She argued that the study of menopause was a victim of disciplinary division so that anthropologists only saw cross cultural difference, clinicians only saw clinical samples and clinical solutions, etc. In 1990 the New York Academy of Science produced a volume of its 'Annals' entitled 'Multidisciplinary Perspectives on Menopause' (Flint et al, 1990), edited by Marcia Flint, an anthropologist, Friedi Kronenberg, a proponent of non-Western and complimentary therapies, and Wulf Utian, the clinician who founded the North American Menopause Association, was a founding member of the International Menopause Society and one of what Greer (1991: 439) describes as the 'Masters in Menopause'. In 1996 the World Health Organisation review of menopause research included in its expert team anthropologists, sociologists and feminists as well as epidemiologists and clinicians. While this collaboration occurred, however, feminists continued to criticise the medicalisation of menopause and clinicians continued to construct menopause as a medical concern (Klein and Dumble, 1994; MacLennan and Smith, 1995). Some aspects of this change, nevertheless, appeared evident at the International Congress on the Menopause in November 1996 (see also Kaufert and Lock, 1997). Instead of a feminist stereotype of a 1960's medical menopause in the advertising plastering the halls of the conference there were images of vital, active and attractive mid-life and older women. The intent of this advertising remained the promotion of hormone replacement therapy but the strategy for this promotion had changed from one portraying menopausal decline to a seemingly more positive image of the mid-life woman.

This intersection of feminist and medical work on menopause highlights the limited critique afforded by classical feminist descriptions of the medical menopause as exploitation by men, medicine, mass media and pharmaceutical companies (cf. Greer, 1991; Klein, 1992; Coney, 1993). These feminists, in criticising medicine's construction of women as weak and vulnerable, themselves construct women, who do not actively resist this medicine, as passive. Because these modernist feminist critiques conceive of knowledge as fixed their arguments coalesce around contests about the 'real' menopause. As a result the shifting focus of knowledge about menopause from constructions based on concepts of femininity to those based on the relationship of menopause to prevention of ill health is not brought into an explanation of menopause and health care at menopause. Rather, associations of menopause with chronic diseases are deployed as further examples of the exploitation of 'menopausal women': that this particular construction of menopause may have implications for contemporary medical practice is not considered outside the framework of 'exploitation'.

I argue that in the context of feminist critiques and the repositioning of menopause as a concern for preventive medicine questions are raised about the role of women, primary medical care practitioners and public health in decision making about health care at menopause.

## 1.2 The Studies

A review of medical and feminist literature demonstrates the shifting meanings and understandings of menopause. One of the key questions is how these shifts of knowledge play out in a practice. Poststructural examination of language, exemplified in the work of Foucault (Foucault 1972, 1979; Marin et al., 1988) and those influenced by his work, draws attention to language as the site wherein meanings and constructions of reality are produced. While many authors refer to discourses of femininity and medical science beginning in the 19<sup>th</sup> century, remodelled in the 1960's and recast in terms of preventive medicine in the 1980's there are few systematic studies of these discourses and their implications in mass media and none in the medical practice setting. This thesis examines the feminist and medical constructions of menopause in contemporary health care practice for women through an examination of the use of language to identify and analyse the ways in which general practitioners and mass media in this study use concepts to describe menopause. I discuss the implications of these for health care and public health for women at menopause and beyond. The analytic framework used in this thesis employs poststructural concepts including discourse and its constitution of object/subjects and technologies of power based on Foucault (Foucault, 1972; Martin et al, 1988). It begins from the premise outlined by Potter:

Reality enters into human practices by way of the categories and descriptions that are part of those practices. The world is not already categorised by God or nature in ways that we are all forced to accept. It is *constituted* in one way or another as people talk it, write it and argue it.

(1996: 98, emphasis in original)

I ask 'how is menopause constructed in general practice and mass media?' and 'what are the effects of these constructions?'

The thesis therefore presents the findings of three studies: two empirical studies and one theoretical study. Medicine and mass media are the focus of the empirical work because feminist critiques of 'the medicalisation of menopause' specifically identify these sites as central to constructions of menopause. Qualitative analysis of semi-structured interviews with nine general practitioners' working in rural South Australia and qualitative and quantitative analysis of 345 South Australian newspaper articles (1986-1998) are presented. In study 1, interviews with general practitioners, my analysis is attentive to the ways language creates structures (cf. Foucault, 1972; Martin et al., 1988; Parker, 1992) and produces sites of power relations (cf. Hepworth and Griffin, 1990; Hepworth, 1999). I therefore look to the language used by these general practitioners to elicit how women are positioned and how language is used in maintaining and reproducing existing structures and to inhibit or enable transformative practices. Study 2 is a systematic description of a large amount of mass media data. I use quantitative analysis to describe the breadth of content based on categories developed through an iterative and reflexive process that examined medical and feminist literature and incorporated understandings from Studies 1 and 2. The theoretical study, Study 3, emerges from a problematic identified in the empirical studies and takes the form of a postmodern critical analysis of Foucaultian conceptualisations of power relations and several approaches to ethics as they relate to women's decision-making at menopause. I use key concepts from

Hepworth (postmodern/feminist critical analysis), Foucault (governmentality, subjectivity, agency) and McNay (feminism and Foucault, agency) to examine the intersection of medical and feminist knowledge in the context of study 1 and study 2. In the methodology chapter I critically review those authors that I use and describe why and how I consider them important in relation to my work

### **1.3 Risk, Choice and Agency**

Women's 'choice', 'informed decision-making' and 'empowerment' are key ways in which menopause is described in the general practitioner interviews and newspaper articles. Analysis of general practice interviews demonstrates that, instead of resisting feminist criticisms, general practitioners in this study subsume and adapt the language of the women's health movement, particularly empowerment, choice and autonomy, and by adopting discourses of prevention in their construction of menopause and rationale for pharmacotherapy with what is commonly called hormone replacement therapy. Three discursive themes are evident in general practitioner accounts of menopause, these include: i) the hormonal menopause, ii) the informed menopausal woman, and iii) women as active decision-makers. Analysis of mass media presentations of menopause demonstrates the availability of a broad range of, sometimes contradictory, language about menopause. Five themes are evident in mass media presentations of menopause, these include: i) the hormonal menopause, ii) feminism and menopause, iii) alternative therapies for menopause, iv) menopause and femininity, and v) choice and decision-making. I describe a menopause produced by these mass media and general practice accounts in which a new subject position

is made available to women at menopause through the use of discourses drawn from health promotion and the women's health movement; a position that is defined by the concept of individual choice and autonomy.

Drawing from a postmodern critical analysis of power relations and ethics in relation to women's decision-making at menopause I argue that an 'ethic of autonomy' is constructed in media and general practitioner accounts and that an 'offer of choice' in relation to health care for women at menopause, far from being emancipatory, serves to intensify power relations. The singularity of choice as currently presented in medical care and bioethics to take or not to take hormone replacement therapy, is *required to be* a choice and is embedded in relations of power and knowledge that produce menopause in medical and popular discourse. While this new menopause is clearly far from unproblematic, I nevertheless argue that in the discursive shift towards women as active decision-makers there has evolved the potential for a reconceptualisation of health care practice for women at menopause by medicine. I argue that conceptions of agency informed by Abrams (1999) and McNay (2000) provide a framework for such a reconfiguration. 'Choice' based on agency is not an individual act of the woman pursuing her rights and using her will but is a choice predicated on an active engagement with the relations of power that hitherto were integral to the limitation of her choice to a decision to take or not take hormone replacement therapy. In such a reconfigured concept of women's decision-making hormone replacement therapy is not excluded but is no longer the only (or primary) issue around which choice is exercised.

#### **1.4 Implications of the Study**

The thesis concludes with a discussion of the implications of the findings of this study for health care practice for women at menopause and for public health more broadly. I argue that a reconfigured health care for women at menopause would see health care practitioners, public health researchers and policy makers actively engage with the multiplicity of menopause, negotiating health care beyond narrowly physiological parameters of traditional discursive constructions of menopause: it would see health policy regarding women's long term health take account of power relations, social inequalities and the social and discursive context of health. I posit the importance of considering the intersection of knowledge, contemporary power relations and practice settings; the importance of examining the location of decision-making in practice settings; and, propose that 'agency' is an important conceptual framework for such an examination.



## **Chapter 2: Literature Review: Menopause in Medical**

### **Literature**

#### **2.1 Introduction**

In this chapter I outline a history of medical responses to menopause from pre 20<sup>th</sup> century to the present as described in both feminist and medical literature. This history of medical responses forms an important background to understanding the precursors of contemporary medical literature and practice and the sources of critical responses to these literature and practices. In the first two sections dealing with pre and early 20<sup>th</sup> century medical concern with menopause I turn to feminist historians, for it is these historians who have taken an interest in this history.

#### **2.2 Pre - 20<sup>th</sup> Century Medical Explanations of Menopause**

The explanation of menopause as 'deficiency', be it moral, psychological or physiological, is a long-standing description. Feminist historians use medical evidence from the eighteenth and nineteenth centuries to illustrate how menopause was linked with descriptions of emotional instability in women.

Conceptions of menopause, as now, were firmly rooted in the explanatory systems of the day. Within an explanation described by humoral theories menstruation was the letting of a plethora or abundance of blood which if not discharged would accumulate and enter the brain causing madness. In this schema amenhorrea was the chief cause of women's illness and, by implication, menopause contributed to insanity (Formanek, 1990b). The standard treatment of amenhorrea (menopausal or otherwise) derived from humoral theory was blood letting through the use of leeches (Formanek, 1990b). The importance of amenhorrea to explanations of women's ill health has been identified since medieval accounts of women's health (Formanek, 1990b)

Smith Rosenberg (1985), Showalter (1987) and Formanek (1990a, 1990b) describe medical accounts that depict menopause in terms of a complex and volatile reproductive system of ovaries and uterus that control women's physiology, emotions and mental state, and dictate her social role. Symptoms and consequences of menopause described by 19<sup>th</sup> century physicians included dyspepsia, diarrhoea, severe vaginitis, rheumatic pains, scrofula, dropsy, collapsed breasts and emaciation (Smith Rosenberg, 1985; Formanek, 1990a).

*[N]ineteenth century physicians used menopause as an all purpose explanation for the heightened disease incidence of the older female; all of her ills were directly or indirectly diseases of the uterus and ovaries.*

(Smith Rosenberg, 1985:191)

Menopausal women were harshly discussed and treated with ridicule in, for example, W. Tyler Smith's recommendation for "injections of ice-water in the rectum, introduction of ice into the vagina and leeching of the labia and cervix" for "the erotic and nervous symptoms of menopause" (Showalter, 1987: 75). Additionally, women were advised to:

...withdraw from the excitements and fatigues of the gay world even in the midst of her legitimate successes, to enter that more tranquil era of her existence now at hand... Most American mothers can find at hand enough to do for their families...to absorb all their energies

(Taylor, 1872 cited in Smith Rosenberg, 1985: 192-93).

This constraining of women to the domestic world is reflective of non-medical attitudes towards menopause that developed in the context of social attitudes towards women and ageing. These largely negative attitudes come to us through the derogatory language developed to describe older women: hag, harridan, crone (Formanek, 1990a). In the 19<sup>th</sup> century these earlier ideas were elaborated in the context of a growing interest with women's health and the conviction that being female predisposed one to frailty; in the form of physical and mental ill health (Showalter, 1987; Formanek, 1990a). These explanations were part of a broader conceptualisation of women during the late nineteenth century in which physicians drew on a discourse of femininity that assumed a relationship between women's reproductive and nervous systems and which gave rise to conditions such as anorexia nervosa (Hepworth

and Griffin, 1990; Hepworth, 1999). The nineteenth century has been described as the "age of the womb" (Stage, 1979) and the "golden age of hysteria" (Showalter, 1987).

This nineteenth century view of women and of menopause did not go uncontested. Formanek (1990c) identifies a group of American women physicians who, in the late 19<sup>th</sup> century, worked with an understanding of menopause as a normal transition. Their writings, she says, are characterised by criticism of male gynaecologists and included the following concepts:

*(1) women are not merely the housing for the uterus and useful only in the role of mother; (2) even postmenopausal women can lead reproductive lives; (3) male physicians had overlooked the well and noted only the ill menopausal women; and (4) only some women suffered from menopausal symptoms, which differed vastly in type and severity.*

*(Formanek, 1990c: 418).*

For feminist scholars menopause was and is of interest not least because historically its medical management had horrific material effects for women. Occurring in the late 1980's and early 1990's these feminist histories must be seen in the context of widespread feminist critiques of a medicalisation of menopause; that is the construction of menopause as a medical problem. In contrast to medical descriptions feminist writing of this time aimed to demonstrate that menopause was a natural transition in a woman's life, discussed fully in Chapter 3. One key strategy in demonstrating the illegitimacy of the medical construction of

menopause was to demonstrate both the sexist antecedents of the medical view of menopause or the divergence of women's experience of menopause from the model presented in medicine. That this feminist history is part of a feminist political project, in this case a project of critique, does not diminish its usefulness in developing an understanding of the response of medicine to menopause; indeed it highlights the importance of social context in this development. Nonetheless, feminist accounts, as other accounts, cannot be taken *prima facie* as descriptive.

### **2.3 1930s - The Development of Sex Endocrinology**

The developing theory of sex endocrinology in the early twentieth century succeeded nineteenth century ideas about women's reproductive physiology providing an explanation of menopause in terms of hormonal functioning that would dominate throughout the century. Medical and feminists writers identify this period and the establishment of both a theory and technology for sex endocrinology as critical in the developing understandings and practices about menopause. Hormones came to be regarded as the defining feature of both femininity and masculinity (Oudshoorn, 1994). The first use of oestrogen (American spelling 'estrogen') to treat menopausal symptoms occurred in America in 1929 following the successful extraction of oestrogen in a pure form (Utian, 1990). The science of sex endocrinology underpinned new explanations of women's bodies, and as Bell (1987) argues, firmly established menopause as the domain of the medical practitioner.

In her historical analysis of the medical treatment of menopause Bell (1987) identifies the 1930's and 40's as a crucial period in the construction of a medical vocabulary to define menopause as a deficiency disease. Bell argues that a transformation of menopause from a normal phase of a woman's life and uneventful for most women to a physiological crisis was made possible through the conjunction of three influences. First, the development of a paradigm of sex endocrinology which enabled the explanation of menopause as the cessation of the production of oestrogen. Second, the development of diethylstilbestrone (DES) an exogenous oestrogen which was easy to produce and purify, was stable and effective, and therefore became a cheap and widely available product for prescription. The third influence, she argues, came about with the rise of laboratory science and its ambivalent reception by medical practitioners, particularly specialists. Advances in sex endocrinology and laboratory science offered doctors the possibility of systematising, standardising and improving their work, yet science could also diminish medicine's cultural authority by placing the importance for decision making and diagnosis in the laboratories and thereby potentially diminishing the value of clinical judgement. Bell argues that the conceptualisation of menopause as hormonal decline served to reinforce the authority of clinicians.

*In recommending that even talking to a physician could be therapeutic and that all women should seek medical advice, specialists were defining menopause as a medical problem - not just for some women but for all women...they argued that clinical judgement was a critical tool...Science could distinguish physiological causes from others, but only medicine could monitor the effects of hormone therapy in individuals and counsel fearful patients.*

(Bell, 1987: 540-41)

The interest of medical practitioners in menopause established in the 1930s with an explanatory system based on sex endocrinology and the availability of commercial quantities of hormones became entrenched in the 1960's largely, it is argued, through the work of one prominent gynaecologist, Robert Wilson (McCrea 1983; Bush, 1992; Coney, 1993).

#### **2.4 1960's - 'Feminine Forever'**

Medical (Utian, 1990, 1997; Bush, 1992) and feminist (MacPherson, 1981; McCrea, 1983; Coney, 1992, 1993; Hunt, 1994) commentators regarded Robert Wilson, working in the 1960s, as a key figure in the medical construction of menopause as a deficit of hormones which now resonates with contemporary practice. It is this gynaecologist who is credited with the feminisation of menopause and its construction as an endocrine deficiency disease resulting in the end of femininity for women (Coney, 1993). Wilson is noted for his misogynist statements about the fate of the "untreated" menopausal woman (Coney, 1993; Lewis, 1993,).

Through his journal articles and popular books Wilson was a strong proponent and an influential advocate of the long term use of oestrogens, promising women that hormone therapy would be the "elixir of youth", which would keep women "Feminine Forever" protecting them from the ravages and vagaries of the female body by providing "hormones from puberty to the grave" (Wilson and Wilson, 1963; Wilson, 1966). Wilson worked from a definition of menopause as an endocrine deficiency with the assumption drawn from sex endocrinology

that oestrogen is the defining feature of femininity. Within this explanatory framework the loss of oestrogen after menopause deprives women of their femaleness and results in a range of devastating symptoms.

*The menopausal woman is not normal; she suffers from a deficiency disease with serious sequelae and needs treatment.*

(Wilson et al, 1963, p110, cited in Utian, 1997, p3)

Utian, himself a gynaecologist and prominent medical writer on menopause, describes as "negative and largely unsubstantiated" the claims of medical writers, such as Wilson, of the 1960's (Utian, 1997).

Coney, a modernist feminist writing in 1993, turns to Wilson's writings to demonstrate the negative constructions of menopause in the 1960's that she determines are the sexist antecedents of medical practice in the 1990's. This perspective is discussed more fully in Chapter 3. In 1963 Wilson writes,

*The unpalatable truth must be faced that all postmenopausal women are castrates. There is a variation in degree but not in fact. Men do not live as long as the so-called weaker sex. However, they age, if free from serious disease, in a proportional manner. From a practical point of view, a man remains a man*



*until the very end. The situation with a woman is very different. Her ovaries become inadequate relatively early in life. She is the only mammal who cannot reproduce after middle age.*

Wilson and Wilson, 1963, cited in Coney 1993, p61)

and in his popular publication, *Feminine Forever*, in 1966,

*Once the veil is lifted, it is remarkable how quickly the previously uninitiated can detect these unfortunate woman - Our streets abound with them - walking stiffly in twos and threes, seeing little and observing less. It is not unusual to see an erect man of 75 vigorously striding along the golf course, but never a woman of this age... Before this moderately advanced age is reached, the more intelligent woman instinctively knows that her loss of physical attractiveness is out of proportion. She sees the marked skin changes, the disfiguring fat deposits, the atrophy of her breasts and the beginning disappearance of her external genitals. If married, an irritated or inadequate vagina may bring more unhappiness. All this has a profound effect upon her psyche.*

(Wilson, 1966, cited in Coney, 1993, p61-2)

For Wilson, women are essentially different to men. This difference is constructed by Wilson as ably demonstrated in the contrasting ways that women and men age. He explains these contrasts as being the result of complete ovarian failure. According to Wilson the menopausal woman is not only a tragedy for herself but is dangerous to her family and society. "There is

ample evidence that the course of history has been changed not only by the presence of estrogen but by its absence" (Wilson and Wilson, 1963). He comments further on "[t]he untold misery of alcoholism drug addiction, divorce and broken homes caused by these unstable, estrogen-starved women." (Wilson and Wilson, 1963). In this way Wilson establishes a case for the use of hormone replacement therapy. Advertisements of drug companies of the time promised of hormone replacement therapy: "It would alleviate those symptoms that bother him most" (Seaman and Seaman, 1977).

Wilson was not alone in representing women at menopause in a negative way.

*When a woman sees her womanly attributes disappearing before her eyes, she is bound to get a little depressed and irritable... Having outlived their ovaries, they may have outlived their usefulness as human beings... The remaining years may just be marking time until they follow their ovaries into oblivion.*

*(Reuben, 1969: 287)*

As Wilson did, Rubin draws upon existing discourses of femininity to describe a death not only of femininity but also of the woman herself. The implication clearly is that without her femininity and reproductive capacity the postmenopausal woman is barely human.

The important elements of Wilson's oestrogen narrative are, therefore: 1. oestrogen is the defining characteristic of femaleness, 2. menopause is female castration and therefore women are no longer women, 3. loss of oestrogen results in a plethora of symptoms, and 4, menopause is a mistake of nature, which has become apparent only with recent increases in life expectancy, and which should therefore be remedied. This narrative has the effect of reducing femaleness to the chemical constituents of a woman's body: a woman is her biology. While the more misogynist interpretations of this explanation of menopause have waned, it is a narrative that continues to resonate in medical literature throughout the 20<sup>th</sup> century in media and medical descriptions of menopause. Critical responses to the 'oestrogen narrative' are described in Chapter 3.

## **2.5 The Fall of Hormone Replacement Therapy and its Reinstatement**

Following reports of the association of hormone replacement therapy with increased rates of endometrial cancer in the *New England Journal of Medicine* in 1975 (Smith et al, 1975; Ziel and Finkle, 1975) the use of hormone replacement therapy declined dramatically. Two studies showed a marked increase in the incidence of endometrial cancer in women using oestrogen. Hormone therapy at this time was called Oestrogen replacement therapy (or ERT, estrogen replacement therapy, in America) reflecting the composition of the treatment regime as included a synthetic preparation of the hormone oestrogen only. The numbers of women using oestrogen dropped markedly (Bush, 1992; Coney, 1993). Bush (1992) and Coney (1993) suggest that the continued contemporary findings about associations between oral contraceptives smoking and increased stroke and myocardial infarction probably reinforced a

believe in the negative effects of oestrogen on women. This was the end of the first 'era' of hormone replacement therapy.

Sales of hormone replacement therapy remained restricted until the late-1980's. Feminist and medical literature present the same series of events as constituting the history of menopause treatment in the 1980's though these authors cite these events to proffer different interpretations of the history. Bush, an epidemiologist, and Coney, a feminist critic, are exemplars, though a number of medical and feminist authors cite the same history (cf. Utian, 1990, 1997; MacPherson, 1992; Lewis, 1993; Hunt, 1994).

For most of the 1980's hormone therapy was used only for women with severe menopausal symptoms: it was used conservatively employing as low a dose as possible (Bush, 1992; Coney, 1993). Towards the end of the decade, however, there was a resurgence in the promotion and use of hormone therapy. Three major trends lead to this revitalisation of the use of hormone replacement therapy (Bush, 1992; Coney, 1993). At the beginning of the decade studies began to indicate a protective effect of oestrogen on hip fractures and other bone breaks from osteoporosis. In the mid-1980's new studies begin to indicate a protective effect of oestrogen on hip fractures and other bone breaks from osteoporosis (Weiss et al., 1980); In the mid 1980's further studies suggested protective effects of oestrogen on cardiovascular disease (Bush *et al*, 1987). By the late 80's it had been found that the addition of synthetic progesterones to the therapy protected the endometrial lining of the uterus from cancer. With this change in the technology it was possible for the research findings to be

adopted in arguments for the use of hormone replacement therapy. Menopause began to be identified, in the medical literature, as a crucial point in a woman's life with regard to the onset of such preventable diseases as cardiovascular disease and osteoporosis. It was suggested that a reversal of the loss of hormones by long term, possibly life time, use of hormone replacement therapy could provide an opportunity to afford better health to women in their later years (Bush and Muller, 1987; Ernster et al, 1988; MacLennan, 1991; MacLennan et al, 1993).

Medical and feminist writers alike identify findings about disease prevention, and the change in the treatment regime to counter the effects of hormone replacement therapy on endometrial cancer, as a major impetus for the renewed enthusiasm for hormone replacement therapy (Bush, 1992; Coney, 1993). In the context of associations of menopause with chronic disease and changes in the technology, Bush, in her paper titled 'Feminine Forever Revisited' in 1992, expresses the argument for hormone replacement therapy as follows:

*Given that many women will live a third of their lives (from 50 to 85 years) in a state where (1) little endogenous estrogen is produced and (2) many tissues are estrogen-sensitive or estrogen dependent, this hormone may be needed to maintain an active and full life.*

(Bush, 1992, p. 3)

And,

*...for many [researchers and practitioners], the abundance and coherence of the data documenting the benefits of estrogen are leading to an affirmation of the old concept of feminine forever, or universal, long-term hormone therapy for postmenopausal women.*

(Bush, 1992, p. 1)

The establishment in the late 1980's of this foundational rationale for the use of hormone replacement therapy at menopause as a preventive therapy became entrenched in the early years of the 1990's. Enthusiasm for this addition to the preventative medical armamentarium is evident in much medical and epidemiological literature (cf. Utian, 1990; MacLennan, 1991; Bilezikian, 1994). Critical and feminist responses to this resurgence in the use of hormone replacement therapy were not as enthusiastic: these are discussed in Chapter 3.

## **2.6 1990's – Benefits and Risks, Prevention and Evidence**

### *2.6.1 Benefits and risks*

Although in the economic literature the dualism of 'benefits' and 'risks' are usually phrased as 'risks and benefits' in the medical literature about menopause in the 1990's it is the benefits

part of the equation that is given prominence: Hence the title of this section. Menopause came to be identified in medical literature as a crucial point in a woman's life because of the possible onset of preventable diseases. Publications in medical journals in the late 1980's and early 1990's, for example, *Medical Journal of Australia* (cf. MacLennan, 1991), *American Journal of Obstetrics and Gynaecology* (cf. Utian 1987), and *Journal of Women's Health* (cf. Bilezikian, 1994), focused on the key idea that a reversal of the loss of hormones by long term, possibly life time, use of hormone replacement therapy would provide an opportunity to afford better health to women in their later years. De-emphasising the symptoms rationale and adopting a rationale of prevention led to two uses of hormone replacement therapy from the early 1990s: symptoms and prevention of chronic disease. Treatment and prevention, in this way, merge. The 1990's history of menopause is, however, characterised by contradiction and disputes about the risks and benefits of hormone replacement therapy. With the rise of evidence based medicine and practice came the desire for 'evidence' to 'once and for all' establish the place of hormone replacement therapy. Benefits or risks of hormone replacement therapy, therefore, became the focus within medical and epidemiological discussions of menopause with critique and discussion of the evidence a nodal point. Indeed few discussions about menopause in the 1990's occurred without hormone replacement therapy as a focus. I outline below shifts in these discussions throughout the decade of the 1990's.

Prominent medical writers in the early 1990's consistently defined menopause as a disease state in need of therapy. Chronic diseases were co-constructed with menopause and interest in the correlation of menopause and chronic disease informed an increasing concern about

the opportunities for preventive medicine afforded by menopause. Menopause is described as a disease state that is the cause of other disease states and which can be rectified by the 're'introduction of hormones. Indeed this description becomes part of the definition of menopause. In 1990 Utian states:

*As a potential endocrinopathy, the climacteric deserves appropriate diagnostic recognition and selective preventive pharmacotherapy. The climacteric, one syndrome occurring over a period of time, has potentially lethal effects, notably coronary heart disease and complications of osteoporotic fractures."*

(Utian, 1990, p. 7)

With the definition of menopause as a marker for the prevention of certain diseases in women after menopause and through the suggested use of hormone replacement therapy to counteract these 'effects' of menopause, the 'oestrogen story' is revisited. With their roots in the ideas of Robert Wilson and David Rubins, in the medical literature's descriptions of menopause oestrogen is still the essential feature that defines women. Menopause is defined by the change in chemical composition of a woman's body and symptoms are the indicators of this change. Medical descriptions that assume menopause is essentially a physiological phenomenon, from which follows a range of symptoms and consequences which are universally experienced are carried into the 1990's by prominent gynaecologists (Utian, 1990; MacLennan, 1991, MacLennan and Smith 1995).



Authors such as MacLennan in Australia in the early 1990's present the use of hormone replacement therapy as a balancing act of risks and benefits. The prevailing view in the medical literature was that most women should take oestrogen for long periods because of the beneficial effects on many body functions (MacLennan, 1991, 1993). The consensus statement of the Australian Menopause Society published in the Medical Journal of Australia in 1991 is typical. It states:

*The risk benefit ratio and cost-benefit ratios are greatly in favour of most women considering taking long term hormone replacement therapy from an age at which oestrogen deficiency symptoms begin or menstrual periods stop.*

(MacLennan, 1991, p. 43)

The author, MacLennan, suggests three major benefits of long term hormone therapy: quality of life through the alleviation of the menopause symptoms experienced "by up to 80% of women...for many years" including "hot flushes, night sweats, sleeplessness, anxiety, depression, tiredness, loss of libido, dry vagina, uncomfortable intercourse and urinary frequency", prevention of osteoporosis and reduction in cardiovascular disease (MacLennan, 1991). Disadvantages are said to be few: cost of therapy and regular medical review. The risk of endometrial cancer is described as small but definite. The author reports controversy regarding the increased risk of breast cancer, suggesting most studies show no increased risk and that there are inconsistent associations of hormone replacement therapy and increased risk of breast cancer in a minority of studies. He associates one confirmed report of an

increased relative risk to older treatment regimes. Nevertheless he suggests contraindication in the case of women with existing oestrogen dependant tumours particularly (MacLennan, 1991).

## 2.6.2 *Evidence - critiques and concern*

### 2.6.2.1 Early 1990's

Critiques of evidence for the risks and benefits of hormone replacement therapy formed a key part of the consideration of menopause in medical literature in the 1990's and into the 21<sup>st</sup> century. Reviews by clinicians and epidemiologists the first half of the 1990s identified observational studies that suggest unopposed oestrogens reduce the risk of cardiovascular disease and fractures but increase the risk of endometrial and breast cancer (Rosenburg, 1993; Green and Bain, 1993; Mack, 1993; Colditz et al, 1995). Some authors (cf Falkeborg et al., 1992) suggested the addition of progesterone to the therapy largely negates the beneficial effects of the therapy on cardiovascular health; studies showing these benefits had been carried out on women taking oestrogen only. Doubts were also raised about the cause of the reportedly beneficial effects of exogenous oestrogens on disease prevention: Are the women taking oestrogen healthier to begin with? What preventive benefit is achieved by hormone therapy? These debates are as yet unresolved (Rosenburg, 1993; Green and Bain, 1993; Mack 1993; Colditz, 1995; Cutson and Meuleman, 2000). In 1995 results of the PEPI (Postmenopausal (o)Estrogen/Progesterone Intervention Trial, a time-limited randomised control trial of placebo, unopposed oestrogen and combined therapy) confirmed the negative

effects of unopposed therapy on the uterus and showed that combined therapy had a favourable effect on cardiovascular disease but not as marked as oestrogen-only( ie. a 50% reduction in risk) trial (Writing Group for PEPI,1995). The positive effects on osteoporosis continued to be confirmed. The limited duration of the trial leaves unanswered many questions about the long term effects of hormone replacement therapy.

The risk of breast cancer has been a key concern in medical and other literature about menopause and hormone replacement therapy in the 1990s. Studies have varied widely in their findings and at the time of writing there is still no agreement about the effects of hormone therapy on the risk for breast cancer. In July 1995 the New England Journal of Medicine published result of the Nurses Health study which reinforced the concerns about the increased risk of breast cancer, particularly after eight years. A paper appearing in the Medical Journal of Australia in November 1995 refuted these findings because of "[t]he many weaknesses and differences in the current observational studies"; ie. cohort studies(MacLennan and Smith, 1995: 484). Significantly, the authors accept the positive findings of these same studies in relation to the cardio-protective effects of hormone therapy. Is this an example of Rosenberg's observation of "the tendency of some clinicians to count as real the benefits of hormone therapy but to discount the potential risks" (Rosenburg 1993: 1672).

Epidemiological reviews highlight the potential biases in cohort studies that show postmenopausal oestrogens to be cardio-protective. Vandenbrouche (1995) identifies five

problems raised in relation to the 'healthy survivor effect', which may result in the selective exclusion of those women with a higher risk for cardiovascular disease from hormone therapy or from the study. Much of the evidence demonstrating beneficial effect of estrogens on cardiovascular disease, for example, have accrued during the years that estrogens were preferentially withheld from women with cardiovascular risk factors (Vandenbrouche, 1995). In analysis, many of the studies adjust for cardiovascular risk, sometimes by removing from the analysis people with overt disease (Vandenbrouche, 1995). Predictors for uptake of hormone therapy have been shown to include higher education and higher socio-economic status, factors which themselves predict an overall healthier outcome (Vandenbrouche, 1995). Studies have demonstrated the operation of this healthy cohort effect in almost all the cohort studies which showed a cardio-protective effect from oestrogens (Posthuma, 1995). A re-analysis of one study shows the selective removal from the cohort of women who became ill (Sturgeon, 1995). Other studies identify a 'compliance bias' in which the effect of continuing adherence to a treatment regime, even if placebo, may be of the same order as the effect of the oestrogen itself (Pettiti, 1995).

A further problem with research reported in much medical literature as evidence for the benefits of hormone replacement therapy is the continuing use of mortality rather than morbidity rates when discussing the risk of breast cancer from postmenopausal oestrogen use. In general, the mortality of women who have breast cancer who also use hormones may be decreased because of their greater use of mammography services which can detect early cancers. 'No increased mortality from breast cancer due to hormone therapy' may be a

meaningless finding in relation to the effect of hormone therapy on incidence of the disease and the subsequent effects on the lives of women diagnosed with breast cancer.

Despite the continuing findings of protection from loss of bone density concerns have been raised about interpretation of this finding. Wark (1993) is concerned to include in the interpretation of the effects of hormone therapy, a consideration of the relative importance of the many factors which contribute to osteoporosis; including, low body weight, low levels of physical activity, impaired vision and the use of long acting benzodiazepines. He is concerned also about the extrapolation of the findings of protection against bone loss for current users, suggesting that there may be no protective effect on osteoporosis in women over the age of 75 who have a past history of oestrogen use. Observing the complex patterns of use of hormone therapy (women may start stop and start hormone therapy again many times) Kaufert (1990) expresses concern about the effects of this on bone loss. She identifies the inability of the randomised control trials (where participants are assumed and expected to be homogeneous, passive and compliant) to account for outcomes of the real-life variations in the use of hormone therapy identified in studies of women in North America and Canada.

#### 2.6.2.1 Late 1990's, early 2000's

Epidemiological reviews in the late 1990's and into the 2000's have continued to be divided on the efficacy of hormone replacement therapy in preventing long term illness. Concerns have especially been centred around the effects of oestrogens on increasing breast cancer rates. Grodstein et. al. (1997) raise doubts about the capacity of hormone therapy to produce

a substantial net health benefit in the long term. Their study demonstrates that the protective effects of hormone replacement therapy were lost after discontinuation of use and that the protective effects of hormone replacement therapy were attenuated with long duration of use as a result of the 43% increase of breast cancers among women who had used hormone therapy for ten years or more (Grodstein et al., 1997). Moerman et al (2000) demonstrated in a study of Dutch women that a woman of the general population who starts hormone therapy at age 55 for 10 years can prolong her life by 1 month and may postpone the occurrence of first incidence of one of the diseases under consideration by 2.4 months. Findings of the Heart and Estrogen/Progestin Replacement Study (HERS), one of the few randomised controlled trial for which results are currently available of the effect of combined hormone therapy on cardiovascular disease to date, demonstrates an increase in cardiovascular events in the first year of hormone replacement therapy use in those women who have existing heart disease (Hulley et al., 1998; Hulley, 2000; Grady et.al., 2000) and no effect on stroke incidence (Simon et al., 2001). Randomised control trials (RCT) of combined hormone therapy have to date been of short duration. As the claims to efficacy in prevention rely on long term use of hormone replacement therapy long terms RCTs are required to establish an evidence base. Such trials have been called for in medical and epidemiological literature for at least a decade (cf. MacLennan, 1991,1993; Bush, 1992). The results of long term RCTs of hormone replacement therapy for the primary prevention of cardiovascular disease, that is in women with no previous disease, will not be available for ten to twenty years; the Women's Health Initiative (WHI) in the United States and the Women's International Study of long Duration Oestrogen after Menopause (WISDOM) in the UK, Australia and New Zealand

(Vickers, 1999; MacLennan, 2000). Questions and uncertainty, therefore, remain about the effects of hormone therapy.

### 2.6.3 *Prevention and Preventive Medicine*

The importance of symptoms in building the case for the association of menopause and the postmenopausal lack of hormones became less crucial, however, when new associations of the lack of hormones with a range of illnesses began to be used. Indeed the association of menopause and prevention of illness with oestrogen therapy had been suggested in the medical literature since at least 1966 (Davis et al, 1966) but only became popularly asserted as a truth about menopause from the mid-1980's onward. As described above it has been argued that the prescription of hormone replacement therapy for chronic disease prevention became possible with a change in the technology (the addition of progesterone to the treatment regime). I argue that in addition a necessary condition of the renewed use of hormone replacement therapy was the developing discourse of prevention (cf. Rose, 1992) and the increased cultural value being placed on health and healthy lifestyles in the 1980's (Bunton et al, 1995; Petersen and Lupton, 1996). The strategy for the preventive use of hormone replacement therapy has increasingly been drawn from health promotion, following 'The Ottawa Charter' (WHO, 1986) which itself drew on developments in the women's health movement, primary health care and community development in developing countries in the 1970's and 1980's (cf. Boston Women's Health Collective, 1978; Declaration of Alma Ata, WHO, 1978). The association of heart disease and osteoporosis with menopause in the 1980's has been supplemented by assertion of associations of menopause with dementia

(Birge, 1996; LeBlanc et al, 2001), Alzheimer's disease (Tang et al, 1996; Silva et al, 2001), urogenital problems (Samsioe, 1996; Willhite and O'Connell, 2001) and bowel cancer (Newcomb, 1999; Prihartono et al, 2000) in the 1990's and early 2000's.

This medical interest in the relationship of menopause to the risk of heart disease and osteoporosis and to the preventive capacities of hormone replacement therapy becomes increasingly evident from the mid 1990's. Included in this interest is consideration of the public health implications of menopause.

*Two of the most important disorders of women as they age beyond their menopausal years are cardiovascular disease and osteoporosis. Not only do these two events carry with them a certain mortality (33%), but they are associated with untold morbidity and an enormous health bill for this country. It is reasonable to expect that the postmenopausal loss of estrogens is in large part responsible for these complications and that replacement therapy with estrogens might significantly reduce the incidence of cardiovascular disease among postmenopausal women. Estrogen is also beneficial for women who suffer with the vasomotor instability of the menopause (hot flushes), and is believed to improve skin quality, mood and mental function.*

(Bilezikian, 1994: 275)

While the promotion of hormone therapy to restore femininity does not appear as blatantly as in Wilson's texts, evidence of a discourse of femininity is present, for example, in Bilezikian's



description of the effects of menopause on 'skin quality, mood and mental function'. The medical menopause, in part constructed through the discourse of femininity, is reconfigured during the late eighties through a shift towards a discourse of prevention, and later, a discourse of health promotion. In this way preventable diseases such as coronary heart disease and osteoporosis are introduced as major public health concerns. The significance of preventing these diseases is highlighted using morbidity and mortality statistics and their potential fiscal burden, that permeate the boundary of the medical menopause. Interest in the correlation of menopause with chronic disease has informed an increasing concern about the opportunities for preventive medicine afforded by menopause.

By the definition of menopause as a marker for the prevention of certain diseases in women after menopause and through the extensive concern about the use of hormone therapy to counteract these effects of menopause, the 'oestrogen narrative' is revisited. Oestrogen is still the essential feature that defines women and their health, symptoms are indicators of this and menopause is defined by the change in chemical composition of a woman's body. Menopause is oestrogen. The development of the preventive model of menopause and hormone replacement therapy thereby paralleled developments in the fields of health promotion and preventive medicine.

Given the association of menopause with an array of diseases menopause itself no longer needs to be defined as an illness, it has become sufficient for it to be the cause of other illnesses for it to come under the medical gaze. Utian, noted above for including in the

definition of menopause the construction of menopause as a disease, "an endocrinopathy" (Utian, 1990), in a keynote address to the International Menopause Congress in 1996 substantially revises this position by referring to menopause as a natural transition.

*Today we recognize menopause to be a time of normal physiological change often coinciding with a changing family- or work-environment. The menopause transition is extremely variable within and across cultures. The complexity of hormonal, psycho-sociocultural and aging factors produces a varied symptomatology and long-term health outcomes.*

(Utian, 1997, p 5.)

By calling menopause a normal physiological event and by using the term 'transition' Utian would appear to acknowledge criticisms made by feminist authors (discussed in Chapter 3) in describing menopause as a 'normal' change rather than a deficiency disease. In addition he recognises the anthropological research (discussed in Chapter 3) by acknowledging cross-cultural differences in the experience of menopause. Neither these references to the critiques of menopause nor an acknowledgement of the complexity of menopause, however, changes the fundamental association made here between menopause and its presumed physiological nature. Utian goes on to argue that "the new paradigm for health care is the 'preventive model'" and that "only a systematic process of screening and preventive care programs can spare our institutions and societies from an escalating financial and social burden" (Utian, 1997: 6). It is in this context that Utian elaborates the relationship between menopause,

associations of menopause with elevated chronic disease incidence and preventive medicine, thereby resolutely maintaining menopause as a physiological and hormone dependent phenomenon requiring preventive medical intervention and raising menopause as "a matter for public health policy" (Utian, 1997, p 7). It would appear that menopause by escaping the definition of a deficiency disease has become more entrenched as a medical concern through preventive medicine.

*Given that menopause is a clear event in the human life cycle, we have here a fortunate alarm system for the individual to become involved in a preventive health program for the rest of her life.*

(Utian, 1997, p7)

Despite not using the 'femininity' or the 'disease' rationale menopause remains for women a time of medical surveillance and treatment. The value adopted here is not one of femininity but one of health.

Preventive health care is often accompanied by considerations of health education and decision-making (cf. Health education and health promotion texts such as Wass (1994) and O'Connor and Parker (1997). With a shift from the deficiency disease categorisation of menopause towards menopause as a marker for disease prevention it might be expected that consideration of women's decision-making becomes possible in medical literature. Numerous

generalist articles about menopause in medical literature in the late 1980's and early 1990's begin with the proposition that a decision about menopause is one to be taken by women themselves (cf. MacLennan, 1993; Petitti, 1995). However, mention of the choice about hormone replacement therapy belonging to the woman herself is evident in much earlier medical literature. How this choice is used in the language of these articles is of interest because the issue of choice was crucial in feminist and women's health critiques of menopause (discussed in Chapter 3). Having identified as part of an introductory or concluding statement that an 'informed choice' about hormone replacement therapy should be made by women, articles in the early 1990's primarily discuss risks and benefits of hormone replacement therapy, life expectancy and morbidity, therapeutic options and issues of patient compliance: the practice of choice and decision-making is not discussed. Compliance is identified by MacLennan as dependent upon "adequate initial education, the elimination of misinformation and myths, early titration of therapy (adjustment of therapy) and easy access to advice early in therapy" (1993, p43). By the mid-late 1990's articles in professional and academic medical journals constructed a triadic argument about menopause and decision-making: menopause is a marker for prevention; hormone replacement therapy, the key preventive pharmaceutical brings with it both risks and benefits; women must make an 'informed decision', with the assistance of her medical practitioner and based on an assessment of her personal risk profile. Utian's goal for preventive medicine encapsulates the ideal of this approach, which he likens to the importance of the introduction of prenatal care to medical childbirth practices.

*Achievement of the dream of widescale introduction of preventive health-care*

*services to a properly informed public is certain to be successful in reducing morbidity to older women, as was the introduction years ago of proper prenatal care in reducing death and disability related to childbirth.*

(Utian, 1997, p9)

In this context questions remain about what is meant by 'choice'.

At the beginning of the 21<sup>st</sup> century medical constructions of menopause as disease characterised by hormonal deficiency are no longer relevant. Menopause is firmly classified as normal transition, albeit a hormonal one. In an editorial in the medical journal *Maturitas*, the premier menopause journal, Speroff (2000) argues that it is time to stop using the term 'replacement' in describing hormones used for therapy. He argues that the term hormone replacement therapy perpetuates the notion that the drug replaces something that is missing or that it restores to reproductive levels the hormone balance in a woman's body and that this is linked, wrongly, to the assertions that menopause is an oestrogen deficiency disease. Since menopause cannot be classed as a disease he argues that it is dishonest to continue with suggests of 'replacement'. Speroff goes further to argue that there are few gender differences in those symptoms previously attributed to menopause (for example, fatigue, nervousness, headaches, insomnia, depression, irritability, joint and muscle pain, dizziness and palpitations) and given as evidence of menopause as a peculiarly female phenomenon and therefore associated with femininity; or lack of femininity, in Wilson's 'oestrogen narrative'. This is clearly a very different position to that held by Wilson in the 1960's and

MacLennan, Utian and others in the late 1980's and early 1990's. This position does not however disrupt the link between menopause and prevention. Speroff argues that clinicians adherence to concepts of menopause as disease may negatively influence women's health care decisions because of the disjuncture between clinician and patient beliefs.

The proponents of the 'menopause is a disease' concept argue that this approach yields better motivation and continuation...I challenge that argument.

Postmenopausal hormone therapy is a preventive health care decision. It is a decision to undergo daily long-term treatment in order to gain the long-term benefits at a time when an individual is feeling well and in good health. To make such a strong, long-term decision when the clinician insists an estrogen deficiency disease is present, when the patient herself (as the longitudinal data tell us) believes menopause is a normal physiological event, viewed without negative connotations, is very difficult because of the inherent conflict between the clinician's and the patient's views on menopause.

(Speroff, 2000, p.2)

This key objection to the conception of 'menopause as disease' and its influence on women's decision-making is presented in terms of its potential effects on therapy continuance (previously called compliance in medical literature). Presented with this argument is a role for clinicians as educator to assist women's decisions.

A wilful, strong preventive health-care decision must originate from an understanding derived from education regarding physiology and health. A clinician who provides

such education and who promotes hormone therapy as preventive pharmacologic therapy will help patients generate lasting and firm preventive healthcare decisions. I believe this approach and attitude will ultimately yield better continuation rates with hormone therapy.

(Speroff, 2000, p.3)

Hormone 'replacement' therapy is thereby more firmly entrenched as a preventive pharmacotherapy by the differentiation of menopause as disease to menopause as a marker for prevention of disease.

The question therefore raised by changes in the construction of menopause in medical literature must be 'what are the implications for medical practice?' Does the shift in medical constructions of menopause, for example from conceptions of menopause as a disease to menopause as a natural transition, fundamentally change medical practice or power relations between medical practitioners and women? This question is taken up in the examination of interviews with general practitioners in Chapter 6.

## **2.7 Conclusion**

Meanings and descriptions of menopause have shifted focus over the past century and a half, more particularly the past sixty years has seen a shift from hormone decline and its relation to

femininity and symptoms of menopause in the 1960's to the possibility for preventive medicine afforded by the occurrence of menopause in women's middle years.

Shifts in descriptions of menopause, treatment and prevention are evident in medical literature about menopause. These shifts do not occur in isolation. They are not the product of the linear progress of scientific knowledge achieved by strict adherence to scientific methodology posited by positivist science (Latour and Woolgar, 1986; Harding, 1991), neither are the gestalt-like revolutions in knowledge of Kuhn's (1970) paradigm shifts. These rather take the form of intersections of knowledge. Development in medical, feminist, anthropological, epidemiological, sociological, postmodern description and argumentation about menopause do not only occur within disciplinary or epistemological boundaries, rather they reflect and influence the direction of each.

I propose that medicine is not a static field in its construction of menopause. It has changed, not least by its engagement (positively or negatively) with critique from both within (epidemiological) and without (feminist and social sciences). Key aspects of a 'medical menopause' nevertheless remain constant: menopause is a loss of hormones that results in predictable effects and risks and may be ameliorated by hormone replacement therapy. A key question emerges therefore about how shifts in knowledge play out in the practice context. 'How and to what effect have medical practitioners and practices engaged with and responded to critiques of the medical menopause.



I have referred above to feminist writing about the history of medicine and menopause. These writings have been important in understanding the backdrop and the emerging constructions and explanations of menopause in western medicine. Equally feminist and other authors are central to understanding the critiques and objections to medical constructions. It is therefore important to examine feminist responses to medical constructions of menopause. I take up a discussion of feminist critiques of these in Chapter 3.

## **Chapter 3: Feminist and other critical responses to medical constructions of menopause**

### **3.1 Introduction**

This chapter reviews critical, predominantly feminist, literature about menopause. As responses to the medical approach to menopause have formed a key framework for feminist discussions of menopause this chapter tracks the shifting arguments that have been deployed in these feminist critiques. As a consequence of this focus on medical approaches to menopause feminist literature is predominantly centred around two key concepts; 1) competing versions or meanings of menopause, and 2) debates and controversies related to the use of hormone replacement therapy in menopause. With the exception of anthropological studies of menopause the vast majority of studies and discussions of menopause in the feminist literature presume a Western woman and a western audience. A notable exception is a study of the construction of menopause in Thailand by Punyahotra and Street (1998) which highlights the problems of imposing Western medical constructions. Even in the case of anthropological studies these are often used to demonstrate some point in relation to menopause in the West, for example in the demonstration of diversity in the experience of menopausal symptoms. This gap is clearly problematic when it is accompanied by an assumption of universality. As my study examines medical practice and mass media in Western context, however, further discussion of this omission in the literature is beyond the scope of this thesis.

## 3.2 Modernist Feminist Critiques

### 3.2.1 *The Critique of 'Symptoms'*

One key premise in the medical rationale that all women could take hormone replacement therapy was the presumption that because all women would eventually experience menopause the medically defined symptoms of menopause, which included physiological, psychological and social categories, would equally be experienced by all. In response to this medical construction of menopause, described in Chapter 2 and referred to as the 'medical menopause', feminists raised a number of criticisms that centred around objections to the medical construction of menopause as a disease and the deployment of negative constructions of femininity. Two major concerns therefore become dominant in the feminist and critical literature during the 1980's and into the 1990's: a critique of the concept of menopausal symptoms as definitive of the menopausal experience and a description of the use and promotion of hormone replacement therapy as exploitative and unethical.

Avis et al suggest

*"It is commonly assumed that, because menopause is a physiologically observable or measurable event in humans, [that] the signs or 'symptoms' surrounding this event are also ubiquitous in the human female. It is assumed that menopause is inevitably accompanied (to a greater or lesser extent) by hot*

*flushes, sweats, prolonged menstrual irregularities, vaginal dryness and a host of other 'symptoms' including depression, irritability, weight gain, insomnia and dizziness. "*

(Avis et al, 1993: 17)

These assumptions they say "become perpetuated with the use of menopausal checklists that ask women retrospectively to report symptoms they experience during menopause" (Avis et al., 1993: 17). They also argue that research on the menopause which comes mainly from Western cultures customarily creates models of the menopausal process based on concepts of the body and its symptoms which are part of Western Medical thought. Kaufert, a sociologist who has long been involved in the study of menopause, sees as problematic the 'working' definition of menopause as the cessation of menses. She suggests that "there is a disjuncture between the concept of menopause as a biological marker, a stage in the ageing of a woman's body and the definition of menopause as twelve months without menses." and that through this definition we have come to "equate menopause not with ageing but with the absence of functioning ovaries" (Kaufert, 1990: 116).

The medical description of menopause assumes that menopause is essentially a physiological phenomenon and that the consequences associated with it are, therefore, universal. Kaufert uses this premise as the basis for her argument, which seeks to undermine the authenticity of the findings from clinical research.

*...clinical researchers work from the assumption that their models of the body and its functioning are universal rather than time-and culture-bound. This partly explains why clinical researchers believe that valid generalisation can be made from their work with small select groups of clinic patients to the universe of menopausal women. This also explains why medical descriptions of the menopausal woman look suspiciously like a white middle-class patient at a menopause clinic.*

(Kaufert, 1990: 115)

The feminist reading described by Avis et al. (1993) and Kaufert (1990) is evident in medical literature: Much as a strong reading of biological determinism posits that genetic make-up determines physiological and psychological make up, dominant medical description of menopause identified hormones as the determinants of women's physiological and psychological health, and well-being (cf. Studd, J, 1997; Greendale, G, 1999; McNagny, 1999). In this way medical descriptions of menopause become all encompassing through the implicit reference to all women at menopause and beyond. Since all women will eventually cease to menstruate, establishing hormones as the cause of menopause enabled medical researchers and practitioners to propose not only that menopause was universal but that those effects associated with hormones or their loss at menopause were universal also. As demonstrated in Chapter 2 the effects associated with a loss of hormones at menopause have changed over time. Arguing from the premise that menopause is universal, maintains each of these changes in descriptions of menopause and its effects. For example 'post-

menopausal' women are increasingly regarded as being 'at risk' throughout their lives from the loss of hormones (cf. Greendale et. al., 1999).

### 3.2.2 *Cross Cultural Studies*

Anthropologists writing about menopause in the mid-1980's were much concerned with the differences that existed across cultures in the experience of menopause. Feminist historians identified that as early last century cultural differences in the experience of menopause have been noted (cf. Formanek, 1990a). Tilt in 1857 and Currier in 1897 recorded differences between North American women of 'high breeding' and native American Indian women; Currier noted that menopause appeared uneventful for most women (cited in Lock, 1993: 310-314). A body of anthropological literature dating back to 1974 which looks at the experience and meanings of menopause in a variety of cultures demonstrates the complicated interactions of culture and biology in constituting women's experiences of menopause (Flint, 1974; Goodman, 1977; Moore, 1981). Ethnographic studies identified a lack of physiological symptoms, such as hot flashes, in some cultures (Davis, 1986; Beyene, 1986; Lock, 1986). The purpose of these studies was to demonstrate that the meaning of menopause is shaped by culture and subject to a wide degree of interpretation. The overarching thesis of these studies is that where the years of reproduction for women are characterised by seclusion, the transition to menopause may represent a freedom that is not available to women who menstruate. Moreover, that in those cultures where the transition from reproduction leads to greater involvement in the political and social life of the

community, and consequently greater personal status and power, the 'symptomology' of menopause does not exist. This is used to support the argument that menopause as described in the West by medical writers does not exist.

In a comparative study of Japan and North America Lock (1993) questions the assumption that hormonal changes associated with female mid-life are universal facts upon which a culture weaves its tapestry. She argues that

*...differing accounts about biological ageing are not simply the result of culturally shaped interpretations of a universal physical experience but the products ... of an ongoing dialectic between biology and culture in which both are contingent.*

(Lock, 1993: xxi)

Lock takes as her starting point the lived experience of women in Japan and their relation to the social and political order the late 20th century Japan. From this vantage point, she argues that it is possible to demonstrate, the way female middle age is completely subsumed by the end of menstruation and its supposed consequences (Lock, 1993). Beyene (1986), exploring variations in the perception and experience of menopause cross culturally, called for explanations beyond social and cultural factors alone for the lack of physiological symptoms such as hot flashes. Beyene considers menopause a biocultural experience suggesting therefore that research on menopause should consider such factors as environment, diet,

fertility patterns and genetic difference which may be involved in the variations of menopausal experience. She asserts that the relationship between the biophysical and the social has been obscured by "the tendency of Western biomedicine to conceive and define menopause as a disease episode rather than a natural process" (Beyene, 1986: 47).

Davis (1986) challenges the thesis that role stability and status gain have an effect on the experience of menopause in non-Western societies. She suggests that the analysis of cross cultural data often reflects white middle class Western values, in particular the assumption that participation in male activities is a universal measure of status gain for women.

*In fact, women in some societies do not necessarily consider male activities to be superior to female roles.*

*(Davis, 1986: 49).*

Beyene (1986) identifies in the work of feminist authors a challenge to the legitimacy of the disease model of menopause. She identifies the key objection in that

*...menstrual and menopausal myths are a form of social control, through which the health care system in Western cultures legitimates sexism and ageism under the disguise of science.*

*(Beyene, 1986: 48)*



Beyene (1986) states that menopause is not an event that limits women's psychological or physical capabilities, but a natural part of ageing. She places herself with researchers who question the universality of the consequences claimed for menopause suggesting the events of menopause are natural and in most cases need no medical intervention.

Lock (1993) and Lock and Kaufert (2001) developed the concept of 'local biologies' to reflect local social and biological differences. Using research in Japan, Canada, and the United States they

*challenge the notion of a universal menopause by showing that both the symptoms reported at menopause and the post-menopause disease profiles vary from one study population to the next. For most of the symptoms commonly associated with menopause in the medical literature, rates are much lower for Japanese women than for women in the United States and Canada, although they are comparable to rates reported from studies in Thailand and China. Mortality and morbidity data from these same societies are used to show that post-menopausal women are also not equally at risk for heart disease, breast cancer, or osteoporosis.*

*(Lock and Kaufert, 2001: 494)*

Lock and Kaufert (Lock, 1993; Lock and Kaufert 2001), drawing from feminist critiques and anthropological research about menopause also examine the situation for women in Western countries.

### 3.2.3 *The experience of Menopause*

Countering the pronouncements of some medical writers that suggest that at menopause all women suffer immeasurably and needlessly, epidemiologist McKinlay, in collaboration with anthropologists Kaufert and Lock, undertook surveys of women's experience in Canada and the North America and later compared these with surveys and qualitative research by Lock in Japan. These studies counter the assertion that most women will experience problems during menopause (McKinlay, et al. 1987; McKinlay and McKinlay, 1989). Cross sectional survey research which took into account biological, demographic and psychosocial variables indicated that women going through a normal menopause (not surgical or early) who experience considerable distress are frequently women who have had poor health status throughout their life (McKinlay, et al. 1987; McKinlay and McKinlay, 1989). Some 30-40% of peri-menopausal and menopausal women reported short term effects on health while the vast majority of middle aged women did not express regret at reaching menopause, did not report poorer health status and did not evidence increased use of medical services. A number of cross sectional mail surveys (Holte and Mikkelsen, 1991; Kaufert and McKinlay, 1985; Kaufert and Gilbert, 1986; Frey 1981) have explored the experiences of women during menopause demonstrating that the 'symptoms' of menopause were not inevitable.

Qualitative studies of women's experience of menopause in the West show this experience and the meanings associated with menopause to be intimately tied to women's experiences and feelings about life in general. Women's experiences do not simply reflect the dominant

medical or feminist images of menopause, rather they are an interplay of social context, discourses of menopause and experience (Daly, 1997; Richards et al, 1997; Rothfield, 1997). Women's lives in their middle years do not equate with their experience of menopause and women's health at mid-life is more than menopause (Murtagh, 1996).

Jones (1994) argues that "a culture's conception of gendered bodies is determined more by social constructions than by the nature of reality, and as such reflects a specific historical, social and political context" (p. 43). In this context she looks to the experience of women defined through interviews with 17 white middle-class North American women. Jones (1994) found that medical practitioners were women's major source of knowledge, though the information derived from this source was regarded as inadequate. Many of the women in her study looked to popular literature, including that produced by authors from a feminist and/or women's health movement perspective. Women identified that in all other aspects of their lives they considered themselves well-informed and knowledgeable but they felt less assured about their knowledge and access to information about menopause. Fox-Young et al (1995) found that women were concerned about lack of reliable, accessible and current information on menopause and they identified the need to foster more open discussion with their doctors and to develop more equal partnerships with them. Likewise, McVeigh (1996) found that women were frustrated by the lack of availability of accurate and up-to-date information, many women found their concerns about menopause were trivialised by their medical practitioners, they wanted to be active in health promotion and wanted to be more involved in the decision-making process when consulting health care professionals. Mansfield and Voda (1997)

reported that midlife women continue to feel marginalised by a health care system that is unresponsive to their needs for current information about the perimenopausal experience and for egalitarian, women-centered care. Typical of the solutions offered in response to women's stated need for information, Jones (1994) proposed that it is the responsibility of health care professionals, in her case social workers, to provide or direct women to resources about health that include:

*(1) basic physiological information if necessary; (2) the different health options which are available including the strengths and limitations of each; and (3) to assist them ... to make informed choices that take into account their own particular situation.*

(p. 62)

Together these studies describe emerging themes in relation to women's responses to menopause and identify that there exist a range and diversity of women's experience of menopause.

#### 3.2.4 *Menopause as Exploitation*

The key critique of menopause as exploitation is directed to the medicalisation of menopause, that is the construction of menopause as a disease, and the portrayal of the menopausal woman in predominantly negative terms.

As early as 1983, McCrae identified a dichotomy between medical and feminist authors:

*The male-dominated medical profession was accused of reflecting and perpetuating the social ideology of women as sex objects and reproductive organs. Treating women with dangerous drugs was defined as exploitation and an insidious form of social control.*

(1983: 111)

McCrae (1983) identified a feminist-medical struggle over the collective meaning of menopause, including critique of Wilson's book *Feminine Forever* (1966) from the early 1970's, with feminists attempting to show menopause as a natural part of ageing that does not limit women's physiological or psychological capacities and countering a view of medical practitioners of menopause as "either 'all in the head' or the result of a deficiency disease to be treated with tranquilizers or hormones" (McCrae, 1983: 119).

From within a framework that acknowledges this feminist construction and considers definitions of health and illness "inherently political" McCrae (1983) defines the medical menopause as having developed from medical definitions of menopause in the 19<sup>th</sup> century as a sign of sin and decay, in the early 20<sup>th</sup> century, through Freudian concepts, as neurosis, and, with the development of synthetic oestrogens and the work of "moral entrepreneur" Robert Wilson (discussed here in Chapter 2) in the 1960's, as a deficiency disease. She states that four themes pervade 'the medical menopause': "(1) women's potential and function are biologically destined; (2) women's worth is determined by fecundity and attractiveness;

(3) rejection of the feminine role will bring physical and emotional havoc; (4) ageing women are useless and repulsive" (McCrae, 1983: 111). McCrae nevertheless recognises the potential danger of rejecting *in toto* hormonal explanations of menopause and the women's health movement's definition of menopause as unproblematic, since to do so may result in the dismissal of the health issues experienced by some women (p. 117).

The key criticisms of feminists in the early 1990's of the 'medical menopause' are typified by the work of Coney (1992a, 1992b, 1993) who brings to bear specific criticisms of the widespread use of hormone replacement therapy. Coney (1993) targets medicine, pharmaceutical companies and mass media as the promoters of these ideas about menopause and the claims about hormone replacement therapy and that they are based on deeply sexist cultural attitudes about the appropriate role of women and negative stereotypes of older women. She argues that women are targeted as no other group in society for the "universal prophylactic use of drugs" to guard against disease that may occur as they age; that the only prerequisites for treatment with the drug are being female and in the age group approaching menopause and beyond (1992a: 179). She suggests that given the large numbers of women in this age group the potential profit for the pharmaceutical industry from long term hormone replacement therapy use is enormous, offering an "irresistible bounty". Also, as the 'baby boomer' generation approaches 'middle-age' these proportions are likely to increase. Coney argues that this situation has been made possible by the definition of menopause as a hormone deficiency disease and by other conditions designed to convince well women of the need for prolonged drug therapy. Specifically: 1. women's existing

relationship with the health system which allows the medicalisation of a normal life event; 2. anxiety among women about the diminution of their social status as they age; 3. the re-definition of the normal biological events of menopause as a disease state which could be treated, and 4. the appropriation of serious non-gender specific diseases, osteoporosis and coronary heart disease, for the inclusion in the 'new menopause'.

Klein (1992) targets medicine and mass media for perpetuating sexist views of women in their definitions of menopause and more importantly regards as unethical the promotion of a drug for which the risks and side-effects are untested. She describes as coercive the 'choice' offered by medicine and mass media identifying an increasing pressure for women to consider the use of hormone replacement therapy. Dumble (1992) raised concerns about the validity of studies about the benefits and risks of hormone replacement therapy calling for a moratorium on the use of hormone replacement until uncertainty surrounding the risks and benefits of their use was resolved. She also urged that women be spared the "barrage of propaganda" (1992: 15) about hormone replacement therapy.

MacPherson (1992) in an analysis of the introduction of cardiovascular disease to the 'menopausal syndrome' counters what she describes as "the negative picture of menopause and the postmenopausal years painted by many biomedical scientists, physicians, and the mass media." (p. 239). MacPherson offers an analysis that describes 'medicalisation' of menopause stating that "menopause, a natural event in women's lives, as been socially

constructed as a disease requiring medical intervention" (p. 242). She proposes her critique as a means to "transcend the dominant patriarchal science model" and to thereby contribute to the emancipation of women (p. 242). MacPherson's critique typifies feminist responses, of the early 1990's, to 'the medical menopause' in its identification of medical science, medical practitioners and mass media as the progenitors of a version of menopause that is described as exploitative, and by defining instead a menopause that is 'natural' by proposing emancipation from 'the medical menopause'.

In the context of calls by women's health activists for recognition of women's health care at menopause, Worcester and Whatley (1992) described medical discovery of menopause as problematic because it was conducted within the context of selling hormone replacement therapy to a 'huge market'. Worcester and Whatley (1992) also identify the mass media as heavily biased towards hormones.

Three key responses can be found in feminist criticism of the medicalisation of menopause 1. Resist hormone replacement therapy, 2. Reclaim the natural menopausal woman, 3. Make informed choices.

Coney (1993) argues that women at midlife in the 1990s were in a historically unique position with regard to their independence with increases in work participation and disposable income;



she cites surveys that demonstrated women are largely satisfied with their lives, relationships, sex lives and themselves.

*Women should resist an ideology which seeks to undermine [the advantages of midlife] and brainwash women into narcissistic preoccupation with lines and wrinkles. They should insist on the normality of menopause, and demand the right to age gracefully, as self-reliant women, not poppers of pills and potions. They can best do this by rejecting passive dependency on medical messiahs with their miracle nostrums, and by asserting their right to be active players in the world."*

(1992b: 11)

Klein and Dumble (1994) call for women "to resist yet another form of medicalisation that, due to its many medical and psychological hazards, has the potential to disempower midlife women" suggesting that "not drugs but a positive old age is needed, so that women can age gloriously" (p.327). They dismiss potential liberal feminist argument that their position denies women agency because they regard the liberal feminist concept of choice implausible arguing that 'choice is not a real option "when the basic information is biased and women are far from 'free' to defy the patriarchal conventions of proper womanhood" (p. 340). In this way they refer to the construction of femininity in menopause. They argue that women have been made to feel guilty if they don't take hormone replacement therapy through strategies that suggest menopause causes financial burden for families, communities and the public health budget. They argue for an integrated theory and practice of agency and resistance though they do not examine what this might comprise. Rather they trust that "women's common sense will

prevail, and that through exposing the 'unethics' and real dangers of hormone replacement therapy, their resistance will be supported" (p. 340). They call for stoicism regardless of the material experience of menopause and base this on an ideological commitment to feminism and the women's movement.

*Ageing with joy and dignity even if hot flashes are bothersome and yes, one's arthritis does get worse, was – and is – part of the agenda for women's liberation that many of us continue to believe in."*

*(Klein and Dumble, 1994: 340)*

Like Klein and Dumble (1994), Greer (1991) supports the notion of stoicism suggested. The solution offered by Greer is also a form of resistance, but it is a celebratory form of resistance. While Greer outlines a strong critique of medical menopause her response does not remain within the parameters of the medical menopause, rather she refers to an essential or natural woman to which the menopausal woman can 'return'.

*If we are to be well, we must care for ourselves. We must not cast the old woman out, but become her more abundantly. If we embrace the idea of witchhood, and turn it into a positive, aggressive, self-defining self-concept, we can exploit the proliferation of aversion imagery to our own advantage. It is after all no shame to know that lager louts find our presence inhibiting. Perhaps we do spoil things for all the boys together propping up the bar in the local pub or littering our highways and by-ways with their cans or bashing and knifing each other at football matches. So much the better. Why not wear a T-shirt that says 'A glance from my eye can make your beer turn rancid'? Some of the work*

*being done with elderly female patients exhibiting the distorting behaviour associated with senile dementia has found that the old ladies screaming obscene abuse and deliberately soiling themselves have cause for bitter rebellion.*

(Greer, 1991: 409)

Though not necessarily a positive view of ageing, Greer sees in middle-age an injunction to exorcise the femininity imposed by patriarchal, consumerist culture. In this schema hormone replacement therapy is symbol of that culture:

*[W]e cannot but be aware that the middle-aged woman no longer has the option of fulfilling the demands of patriarchal society. She can no longer play the obedient daughter, the pneumatic sex object or the Madonna. Unless she consents to enter into the expensive, time-consuming and utterly futile business of denying that she has passed her sell-by date, she has sooner or later to register the fact that she has been junked by consumer culture. She is on her own; as menopause usually cures uterine dysfunction, it also cures the anguish of the feminine supermenial.*

(Greer, 1991: 424-25)

Greer ends her book with a final reference to the crux of her argument. Menopause, she says, provides an opportunity for the return to the natural, real woman, the one who was lost into puberty when the constraints and imperatives of reproduction, femininity and patriarchy begin

to impose themselves.

*The climacteric marks the end of apologizing. The chrysalis of conditioning has once and for all to break and the female woman finally to emerge.*

(Greer, 1991: 440)

Campioni (1997), following Greer, calls for women to revolt, to engage “an overpowering capacity for political disturbance embodied in the figure of the older woman” (p. 83) and to be revolting, and in doing so reject patriarchally imposed conceptions of woman and femininity and to allow natural ageing. She argues that culturally the power of the ageing woman has been replaced by the unwell woman: unwell at menopause and potentially always unwell in comparison to men.

*The modern creation of menopause as a problem and a loss/lack rather than a gain of physical maturity and female cultural wisdom, coupled with “suitable treatment” to better label it a misfortune of the female body in need of rejuvenation, has cut the link to the history of each woman’s body and to a history of humankind as well. It has replaced a representation of the old woman as culturally approaching the status of oracle, witch, healer, soothsayer, wise woman, harridan, and virago – her sharp tongue emitting “bitter truths” and her behaviour unpleasantly devoid of feminine decorum – with that of the unwell woman. “Unwell” to the extent that her body/presence no longer represents the comforting continuity of sexuality/maternality of that normally “unwell” figure: Woman, compared to Man.*

(Campioni, 1997: 78)

Incorporating a critique of the medicalisation of menopause O'Leary Cobb offers a more positive 'celebratory' menopause. O'Leary-Cobb, founder of a menopause newsletter and author of popular book about menopause, positions her view of menopause in the context of an ageist and sexist society in which medical scientist and practitioners "inevitably" share a fear of ageing and who begin from the "misconception that [the] reproductive woman is the norm and that [the] non-reproductive woman is therefore abnormal, inadequate and potentially diseased (p. 8). She proposes instead of this negative and derogatory view of menopause and women at midlife an examination of the experiences of well-women and an attention to complex and changing context of women's lives. O'Leary-Cobb argues that as more is learned about menopause and the end of women's reproductive lives it will be possible to "counteract outmoded prejudices and to openly welcome research which will help us to stay healthy for years to come" (p. 12). Hers is an optimistic view that maintains an interest in the value of health for women.

A third possible response offered to women by feminist writers is to seek to make informed choices. This approach has its history in the women's health movement. Worcester and Whatley (1992) suggest that hormone replacement therapy raises questions about decision-making for the women's health movement; though she shies away from simplistic solutions stating that "[t]here are no simple answers for either women or for feminist health activists" (p. 22). She argues that the decision to "balance known and unknown risks within the narrow range of choices available" (p. 22) is a personal decision to be based on information and

personal history. She proposes that debates, or lack of debates, about hormone replacement therapy may act as a catalyst for the empowerment of women to understand their bodies and to have access to appropriate information (in terms of language, literacy level and relevance to their own issues) for them to make choices. That choices are to be made is taken as given. The basis upon which choices are made is questioned only in so far as the truth claims are provable or not. There is an assumption that it is possible to produce good (unbiased) information for women.

In highlighting their critique of menopause and calling for women to resist hormone replacement therapy, feminists such as Coney (1993) by describing the menopausal woman who engages with medical practices as passive, naive and unknowing, a victim of medical dominance, may effectively preclude the autonomy they seek for women.

*The relationship between mid-life women and the health system is distorted by negative stereotypes of ageing women which are exploited by vested interests for their own ends. The mid-life woman is oblivious to the deeply sexist ideology underlying the options she has laid before her. Naively she may think these are offered simply for her own benefit. She is not cognisant of the others whose benefit may also be served by her decisions. She is unaware too that the options themselves may be incompletely tested, that there may be considerable controversy about them in the medical literature and that doctors differ in their views. What she is told – how much and how – is mediated by her doctor.*

(Coney, 1993: 3)

For Sandra Coney power is held by doctors and wielded to control and subject women.

Medicine is understood as having a sovereign power, a power that displaces the idea of the natural woman. Other feminists (cf. Daly, 1978; Greer, 1991; Klein, 1992) support this view.

Germain Greer (1991) argues women are to reclaim their true selves; a 'witch-like status' and a power of the self that is separate from men; and in direct rejection of the feminine subjectivity produced by men in medical descriptions of menopause. For Greer, Coney and Klein feminist criticism, therefore, involves a subject position for women in which the rejection of medical intervention and power plays a key role.

### *3.2.5 Empirical Studies of Medical Practice and Mass Media from a Feminist Perspective*

Despite the extensive critique of medical practice few empirical studies of medical practice are available. Lock (1982) warns against assumptions that medical practice shares a medical model that is adhered to by practitioners or that "contents of texts for medical and lay audiences are closely allied to, or even synonymous with, ideas and behaviour that patients will encounter in a clinical setting" (p. 263). In a small sample questionnaire and interview study with general practitioners Richards et al. (1997) identified a wide range of approaches in medical practice and that "there is no single biomedical model behind the doctors' interpretation of their role and that the women have no single perception of doctors' authority" (p. 195). They suggest that this diversity does not mean doctors' are free of the 'ideology'

identified in feminist critique. However, they do not investigate the working of these 'ideologies'.

While feminists have long identified mass media along with medicine as one of the key sites for the construction of menopause empirical studies of mass media representation of menopause emerged only in the latter part of the 1990s (Carlson et al., 1997; Gannon and Stevens, 1998; Shoebridge and Steed, 1999). Andrist (1998), in her study of women's decision making about hormone replacement therapy, described media attention to biomedical research as "very influential" in women's decision making. Rogers (1997), speaking as a feminist and General Practitioner, noted the disjuncture between "the barrage of advertising, info, and promotional material that crossed my desk" (p. 225) and the low number of women taking hormone replacement therapy long term. Those studies conducted in the modernist feminist framework described above are discussed here, those in a postmodern framework are discussed in section 3.3. Carlson et al (1997) and Gannon and Stevens (1998) in the United States examine women's and health magazines covering the periods 1982–1993 and 1981-1994 respectively, Showbridge and Steed (1999) examine selected newspapers and women's magazines in the period 1985-1994.

Of the few analyses of representations of menopause in the mass media or popular press most are contextualised within arguments about the need for women to have access to reliable, accurate and unbiased information, where the media is conceived of as one form of



information. Carlson et al. (1997), in their study of American popular press from 1982 to 1993 (women's, health and news magazines) determined that most articles "blend opinion with fact", that few commentators had qualifications in women's health at midlife and most cited experts were medical (p.557). They argue that negative views of menopause and menopausal women and a "pervasive attitude that treatment of menopause "just in case" is the best thing a woman can do for herself" (p.563), it is difficult for women to make educated or informed decisions. Information is unproblematised and is treated as transparently biased or unbiased, true or untrue. Likewise Gannon and Stevens (1998) in their study of American popular press from 1981 to 1994 identify an overarching presentation of menopause that mirrored the medical model and that presented a pervasively negative view of menopause. In this presentation hormone replacement therapy was the only cure. Gannon and Stevens (1998) suggest that the information provided by the media could be alarming to women seeking reliable information upon which to make decisions. They treat as one in the same a negative perspective on menopause and a medical perspective:

*...a medical perspective on menopause [is] evidenced by the portrayal of menopause as deterioration and disease and a condition to be treated by drugs.*

*(Gannon and Stevens, 1998: 13)*

Shoebridge and Steed (1999), in their analysis of newspapers and women's magazines from 1985 to 1994 argue that the media presents a dominant discourse which "effectively silences reports of growth, freedom and independence not uncommonly experienced by women from midlife" (p480), a discourse drawn from and reinforcing concepts of menopause including ill

health, psychological disturbance, vulnerability, decrepitude, biological determinism and disease management.

Whittaker's (1998) study of advertisements in professional medical journals describes how well known images from art are deployed in framing images of women in certain fixed ways thus defining the parameters of acceptable 'feminine' behaviour. Examining and comparing advertisements for oestrogen and testosterone 'deficiency' she demonstrated how images are used differently in relation to women's and men's health and ill health. She proposes that health professionals engage with the media in an attempt to present more representative, less biased images of women.

Mittiness (1983) in a content analysis of popular press from 1900 to 1976, which drew on the same data source as Carlson et al. (1997) and Gannon and Stevens (1998) (the Reader's Guide to Periodical Literature), described considerable change over time.

*Prior to 1950, the menopause was given both positive and negative valuation and was considered a natural physiological event that seldom required medical intervention. Moreover, it was seen as the beginning of a new serene period in a woman's life. During the 1950's, however, information about the menopause began to alter; statements concerning loss of sexuality and loss of youth became more frequent. The 1960s saw a substantial increase in negative affect and in loss-of-youth and loss-of-sexuality statements about menopause.*

(p.161)

Mittness (1983) identifies that 47% of articles published in the 1960's used Wilson (1966) (see Chapter 2) as their only source of information (p174).

### 3.3 Social Constructionist Readings of Menopause

Like modernist feminists postmodern feminists look to the social construction of menopause. Postmodern social constructionist feminists question the construction of the categories upon which menopause is based. They look at the social construction of knowledge and not only the socially constructed interaction of agents and their social and cultural environments (see Chapter 4 for further discussion). In contrast modernist feminists understand social construction in the terms set out by Crotty (1998) as social constructionism:

*... all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.*

(Crotty, 1998: 14)

Postmodern feminists offer a critique of essentialist positions and truth claims found in modernist feminist critiques of a 'medical menopause'. There are nevertheless, many themes common to modernist and postmodernist in the examination of menopause, for example the construction of menopause as decline and the siting of these constructions with medicine.

Postmodern feminist readings tend to disrupt medical and feminist readings of menopause by looking to the knowledge upon which both feminist and medical writers base their arguments. In addition they examine historical and cultural products (mass media and medical texts) as well as conducting research with women.

### 3.3.1 *Critiques of Modernist Feminist Positions*

Harding (1997) identifies vigorous debate between medical and feminist authors with each group trying to convince women of their position. Each commentator, medical or feminist, she says, encourages postmenopausal women to engage in self-surveillance and presumes she is willing to do so. However, she argues, the significance of hormone replacement therapy as a technology is not fully explored because "debate about the pros and cons limits what might be said about HRT" (p. 137). Additionally the categories of 'women' and 'risk' remain unproblematised.

*In different ways, both medical and feminist health discourses participate in the construction of a (post) menopausal woman who is in need of detailed knowledge of the risks she faces in order to control her destiny.*

*(Harding, 1997: 138)*

Harding (1997) argues that both medical and feminist authors address a postmenopausal woman who possesses a body circumscribed by its reproductive capacity and is

problematized at the level of 'choices' about what to do. Harding (1997) argues that in this way the women's health movement allows women only two subject positions - "sick, misinformed, over-dependent on medicine and disempowered or well informed, engaging in non-medical and self help practices and empowered (p. 140). Medical and feminist authors, she says, share common assumptions of the underlying physical body and its reproduction capacity as fixed.

Leng (1997) considers feminist and medical description of menopause.

*The central argument in the feminist model is that the biomedical definition of menopause is an assault to the autonomy and integrity of women's normal bodily existence. It is argued that through a carefully orchestrated propaganda campaign conducted by the male-dominated medical profession, pharmaceutical industry, and media, the biomedical model of menopause extends its view of menopause as a deficiency disease and coerces women into buying its product: hormones.*

(p. 257)

Leng argues feminists propose an alternative for women based on "a perfectly accessible and innocent experience of nature" (p. 256). Nature is contrasted with culture, drugs and technology and the 'natural body' is proposed by feminists as the only antidote to medicalisation. Like Harding (1997), Leng argues that feminist and medical models share an epistemological assumption about truth and in this way they are similar. She says there are

two positions available to females in the feminist literature: "they can either submit to the biomedical paradigm (accept HRT) or resist it (reject HRT)" (p. 265). But she argues these positions are reduced to one because to do other than to resist is to be passive to and a victim of medicine and that therefore resistance is the only appropriate menopausal subjectivity offered by feminists. Leng (1997) suggests that the problem with either the medical reduction to biology or the feminist to nature is that they are closed explanations, they do not allow for the diverse experience and construction of menopause. Menopause is not one type of fixed physical or social experience. The menopausal body is not fixed. Women at different times in history have different life histories in relation to menopause. In the past women who 'bred more and bled less' moved from last pregnancy and lactation to menopause, some women in some cultures may still do this. The menopausal body can inhabit the woman, through surgery or other processes. There is no 'natural' or normal menopause, just a diversity of manifestations and constructions. According to Leng (1997) denial of these differences effects a metaphysical closure.

### 3.3.2 *Accounts of the Historical Constructions of Menopause*

Oudshoorn (1994, 1997) identifies cultural and institutional circumstances in the development of hormonal therapies that enabled scientists greater access to female hormones for research and therefore drive sex-specific research. Additionally the gynaecological clinics that provided access to female hormones, provided access to a market for those hormones.

*With respect to female sex hormones Organon [a pharmaceutical company] was quite successful in enrolling the relevant actors to promote this new type of*

*drugs to a wide variety of audiences, sponsors and consumers. Clinicians and the pharmaceutical companies could rely on an already organised medical practice that could be easily transformed into an organised market for female sex hormones. The gynaecological clinic functioned as a powerful institutional context that provided an available and established clientele with a broad area of diseases that could be subjected to hormonal treatment. ... The promotion of female sex hormones fitted seamlessly in the already existing institutional structures formulated earlier in the century as part of the professionalisation of medicine and the rationalised organisation of service delivery.*

*(Oudshoorn, 1997: 141)*

Harding (1996), following Oudshoorn, argues that "sex hormones were discursively constructed as embodying the *essence* of sex" (p. 99, emphasis in original) and that through the definition of women as susceptible to multiple pathologies the hormonal body has been rendered "self-evidently in need of regulation and control" (p. 101).

Klinge (1997) demonstrated how two competing pathophysiological theories for explaining osteoporosis have emerged in parallel with constructions of menopause as hormonal: the 'hormonal osteoporosis' and the 'mineral osteoporosis'. Klinge identifies two key issues that are used to promote the hormonal explanation. First, "the 'hormonal solution' is able to involve many more elements of a woman's life" (p. 105). The second aspect concerns the relationship of osteoporosis to risk:

*...in the 'mineral world' risk concerns osteoporosis itself; in the 'hormonal world' risk concerns osteoporosis but no less femininity and sexual attractiveness.*

(p. 105).

Palmund (1997) too identifies the social construction of menopause as risk as a key context in which women experience menopause. Like Coney (1993), and others (see above), Palmund (1997) identifies medicine and the pharmaceutical industry as the source of this construction.

*Menopause is now being integrated as a symbolically loaded and medically defined social phenomenon in popular literature in richer countries of the world. This social reconstruction of menopause as a risk to women's health and well-being has strong roots in a domain where the interests of the medical community and the pharmaceutical industry converge.*

(p. 87)

### 3.3.3 Cultural Constructs of Menopause

Postmodern feminist examination of mass media and other cultural texts does not begin from assumptions made by modernist feminists above about mass media as a source of information. Rather media and other texts are a site for the examination of the social construction of menopause and the menopausal woman. Gullette, for example, argues that because the media dwells on women's diseases and decline, men are exempted from anxiety about ageing and their ageing becomes invisible (p. 186). She also argues that menopause and ageing are collapsed in the media to be synonymous.



Lyons and Griffin (2000) identify that the negative and technical language used in medical texts and academic literature has certain consequences for women's experiences of menopause. They examine the construction of menopause in self-help literature finding discourses of 'menopause as disease' and 'menopause as natural' contrasted there. Also they identify discourses of choice and responsibility with menopause being represented as "a period of life in which women were expected to make sensible and responsible decisions" (p473). They demonstrate how linking negative consequences of hormonal change to menopause positions a decision of choosing not to take hormone replacement therapy as "somehow silly, or not sensible" (2000: 475). Additionally they identify gaps in the presentation of menopause: lesbian or bisexual women, women of colour and poor women rarely appear in academic or self-help texts.

Lupton (1996) examining the presentation of menopause in a newsmedia text discussed menopause in the context of late modernity which, she says, emphasises and privileges the self-governing rational individual. In this context the menopausal body is a body out of control.

*The ageing body .... Is a grotesquerie, an unwilling transgression body, a body that is no longer fully under its owners control.*

(p. 93)

Lupton (1996) also criticises modern feminists' response to the medicalisation of menopause, ridiculing the "puritan notion" (p. 96) that women should forgo treatment and endure menopause rather than become medicalised. She says that in calls by feminist for women to become more informed and empowered feminists are themselves, like medicine, directing the form of subjectivity.

### 3.3.4 *Alternative Discursive Accounts of Menopause*

Hunter and O'Dea (1997) offer a material discursive account of the experience of menopause which contrasts with studies of women's experience from the modernist feminist perspective but which goes beyond a purely discursive account. They suggest that a woman's subjectivity is positioned between her perception of biological changes and the discursive construction of menopause (p. 199). In this way menopause is mediated and negotiated through multiple meanings of menopause. They argue that the dominant meaning of menopause that women encounter in mass media and that pervades research literature is the biomedical one. From their qualitative analysis of interviews with women Hunter and O'Dea (1997) argue that the biomedical account does not adequately reflect women's complex subjectivity which is varied, multidimensional and contextually determined (p. 218).

Martin (1997) argues that the metaphor of the production factory is the most pervasive image used to describe women's bodies in western medicine. This model conceives of the body as a "hierarchical system held rigidly in order by its central control system" p245. Therefore,

menopause is loss of this control system. Martin demonstrates the operation of this metaphor by examining the language used in standard medical texts to describe menopause. She positions menopause system failure in the context of a late capitalist dread of lack of production. In the place of the production metaphor Martin proposes a model of the working body drawn from chaos theory. She demonstrates a shift in thinking about the workings of the heart as an example of the emergence of chaos theory as an explanatory system.

*Cardiologists, for example are coming to see the heart not as the quintessential mechanical body part, a clock like pump, but as a self organising and responsive system that only beats with a clocklike regularity when the body is near death and the heart can no longer respond to all the changes going on around it.*

*(Martin, 1997: 248)*

She considers two characteristics of chaos, first that it is both deterministic and periodic and second that chaotic systems have a sensitive dependence on initial conditions (p.249).

This enables chaotic systems to operate in a range of conditions and that are therefore adaptable and flexible. Martin (1997) proposes to view menopause in a different way. Far from seeing menopausal change as pathological she views irregularities as an adaptive response to the internal and external environment.

*...the change women undergo during menopause, itself would be described as a phase change of the sort complex systems often undergo... For a women undergoing menopause thinking of it as a state change from reproductivity to*

*maintenance of non-reproductivity would constitute a far more positive view of her body than thinking of it as a breakdown of centralised control.*

*(p. 251).*

### **3.4 Conclusion**

Feminist writers have drawn attention to the deeply gendered construction of the body, especially in relation to reproduction and sexuality. However, as I demonstrate above, feminist perspectives on menopause are not unitary. This chapter traced the response of feminist and critical authors to the 'medical menopause'. Few of the writers in the modernist feminist tradition in the mid-1990's addressed their critique to the construction of the conceptual categories of prevention and risk that underpinned the new menopause. In doing so they also close the options open to women. While writers in the postmodern tradition engage in critique of the construction of the category 'menopause' few offer an examination of the implications of medical practice or cultural constructs. Social constructionists offer a range of insights to understanding of menopause. It is concerning (and intriguing), therefore that few postmodern social constructionist readings of menopause have appeared in the academic literature since 1997.

Both modernist and postmodernist feminists identify medicine and medical practice, and mass media as key sites for the construction of the meanings of menopause; albeit from different epistemological positions. Given the changes observed in the medical literature in Chapter 2

and the changing examination of menopause by feminists above, in this thesis I examine the following questions relating to mass media presentations of menopause: 'How is menopause constructed in mass media and what are the effects of these constructions?', 'Does the shift identified in medical literature alter the presentation of menopause in these media texts?', and 'What are the implications for women of shifts in medical constructions of menopause?'

I turn now to a discuss the methodology and methods I employ to examine these questions about mass media and the questions identified in Chapter 2 about medical practice.

## Chapter 4: Methodology and Methods

### 4.1 Introduction and Description of the Research

The focus of this thesis is on the shift in the construction of menopause away from a historical approach of primarily symptom treatment towards the preventive use of hormones and the implications of this for women. In Chapters 2 and 3 identify issues raised by dominant feminist criticisms of medical and mass media constructions of menopause. I therefore examine these in relation to the construction of menopause in contemporary health care and mass media. I fo

cus on general practice as an example of health care because this is the most commonly accessed setting by women for menopause. I examine mass media because it is a key source of health information for women and focus on newspapers because they are a widely accessible form of mass media. Conducting this analysis in the context of feminist critiques of medicine and mass media discussed in Chapter 3 I acknowledge here the differences between dominant feminist criticism of medicine and the approach to health care taken by the women's health movement, however, it is not my intention to examine these differences in detail. Rather, I am interested in the ways in which popular feminist criticism intersects with medical practice and mass media and how concepts that are shared by popular feminism and the women's health movement are taken up in general practice and mass media.

This thesis starts, therefore, from a feminist understanding of poststructuralism in order to examine general practitioner frameworks and concepts. Moreover, following Kitzinger (2000), the research design is methodologically eclectic. Kitzinger states "theoretical and methodological eclecticism is crucial to the feminist project of better understanding and improving women's lives." (p. 360)

My aim was to conduct a series of research studies that would provide a rich and detailed basis to the examination of the construction of menopause. These studies are as follows (i) a semi-structured interview study with general practitioners, and (ii) an analysis of the presentation of menopause in an example of mass media (newspapers) and (iii) a postmodern critical analysis of a range of ethics literature. For ease of reference I will refer to these studies as Study 1 (GPs), Study 3 (Media) and Study 3 (Ethics) hereafter. In this chapter I describe the methodological framework of these studies, research design and selection of methods, the conduct of each of the research studies, and the stages of analysis and interpretation. Within each of these sections I will address studies 1 and 2 in turn. The design of the study as a whole is an emergent one. I will therefore discuss the design and conduct of Study 3 in Chapter 8, where it is more appropriately situated as part of the development of the problematic identified in Studies 1 and 2 and discussed in Chapter 7.

## **4.2 Methodological Issues and Framework**

The methodological framework in this thesis employs poststructural concepts, including

discourse and its constitution of objects/subjects, and technologies of power, based on Michel Foucault (Foucault, 1972; Martin *et al*, 1988) and feminist post-structuralism (Weedon, 1997).

#### 4.2.1 *Poststructuralism: the production of subjectivity and power relations in language*

Poststructuralism, working from Foucault's concept of the production of subjects, power relations and discourse enables an examination of power relations and how power is exercised. Through such an understanding of the exercise of power possibilities and opportunities for change or transformation may be identified.

Poststructuralism underscores the role of language in forming individual subjectivity and social institutions, and power relations. Language is the site where meanings are produced; linguistic meanings play a major role in organizing the self, social institutions, and the political landscape. Derrida (1976) argued that whenever a linguistic and social order is said to be fixed or meanings are assumed to be unambiguous and stable, that this should be understood less as a discourse of truth than as an act of power; in that the capacity of a social group to impose its will on others is exercised by freezing linguistic and cultural meaning. By examining these processes poststructuralism can be deployed to oppose efforts at linguistic, social and political closure.

What interested Foucault about power was how particular kinds of subjects are produced as



effects of discursive and power relations (Foucault, 1982). Foucault's subject is not the Enlightenment's pre-given or sovereign individual based on a free and separate consciousness. Where Descartes (1647, 1990) posits consciousness, *cogito ergo sum*, as the ontological essence of the human being, poststructuralists following Foucault (1982) and Derrida (1976) reject the notion of the subject as unitary and fixed. Rather the subject and subjectivity are constructed; as are objects. Language is the site for that construction and therefore the subject, the menopausal woman, and the object, menopause, can be examined in language.

Foucault (1972, 1973, 1975) investigated the social effects of disciplinary knowledges such as science, medicine, psychiatry and how dominant discourses play a normalising role as knowledges and ideas of society shape human life by naturalising and normalising the construction of personal and social identities. Particularly scientific knowledge functions as a major social power, that through the state, the family hospital and therapeutic institutions the scientific disciplines shape our dominant cultural ideas about who we are, what is permissible and unacceptable, what can be said, by whom, when and in what form.

From his *Histories of Sexuality* Foucault (1981, 1986, 1988a) demonstrates how identities function to control our behaviour. That to define an identity, for example menopause, is to control how it is to be a menopausal woman and that the individual and institutions involved in that definition reinforce and control the maintenance of that identity. In this way Foucault

described a system of social control that operates less by coercion and repression than by the very cultural meanings and self identities that it produces.

Foucault drew attention to how power works; not only how it is manifested but how it is exercised. Foucault's (1982) understands power as a relationship between partners. In the question of how power is exercised power is twofold: a relationship and an action. Power is exercised as an action between partners and as an ensemble of actions that induce others to act, respond or resist.

*The exercise of power consists in guiding the possibility of conduct and putting in order the possible outcome.*

*(Foucault, 1982: 221)*

This is a more subtle power than the duality offered by Enlightenment concepts of sovereign power that can be held by an individual or group. Power is, in this understanding, less a confrontation than an act of government not only of the management of states but of the conduct of individuals and groups. Foucault uses the term government in the broader sense employed in the 16<sup>th</sup> century whereby government

*...did not only cover the legitimately constituted forms of political or economic subjection, but also modes of action ... which were destined to act upon the possibilities of action of others. To govern in this sense is to structure the possible field of action of others.*

*(Foucault, 1982: 221)*

When power is defined in this way as a mode of action upon the actions of others then power includes within it the necessity of a freedom in which the range of possibilities can be realised. In this conception slavery, for example, cannot be a power relation because the slave does not have open to her this field of possibilities. Freedom therefore is a condition of the exercise of power and its pre-condition "since without the possibility of recalcitrance, power would be equivalent to physical determination" (1982: 221). Foucault's work is useful not least because looking at how power works may give clues about how it might be changed.

Within this understanding of power as actions upon individuals to act upon themselves Foucault examines the way a human being turn themselves into a subject. (1982: 208). He regards subjectification as a dialectic of freedom and constraint:

*The subject is constituted through practices of subjection, or, in a more autonomous way, through practices of liberation, of liberty.*

*(Foucault, 1988b: 50)*

In his later work Foucault develops further his conceptualisation of the subject and power relations in the concept of technologies of the self (Foucault, 1997). Foucault identifies four major forms of technology which are each a matrix of practical reason.

*1) technologies of production, which permit us to produce, transform or manipulate things,*

*2) technologies of signs systems, which permit us to use signs, meanings, symbols, or signification,*

*3) technologies of power which determine the conduct of individuals and subject them to certain ends or domination, an objectivising of the subject, and*

*4) technologies of the self, which permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality.*

*(Foucault, 1997: 225)*

Further, he regards the encounter between technologies of domination and technologies of the self as a form of government: this he calls governmentality.

Foucault in developing an approach to the creative self-construction of subjectivity suggests that the contemporary challenge is not to discover who we are but rather to "refuse what we are" (1982: 216). He considers this a political, ethical social and philosophical problem. His

solution is to reinvent the self.

*We have to promote new forms of subjectivity through the refusal ... of individuality which has been imposed on us.*

(1982: 216)

Weedon considers women's subjectivity to be produced and constrained in forms of governmentality. Foucault's concept of subjects and power relations, she argues, has great explanatory power in examining the possibilities for action available to women in certain constructions of objects and subjects, for example menopausal women.

*Language is the place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested. Yes it is also the place where our sense of ourselves, our subjectivity is constructed.*

(Weedon, 1997: 21)

Weedon (1997), following Foucault, argues that language is an important site of political struggle.

*Different discourses provide for a range of modes of subjectivity, and the ways in which particular discourses constitute subjectivity have implications for the process of reproducing or contesting power relations.*

(p. 88)

Some feminists (see Nicholson, 1990 and McNay, 1992, for a discussion of feminist critiques of postmodernism, poststructuralism and Foucault) object to Foucault's work on the basis of his omission of the particular circumstances of women in his historical accounts and his rejection of the unitary subject and thereby the ellision of the identity category 'woman' which is seen as central to a modernist feminist politics. However, it is in the very production of the categories 'woman' and 'man' as fixed and the possibilities this fixity enables or constrains that we are able to see the exercise of power. Moreover, as discussed in more detail below, it is not necessarily the case that a postmodern or poststructural position is apolitical; it is precisely the deployment of poststructural concepts of power and subjectivity that may constitute a political act. Weedon (1997:1) describes feminism as a politics directed at changing the existing power relations between women and men that structure all areas of life. In this study I am interested in how power relations are structured in the arena of health, in particular women's health and health care at menopause.

Language is the site where the production and maintenance of particular power relations are enacted. I therefore look to techniques of discourse analysis to examine language about menopause.

#### 4.2.3 *Discourse and Discourse Analysis*

There are many versions of discourse analysis. Van Dijk (1990) describes a rapidly expanding cross-discipline of discourse studies in the humanities and social sciences. With its beginnings somewhere in the late 1960's in anthropology, semiotics, literary studies, linguistics, sociology, psychology and communications and more recently in history law and politics, Van Dijk describes the change in focus from "an age-old tradition of classic rhetoric" to a focus on text and dialogue. He suggests concerns with the structuring effects of language came as, "[s]omewhat hesitantly at first, linguists and grammars dared to go beyond their self-imposed barriers of the sentence in order to discover a rich field of discourse constraints on grammatical rules" (1990: 5). Van Dijk describes the development of discourse studies in varying disciplines differing according to the theoretical and methodological concerns of that discipline as it took the turn to language. Not surprisingly then, in 1993, Burman and Parker identify a proliferation of types of discourse analysis from multiple origins, each involving involves different emphasis or levels and styles of analysis.

Van Dijk (1990) suggests that one consequence of the differential development of discourse studies has been the different emphasis given in the analysis process as some forms of discourse analysis paid more attention to the intricacies of structure than to the social contexts of their actual use. These tensions between form and content are still evident in current work on discourse analysis. The attention to the micro-context of 'how' language is constructed, runs the risk of ignoring the macro constraints of social and political structures

and, consequently, 'what' language does.

In the recent development of discourse analysis, the work of British social and critical psychologists has featured prominently. While there exist a number of philosophical frameworks for understanding and many approaches to the practice of discourse analysis, the versions used in social psychology nevertheless hold in common an "attention to the significance and structuring effects of language, and are associated with interpretive and reflexive styles of analysis" (Burman and Parker, 1993: 9). The other continuity among these approaches is the move away from a modernist ontological commitment to an essential or underlying reality, of which language is a reflection, towards an understanding of language as representation. Aligned with this shift is the implication that meanings are multiple and shifting, rather than unitary and fixed. Two versions of discourse analysis, in particular, predominate in critical psychology: Potter and Wetherell (Potter and Wetherell, 1987, 1994; Potter 1996) and Parker and Burman (Burman, 1990; Parker, 1992; Burman and Parker, 1993).

Potter and Wetherell (1987, 1994) develop their form of discourse analysis drawing from sociology of scientific knowledge (Gilbert and Mulkay 1984) and the continental social philosophy tradition (particularly semiology and poststructuralism), integrating insights from conversational analysis (Atkinson and Heritage, 1984) and analysis of rhetoric (Billig, 1987, 1991). Potter and Wetherell (1987, 1994) use the concept of interpretive repertoires. For them



three features characterize discourse analysis. First is the concern with talk and texts as social practices. While an attention is paid to both form and content the task of discourse analysis is seen to be to answer social questions not linguistic ones. Second there is concern with action, construction and variability.

*People perform actions of different kinds through their talk and their writing and they accomplish the nature of these actions partly through constructing their discourse out of a range of styles, linguistic resources and rhetorical devices.*

*(Potter and Wetherell, 1987: 163)*

These resources are the repertoires "which we do not create anew when we speak, but which we have to borrow and refashion for our own purposes" (Potter and Wetherell, 1987: 15).

Therefore, for Potter and Wetherell, one of the principle aims of discourse analysis is to "reveal the operation of these constructive processes" and to look for variation in the performance of these actions to provide a lever for analysis (Potter and Wetherell, 1987: 10).

Third, from Billig (1988, 1991), they incorporate a concern for the rhetorical organisation of texts to ask how it is that a particular discursive version of some putative reality is designed to compete successfully with its alternatives: that is, to ask how people negotiate the competing public and collective ideas to construct their accounts of some reality or action. Potter (1996) elaborates this account of discourse in the examination of the ways facts are constructed as real. Potter (1996) argues that 'factual' accounts have an orientation to accomplish an action and that therefore analysis can examine how this is achieved. Additionally, Potter (1996)

argues that 'factual' accounts have an epistemological orientation; that is, they are used to build the status of a particular account as factual and that therefore analysis can examine how these accounts are built/constructed.

Burman and Parker describe language as being organised into discourses which have "an immense power to shape the way that people...experience and behave in the world" and that "language contains the most basic categories that we use to understand ourselves" so that when we talk about any particular phenomenon we draw on shared meanings produced by these discourses (1993: 3). Parker (1992) works from the premise that "[language] is so structured to mirror power relations that we often can see no other ways of being" (p.7).

Parker (1992) draws on poststructuralism to develop an analysis which focuses on the role of discourse in the reproduction and transformation of meaning, arguing that discourses both facilitate and limit, enable and constrain what can be said by whom, where, when. Burman and Parker (1993) describe discourse as being concerned with:

*...the ways language produces and constrains meaning, where meaning does not, or not only, reside within individuals heads and where social conditions give rise to the forms of talk available" and that discourse analysis "offers a social account of subjectivity by attending to the linguistic resources by which the socio-political realm is produced and reproduced.*

(p. 3).

Parker and Burman's methods look to the text to elucidate the discourses constructed there, specifically exploring: the picture of the world constructed through the discourse in objects, subjects and meanings; the nature of the discourses, their relation to other discourses, their way of speaking, their historical location; and, the effects (the reproduction of power relations and ideological effects) produced by that discourse and how these effects are achieved.

The key element of the above approaches is their attention to language as a social practice. Texts are a site for the construction of social relations as well as a site for the exploration of these, as such they exist within the context of and they often refer to other social relations. Attention is therefore drawn both to what is said, (by whom, for what audience, for what purpose), and how (what is the mechanism of this particular construction)? it is said and, importantly to what effect.

My use of discourse analysis here is not to determine any generalisable features of the language of general practitioners *per se*. Rather, it is my purpose to examine in this particular sample the discourses deployed by, and therefore available to, these general practitioners. And in so doing examine the implications of these medical constructs.

In this research I employ insights from Potter and Wetherell (1987), Potter (1996), Parker (1992), Burman (1991) and Burman and Parker (1993) to the analysis of discourse. While

discourse analysis is used in analysis of general practitioner interviews, where I use content analysis to describe the breadth of constructions of menopause in the mass media example an understanding of language informed by poststructuralism and the discourse analysis described above informs the qualitative and interpretive process of developing the coding categories. Conduct of research and analysis is discussed in Sections 4.3, 4.4 and 4.5.

#### *4.2.2.1 Discourse Analysis: methodological issues*

Burman (1991) and Burman and Parker (1993) outline some problems associated with discourse analysis. Some of the problems are practical constraints: the labour intensive nature of the analysis process and, related to this, the restrictions on the range of materials able to be analysed during the course of most research project. Many are seemingly problems of method associated with the practice of discourse analysis but can be located in the theoretical move of discourse analysis away from modernist, positivist research and the failure of some discourse analytic studies to fulfill the requirements of this development: treating discourse analysis as a value-free technology; reifying the discourse; banality; reductionism; atemporality and/or ahistoricism.

Four major theoretical concerns emerge in relation to concepts common to discourse analysis; difference, resistance, relativism and reflexivity, which have implications for the political dimensions of discourse analysis. Burman (1991) describes the four theoretical concerns: difference, resistance, relativism and reflexivity.

Difference. The attention to variation, while potentially fruitful in its acknowledgement of complexity, leads to a fragmentation of positions which may preclude collective action and may mask the exercise of power through inequitable social relations (gender, class, race).

Resistance. In Foucault's analysis, power is a diffuse, all-pervasive and shifting force against which resistance is initiated by individuals who themselves inhabit different discursive positions (different frames of reference). Burman (1991) suggests that this concept of power could as easily lead to a fatalism as to a potentially fruitful way of politicising discourse.

*If power is everywhere, and where there is power there is resistance, then why bother trying to change the order of things?*

(Burman, 1991: 331)

Relativism. Postmodernism challenges the modernist notion of fixed, knowable truths. A relativistic account is useful in acknowledging multiple and co-existent readings or interpretations, thereby challenging the truth claims of dominant readings. If, however, all interpretations are equal valid and valuable it becomes difficult to elaborate or commit to one position in favour of another, potentially blunting the critical edge of the critique.

Reflexivity. An understanding of the explicit exploration of researcher involvement and its

effects bring to discourse analysis a tool to secure accountability in the research process. Yet this may result in reducing everything to discourse thereby detaching rather than engaging with the 'real'.

These critiques are evident also in the comments of some feminists (Gill, 1995; Widdicombe, 1995; Wilkinson and Kitzinger, 1995) and other authors (Van Dijk, 1990, 1993, 1994; Burman and Parker, 1993) working within the broadly defined field of discourse studies. Widdicombe (1995) is concerned about the use of discourse studies that the political importance/significance of the discourses may be lost in "the analytic rush to identify discourses" (p. 108) and that this might displace the more important political activity of analysis. Gill (1995) suggest discourse analysis has much to offer feminists in, its account of language but that the relativist foundations of some discourse analysis do not account adequately questions of politics. She cites Benhabib (1992) to emphasise this point.

*Postmodernism, in it's infinitely sceptical and subversive attitude toward normative claims, institutional justice and political struggles is certainly refreshing. Yet, it is also debilitating.*

*(Behabib, 1992, cited in Gill, 1995 p. 168)*

Gill argues, as others, that its precisely those features of DA that are productive for feminists - its problematizing of truth claims, socially constructed knowledge and rejection of the unitary

coherent subject and attention to exercise of power in local practice - that also make it problematic. As a response to these concerns Gill proposes a "passionately interested inquiry" (1995: 175) and, like Weedon (1997) speaking of a feminist poststructuralism, calls for a relativism which is "unashamedly political" (Gill, 1995: 182).

*Make social transformation an explicit concern of our work, acknowledge the values which inform it and situate all interpretations and realise in a realm in which they can be interrogated and argued about.*

*(p.178-179, emphasis in original)*

Potter's (1996) response to concerns that relativism in social constructionist positions preclude politic is to de-couple the implied equivalence of relativism and lack of political commitment (Edwards et al., 1995). He proposes to explore the way descriptions are constructed as real and how reality is constructed or undermined (Potter, 1996). The concern, therefore, is not with what is or isn't real but rather how what/which descriptions are constructed as real.

Burman (1991) notes that, paradoxically, the "features that seemed to provide the bridge to bring in political concerns, can also be seen to be the route by which those very political concerns depart" (p. 332). She suggests that discourse analysis does not itself provide a political position but that its political nature is realised through the strategic appropriation of its

framework. This point is taken up elsewhere by Van Dijk in editorials and other papers in the journal *Discourse and Society* in which the editor makes an explicit appeal for the construction of a critical discourse analysis (Van Dijk, 1993). In 1993 Van Dijk called for a study and critique of social inequality "by focusing on *the role of discourse in the (re)production and challenge of dominance*" (p.249, emphasis in original), suggesting that 'critical discourse analysts' unlike other discourse analysts should take an explicitly sociopolitical stance, spelling out their point of view, perspective, principles and aims (Van Dijk 1993: 252).

Looking at the field of discourse studies in 1990 Van Dijk suggested that social, political and cultural dimensions have received short shrift in the study of language use and discourse and that concepts of power and dominance, group relations, ideologies, cultural reproduction, institutional decision making among many others, were and are hard to find. He ascribes this gap to the difficulties of relating 'macro-notions' such as power and dominance and social inequality with 'micro-notions' of text, talk and communicative interactions. Indeed Hepworth (1994) suggests that:

*The main strength of discourse analysis is in its ability to theorize relations between social processes and individual subjectivity [and] poststructuralism in particular criticizes individual-society dualism and thus provides a theorization of social processes that are constitutive elements of discursive practices rather than external factors that influence behaviour.*

(p. 180)



Parker (1992) suggests that discourse analysis radicalises the turn to language, that it has specific moral and political consequences, particularly in its implications for scientific and social scientific 'knowledge'. Burman and Parker (1993) see three useful contributions of discourse analysis for psychology but which could easily apply to other disciplines. The first is associated with the introduction to the discipline of Foucaultian ideas to provide a critique of the discipline. Second, by drawing attention to the discursive structures of the discipline to highlight the underlying assumptions and thereby to challenge their facticity. Third, the attention to context as well as content gives rise to a focus on reflexivity. Reflexivity is seen as an aid to accountability in discourse analysis by rendering the interpretive resources and processes public and available to public evaluation (Wetherell and Potter, 1988) and as it is used in feminism, to draw attention to the participation of the researcher in the research process (Wilkinson, 1995). By facilitating an historical account of knowledge and a challenge to truth claims and so commenting on social processes which participate in the maintenance of structures of oppression, Burman and Parker argue that discourse analysis can be used to inform political practice and struggles.

#### *4.2.2.1 Validity*

Validity means quite different things to researchers informed by different research traditions, using different methodologies and with different purposes for the research. It also follows, therefore, that the form of validity applied or enacted should relate to the research methodology, specifically taking account of the epistemological and ontological premises

and assumptions as well as the purpose of the research. It is beyond the scope of this thesis to engage in critical discussion of the issue of validity in the use of qualitative and quantitative methods in a study informed by poststructural theory. Fairclough (1992) comments that there will always be alternative interpretation of discourse and therefore:

*...the question arises of how analysts can justify the analyses they propose (how they can 'validate' them.) [and] all one can do is decide, given alternative analyses, which seems to be preferable on the balance of evidence available.*

*(p. 238)*

Patton writing in 1980 from a modernist perspective about validity in qualitative methods presented four forms of validity.

- 1) *Verification: "data analysis must be presented to other in such a way that they can verify and validate the findings of the analysis themselves."*
- 2) *Rival explanations.*
- 3) *Negative cases.*
- 4) *Triangulation from Denzin (1978) including a) reconciling qualitative and quantitative data, b) comparing multiple qualitative and c) considering multiple perspective from multiple observers/researchers.*

*(p.326)*

Patton's four criteria are a useful starting point for describing what I do and do not employ in examining validity within the poststructural and eclectic methodology used in this study.

In this thesis I address the issue of validity by using a concept of reflexivity derived from a perspective based on Burman (1990) and feminist standpoint theory (Griffin, 1995). As Griffin (1995) states, feminist standpoint research includes "feminist objections to the positivist myth of the apolitical, value-free researcher" (pp. 119/120). I conducted all the consultations and interviews using a framework of feminist standpoint research. The interviews were carried out using a standardized procedure, yet a certain degree of flexibility was required with which to respond to minor differences between individual respondents and their changes to the sequence of interview questions. During the analytic process I employed the concept of 'reflexivity' (cf. Burman, 1990; Griffin, 1995) in a systematic application of feminist post-structural theory to the analysis of interview and media data. Burman's (1990) work on reflexivity is discussed by Griffin (1995) as "a self-conscious awareness of the ways in which what counts as 'knowledge' and the whole process of research are structured by relations of dominance around gender, race, class, age and sexuality" (p. 119/120).

Working from a feminist poststructural position the research design I employed was an emergent one that was informed by medical and feminist literature as well as by readings of the general practitioner interviews, mass media texts and ethics literature. During analysis I used a reflexive process moving between the analysis of general practitioner interviews,

media articles and ethics literature. In this way my interpretations informed each other as key issues arose again and again. I have chosen to present the analysis of general practitioner interviews as a discourse analysis, demonstrating the construction of discourses and how these constructions are achieved linguistically. I have chosen to present the media analysis in as a quantitative description to demonstrate the historical shifts in the presentation of constructions of menopause. It is not my intention to compare the general practitioner interviews, or to use comparison to make assertions that the discourses I identified were somehow more real or valid. Rather my aim was to investigate discrete, though interlinked, locations of discourse.

In the context of my deployment of reflexivity and feminist standpoint theory I use Potter and Wetherell's (1987) and Potter's (1988) approach to validity by opening to scrutiny the interpretive process in the presentation analysis. Wetherell and Potter (1987) suggest that the report of the research is a means for the reader to evaluate of the conclusions of discourse analysis, proposing that discourse analytic studies:

*...include a representative set of extracts along with detailed interpretations which link the analytic points to specific features of extracts in such a way that the reader is able to assess the success of the interpretations and, if necessary, offer alternatives. The overall goal is to openly present the entire reasoning process.*

(p.183).

In presentation of interview data analysis I open this analysis to scrutiny by including extended illustrative extracts and detailed analysis. In addition, following Parker (1992), I opened the analysis to scrutiny by academic peers and health care practitioners by engaging other researchers in the analytic process and by opening up the analysis of interview and media data to external scrutiny at numerous stages of the research through presentation at conferences, seminars and to peer review in the submission (successful) of two papers to international social science publications (See Appendix 5). As my theoretical position is a feminist one informed by poststructural understandings of subjectivity, power relations and discourse the validity of my interpretations may be determined on those grounds.

#### **4.3 Research Design, Selection of Methods and Conduct of Research: Study 1, GPs**

General practitioners were selected for interview because they constitute the key professional group responsible for the delivery of medical services to women. In rural Australia limited access to a range of health and medical care for women may serve to intensify the health care relationship with general practice (James, 1989; Franklin, et al., 1994; Jones, 1996). One rural region of South Australia was chosen because it was identified in consultation with key stakeholders (women living in rural South Australia, health care providers and rural health policy makers) as a region characterised by especially limited access for women to a range of health services and health care providers. All general practitioners practising in this area (n=29) were invited to participate in this study. A written invitation, which was accompanied by a supporting letter from the Mid-North Division of General Practice (the local professional

organisation), plus follow-up phone calls were used to recruit participants. In response 10 general practitioners agreed to participate in the study, one later withdrew prior to interview. Subsequent discussion with key stakeholders, when I expressed concern about the low response, revealed a cultural divide that saw populations and health care professionals identifying with micro-regional boundaries. This may explain the absence of any participants from one town (n=7) and the preponderance of participants along the main road and rail route between two major Australian cities. The study sample did not differ substantially from the population of general practitioners: 4 women and 5 men (compared to 8 women and 21 men in the study population), ranging in age from mid 30's to early 50's, participated in the study. With the exception of the one town mentioned above the geographical distribution of practices involved was representative. At least one general practitioner from more than 75% of all practices in the geographical study area participated.

Face-to-face semi-structured interviews were conducted with nine participants in a location of their choosing; frequently their office or lunch-room. With the permission of each participant the interviews were audio-taped and transcribed in full. The interview schedule, developed through consultations with women, health care professionals (including general practitioners) and critical analysis of literature, employed open-ended questions, reflecting the exploratory nature of the research. The purpose of the interviews, their part in my doctoral research and my social science academic background were made explicit at the start of each interview.

All interviews took place in a venue selected by the respondent. Most often the interview took place in their office in their clinic or surgery. I interviewed two respondents in the lunch room of their surgery and one in his home outside of working hours. I accepted any appointment that I could accommodate on a series of days that I had selected over a period of ten weeks.

All interviews were conducted by me as the researcher. At the beginning of each interview the purpose, aims and methodological approach of the research were outlined by the interviewer. It was made clear at this time, as it had been in the information sent to prospective participants, that the research constituted the empirical portion of the my Ph.D. thesis. All respondents were asked to confirm whilst being audiotaped that they understood the reasons for the research and agreed to their involvement in the research. Formal verbal consent was requested from all health care practitioners. All interviews were tape recorded with the permission of the respondent. Interviews lasted between twenty minutes to two hours with most taking approximately one hour.

During each interview I referred to a question guide (Appendix 1) that I had constructed to cover the issues that I wished to investigate in my research. Respondents were told that the list of questions were a guide only and that they were free to discuss aspects of the research question that they found interesting or relevant. This was an attempt on my part to allow a comfortable and relaxed discussion to develop. This also allowed the respondent the scope to discuss the areas of their own interest without restriction. In all cases, however, the interview

covered all the areas that I was interested in.

#### **4.4 Research Design, Selection of Methods and Conduct of Research: Study 2 Media**

Medical and feminist literature alike identify mass media as an important source of representations and constructions of menopause, and of health information for women at menopause (see Chapter 2 and 3). Moreover, in a poststructural framework mass media is considered a key site for the construction of subjects and objects in language. Lyons (2000) argues for critical approaches to examine health issues in mass media, specifically, she says, a critical approach enables examination of the social, cultural and political context of health and illness and thereby a means of not only identifying power relations embedded in the mass media constructions but also, by making these constructions explicit, provide possibilities for the resistance of dominant representations.

Quantitative description of media was one of a number of ways of demonstrating the findings of my analysis. It was the most appropriate because the number of articles studies lent themselves to quantitative description of change over time. I chose to examine newspapers articles drawn from four South Australian newspapers over a 13 year period as these newspapers were a key form of media available to rural residents, health care professionals and women. Additionally, the period over which the articles spanned was a time during which a number of key shifts were evident in medical and feminist literature.



Lyons (2000), also working from a feminist reading of poststructuralism argues:

*...portrayals in the media have a vast influence in defining and shaping societal attitudes and views concerning health and illness. Media representations are also widely influential at the individual level.*

(p. 350)

Mass media influence people's perceptions concerning risk to certain health threats, media representations also influence conceptions about who is responsible for health (Lyons, 2000). She argues that dominant representations in media texts mediate lived experience since we understand our experience of our bodies within a social and cultural framework. Moreover, media functions to reproduce normative reality for women at menopause. Lyons (2000) using the example of a television documentary about early menopause demonstrates how negative constructions of menopause embedded within dominant representations of disease.

*...function not only to reproduce negative attitudes towards ageing women, but also to influence women's understandings of themselves.*

(p. 353)

Media, she says, is a site for the production of subjects. It influences behaviour through the

constructions of the subject positions available to individuals, and therefore to the actions (behaviour) possible within those subject positions.

Data for this study was collected using the Presscom database operated by library staff at the University of Adelaide for the collection 1986 – 1995 inclusive and at Flinders University of South Australia for the collection 1995 to 1998 inclusive. Data in the year 1995 collected from both sites was examined for consistency of data downloaded from the database. Four local South Australian Newspapers were selected The Advertiser, The News, The Sunday Mail and Messenger: morning and evening daily, Sunday paper and a free regional weekly paper respectively. During the collection period The News ceased operations and The Advertiser changed ownership and changed from broadsheet to tabloid format. All articles from these four newspapers for the period 1986-1998 inclusive were collected by use of the following keywords: menopause, hormone replacement therapy and HRT.

I use the term representations throughout this chapter to indicate the edited as well as constructed form of mass media presentations. I interrogate the way these representations are produced as believable accounts. I use the term not in its sense of being representative, a typical example from a sample, but rather as a portrayal of an object, in this case menopause. Print media texts are unlike many other texts that are examined in qualitative research such as conversations and interviews media texts are always already edited. This editing process relates to the political and institutional structure of mass media (media ownership and

advertising and sales imperatives) and includes attention to a range of news values (newsworthiness, accuracy, balance) practical considerations (clarity of expression, space, juxtaposition with other articles on the page) and the exercise of journalistic judgement and choice about what to include (which descriptions, quotations or interviewees, scrutiny of other media sources – syndicated media outlets such as AAP and Reuters and rival media providers) (Chapman and Lupton, 1994).

## **4.5 Analysis and Interpretation**

### *4.5.1 Analysis and Interpretation: Study 1, GPs*

Discourse analysis was used to analyse the text produced by the interview transcripts. Initial analysis took the form of close reading and subsequent categorisation of the text by content to allow detailed analysis of manageable sections. Each category was analysed systematically, examining the descriptions of objects in the text to identify the strategies used in their construction (cf. Potter, 1996) and the subject positions produced by these descriptions (cf. Parker, 1993). Interpretation of qualitative research is a complex reflexive process (Denzin and Lincoln, 1994). In this study tentative hypotheses regarding the discourses employed and their effects were developed and noted throughout the analysis. These hypotheses were challenged by examining examples of the text for conformity and variation, and by posing alternatives to the proposed explanation. This development and examination of possible explanations was an iterative process. The resultant interpretation of

the text produced in this study is one of a number of possible interpretations. This being so, a representative selection of extracts with detailed interpretation is included so that the reader may assess that interpretation (cf. Potter and Wetherell, 1987; see also 4.2.2.1).

#### *4.5.1.1 Transcription*

All the interviews were transcribed verbatim into a word processing program. A dedicated program for qualitative analysis was deemed unnecessary, as the analysis of discourses themselves in the text did not require electronic management. To ensure anonymity names of people and places have been changed. Having fully transcribed the interviews these transcriptions were checked against the tape recording for accuracy. Standard conventions based on Jefferson (1985) for transcribing text were followed (See Appendix 2). Both the questions and answers were included as were short verbal comments such as 'right' and 'really' but non verbal 'um's and 'er's were not included as they were not considered necessary in this type of analysis. Pauses and interruptions were also included. Intonations and speed of delivery were not recorded. The specific conventions used in the presentation of transcripts in this thesis are detailed in Appendix 2.

#### *4.5.2 Analysis and Interpretation: Study 2, Media*

In a quantitative description of a content analysis of the media articles in this study I describe numerically the shifts apparent over the 13 year period. Quantitative descriptive analysis of articles is used to demonstrate the thrust of the presentation of menopause and the shifts in

this. The organisation of content categories into themes occurred on the basis of the constructions of representations. The process of developing the categories was a qualitative one. The study identified one dominant presentation of menopause, the 'hormonal menopause', and two alternative presentations in the framework of 'feminist' and 'alternative therapies'. A fourth way of presenting menopause, 'information, choice and decision-making', saw coalescence of the three dominant and alternative categories.

Simple descriptive statistics only are reported here. Frequency and distribution were recorded and the proportions of the total number of articles for each years were calculated as a percentage for the 13 year period. A table of the distribution of media articles according to category is included in Appendix 3. Using an excel spreadsheet the distribution of article categories over time proportions were plotted on a scatter graph. A 'trendline' was calculated in the Excel program to determine whether the appearance of the category had increased or decreased and, using the slope and correlation coefficient calculation, to what extent.

Graphical representation of the trends reported here are included in Appendix 4.

The content analysis employed a coding frame developed by categorising the articles on the basis of themes that developed inductively after multiple readings of the text, examination of similar studies (see Chapter 3) and an iterative process of moving between the literature, and Studies 1 and 2. A content analysis was conducted by counted all articles in which the category or subcategory appeared and recording these instances (see Appendix 3).

Tabulated results and descriptions of each category and its representation in the newspapers are included in Chapter 6. A description of the change in these categories over the period is also included.

## Chapter 5: General Practitioner Interview Study

### 5.1 Introduction

As identified in Chapter 3, the key criticism of many feminists relating to medical constructions of menopause and by implication some medical practices is that these constructions reproduce and maintain social power relations in such a way as to disadvantage women. This, they argue, is achieved through the use of misogynist discourses of femininity, which produce subject positions for women that construct them as inherently weak and vulnerable. Particularly in the medical sphere, feminists argue, this version of femininity is reducible to and explicable by what are seen in the biomedical sciences to be fundamental biological processes.

The focus of this chapter is a presentation of the findings of a discourse analysis of interviews with general practitioners. Questions raised in Chapter 2 about medical practice in relation to menopause are asked here in the examination of interviews with general practitioners:

- a) 'How is menopause constructed in general practice and what are the effects of these constructions?'
- b) 'Does the shift identified in medical literature in the late 1990's (see Chapter 2) from conceptions of menopause as a disease to menopause as a natural

transition, albeit a marker for prevention, fundamentally change medical practice or power relations between medical practitioners and women?

- c) 'What are the implications for medical practice of shifts in medical constructions of menopause?'

## **5.2 The Hormonal Menopause**

Given the questions evident in the critical, largely feminist, literature regarding the nature of menopause, one of the areas explored in the interviews was: What is menopause?

Participants were specifically asked: What does the term menopause mean to you? and, to develop and clarify this explanation, How do you explain/describe menopause to your patients? In their discussion the general practitioners produced descriptions of menopause which relied on what I have called a hormonal determinist discourse of menopause; the 'hormonal menopause'. This discourse is determinist in two specific ways. Firstly, the discourse of hormonal determinism in menopause produces an explanation in which decline or depletion of hormones is the cause of menopause: menopause is a fundamentally biological phenomenon. Secondly, in the hormonal determinist discourse hormones determine the consequences of menopause.

Asked for a definition of menopause, Dr. B. described menopause as a finale, the end of reproduction.



*Menopause as the name indicates 'meno' means menstrual cycle, 'pause' means there's a pause in it. So when a woman stops menstruating...and when it totally stops..that's what is known as menopause. (Dr. B.)*

*So when you're talking to a patient do you..what aspects of menopause do you talk about with them? (MM)*

*Well..the answer which I gave you just now, about menopause that to stop the periods..it can stop even if it is not menopause, but it is at a certain age when they stop menstruating say after.. at the end of their productive life..because they can stop their period even when they're pregnant so that is not menopause. (Dr. B.)*

*Sure, of course. (MM)*

*At the end, you know, of the reproductive cycle when they stop periods and they don't have any more periods because of the hormonal lack in the body...you know oestrogen and progesterone. That's menopause. Just to clarify. (Dr. B.)*

Menopause here is a biological phenomenon exclusive to women. This construction is established through the definition of menopause as the end of a biological function, menstruation, which is experienced by women only. Dr. B. uses two strategies to establish this particular construction of menopause. Firstly he provides authenticity to his description by presenting an etymology of the word menopause to underscore his definition. In relating "meno" to the menses and "pause" to the cessation of these menses the biological nature of menopause is consolidated. In addition he calls on common knowledge to affirm this

construction: "*what is known as menopause*". By presenting his version as officially established, as well as popularly understood, Dr. B. engages in a process of making this version unproblematic and true. This is a necessary basis upon which to build his later arguments in relation to what he considers ought to be done about menopause.

When asked to expand on this description of menopause Dr. B. seeks to confirm the definition he has already given. This recasting of his definition is used to clarify and make explicit some of the elements of the definition but its ultimate purpose, through repetition, is to consolidate his version. In this short excerpt Dr. B. uses the words "*stop*", "*stops*" and "*end*" no less than nine times. No longer merely a "*pause*", suggesting the possibility of resumption, menopause is "*the end*": the end of productive life, the end of reproduction, the end of menstruation and the end of hormones. Through his 'clarification' Dr. B's construction of a biological menopause is developed as an end point which occurs in all women "*at a certain age*" as the result of a "*lack*" of hormones.

Asked for a definition of menopause, Drs A., D., E., F. and G. described "*oestrogen withdrawal*" and "*hormonal change*", "*cessation of ovulation*" or "*periods*" as the basis for the onset of menopause and as an approach to treatment.

*Well, I mean the medical definition is the cessation of ovulation. I mean, I think they've defined as six months of no menses.* (Dr. A.)

*Oh, well basically we're dealing with a hormonal change situation. A woman's reproductive life lasts a variable period of time and comes to an end with a drop off in hormone levels in the system which makes changes in the body. Those changes are often heralded by, so-called hot flushes and all the symptoms that everybody knows are related with menopause.*

(Dr. D.)

*It's a period of time over which the body gets...the ovaries stop functioning, and the body gets used to the ovaries not functioning. And some people get symptoms, other people don't. And the symptoms are basically because of oestrogen withdrawal; the same as any other withdrawal. And... depending on a few... things, you can do certain things about it.*

(Dr. E.)

*Well menopause is cessation of periods.*

(Dr. F.)

*As far as I'm concerned it just means that the, means that the ovaries stop producing the hormones that they've been producing and it causes all sorts of disturbances in the body.*

(Dr. G.)

A medical menopause is typified by the example of hormonal determinism found in these extracts. The end of reproductive life is heralded by an end to menstruation that is caused by the cessation of ovulation resulting from a decline in the sex hormones oestrogen and progesterone. These general practitioners describe menopause as a physiological process and in doing so establish one premise in the understanding of medicine as being the most able to understand and respond to menopause.

The elements of the construction of 'menopause' as biological, seen in Dr. B.'s description, are evident also in the four responses above to the question: What is menopause?

Menopause here is female; only women ovulate or menstruate therefore, as for Dr. B., the cessation of ovulation and menstruation establish menopause as a woman's condition.

Menopause is the end of reproduction. A lack of hormones is presented as being the cause of these phenomena. In contrast with the central place of 'the end of menstruation' given in each of the other accounts, Dr. G. and Dr. D. make explicit the relationship of menopause to the lack of hormones, by using 'hormones' as the defining feature of menopause. By assigning to these hormones a determining function in menopause it therefore becomes possible to attribute to menopause a range of effects on a woman's body.

In establishing this construction of menopause each uses a slightly different strategy; Dr. A. appeals to medical authority, Dr. G. to her own understanding while Dr. F. and Dr. D. each present an unequivocal statement of what menopause is. The assured presentations by Dr. F.

and Dr. D. are enhanced by the simplicity of the definition in Dr. F. and by Dr. D.'s implied reference to an essence of menopause: "*basically we're dealing with...*". For Dr. D. menopause is an entirely physiological phenomenon definable and explicable in terms of a shifting hormonal balance. Dr. D.'s description is illustrative of a construction of menopause as the end of a woman's reproductive life. Additionally, Dr. D. draws, as Dr. B., on a strategy of establishing these consequences of hormone depletion as real, by appealing to a wide and established knowledge of these consequences: "*all the symptoms that everybody knows are related to menopause*". These strategies serve to support the versions given by the speakers as real. These 'real' definitions provide a rationale for their responses to menopause in the clinical setting.

The descriptions of menopause in these five accounts establish a construction of menopause that incorporates four key elements, the end of reproduction, sex difference, age and hormones. In this construction menopause is exclusively a woman's condition, it represents the end of a woman's reproductive life and is heralded by an end to menstruation that is caused by the cessation of ovulation resulting from a decline in the sex hormones oestrogen and progesterone. The elements of this construction of menopause underpin two important functions for medical practice in relation to menopause; first, it enables medical intervention in menopause to be deemed appropriate and second it provides a rationale to establish the acceptable range of medical intervention in menopause. This definition is, however, insufficient to carry out these functions. A key strategy, therefore, in maximising the effectiveness of this construction of menopause lies with the possibilities that it opens up for

the association of specific effects and consequences with the menopause. The strategies employed to achieve this effect, however, are varied. The subject positions made available to women as a result of these strategies also vary. Hormonal explanations of menopause were used by all general practitioners. Additionally a key component of responses included expanding this explanation to the relationship of menopause to symptoms and long-term health risk.

### *5.2.1 Consequences of Menopause: Hormones, Symptoms and Risk*

The definition of menopause as the end of reproduction and ovulation described in section 5.2 explicitly links a decline in hormones to a range of effects, symptoms and risks.

For Dr. A., menopause is the beginning of the end. With the decline in hormone production a woman's body slides into decay as the consequences of the lack of these hormones take effect. This construction has a particular purpose, that of enabling and encouraging medical intervention: specifically pharmacotherapy.

*Well, I mean the medical definition is the cessation of ovulation. I mean, I think they've defined as six months of no menses. (Dr. A.)*

*OK.. If you're explaining it to a patient.. (MM)*

*OK right.. If I was explaining to a patient I'd usually say well.. when you went through puberty you'd started getting your period that's when your ovaries*

were turning on.. producing eggs.. some women cyclically once a month, some women you know.. irregular and things. That at a certain time the ovaries decide that they are not going to produce more eggs, and it doesn't matter how much the brain tells them to produce the eggs they stop producing the eggs.. therefore they stop producing.. stop producing the hormones and then stop menstruating. Then I go on to say that.. while it doesn't matter that your not producing the eggs what really matters is that your not producing the hormones associated with those eggs.. and.. that they have. Then go into all the other effects that the oestrogen has [...] talk about the bones, the heart disease.. the vaginal lining, the bladder lining. I mean skin, depression, mood swings.. hair, hair loss all that sort of thing. Protection against strokes, protection against heart disease. And I tell them that they probably don't know any women under the age of 50 that have had a heart attack but there are plenty of men who have had heart attacks. All those sort of things... Talk to them about.. you don't see too many 70 year old men falling over and breaking their hips but you see quite a few women falling over and breaking their hips. Try to bring it down to very much their own experience.. try to convince them to take their hormone replacement therapy.

(Dr. A.)

Dr. A. establishes what he understands by "*the term menopause*" using key elements of the biological construction of menopause as the end of reproduction and ovulation and by calling on the authority of a "*medical definition*". Dr. A. then responds to my question asking him to expand on this definition by talking about how he would explain this to a patient drawing upon a reverse puberty model. Of the possible range of quite complex models available in medical texts and literature which describes the production of a range of hormones by the ovaries, the

variations of these hormones in the body and over time (oestradiol, oestrone), and their production in a number of sites in the body (ovaries, fat tissue and adrenal glands) Dr. A. presents a simplistic production model of ovaries that 'turn' on at puberty and 'turn' off at menopause. Since the industrial revolution medicine has often used the metaphor of vehicle manufacturer Ford's scientific management inspired line production model as a model for health and human physiology (Martin, 1992). Inputs are made to produce or maintain the machine or body; outputs are the completed machine or well functioning body. An imbalance in the mechanism will result in an impaired or inadequate machine/body. In this vein Dr. A. refers to production and the cessation of production using the terms "stop", "produce", "producing" eight times: "*they stop producing the eggs.. therefore they stop producing.. stop producing the hormones and stop menstruating."* This repetition reinforces the construction. The production model used here serves a double purpose. First, it establishes the link between ovulation and hormone production and therefore the association of menopause to declining hormone production. Second, using this simplistic model of the functioning of the ovaries obviates the need for a more complex explanation, one that may appear contradictory to Dr. A.'s present version of menopause. This is just one of a number of possible explanations. Martin (1997), in a review of the presentation by medical texts of the subject menopause, shows how almost invariably menopause is constructed as an end point rather than a transition. Where menopause is described as an end point the language used is that of decline and decay. This is the version of menopause presented by Dr. A. and the other general practitioners in this study.



For Dr. A. menopause is hormone deficiency. This hormone deficiency and therefore menopause has certain consequences that require medical intervention. The production model is used here to establish an explanatory model of menopause, which makes possible the replacement of endogenous hormones with manufactured oestrogens. This reverse puberty model is also presented as a process in which a woman's body exerts control. The ovaries and brain are given agency in this process; *'the ovaries decide that they are not going to produce more eggs, and it doesn't matter how much the brain tells them...'*. In this way the subject position built for the 'menopausal woman' is of a woman who is separated from her body. It is a 'menopausal' body over which she has little control. A 'menopausal' body which, because *it* not *she* has agency, is implicitly a body which can be separated from a woman's own knowledge of it; thereby leaving a space for expert, medical, knowledge.

Having established a relationship between the end of ovulation and hormone depletion as 'menopausal', Dr. A. proffers a list of symptoms and effects of oestrogen. In this enumeration of decay and degeneration to which the 'menopausal woman' is subject, Dr. A. demonstrates the wide reaching and devastating effects of oestrogen loss. Dr. A. follows this description with a story about gender difference that serves to reinforce the 'oestrogen connection' in a demonstration of the peculiarly female nature of these changes. He says that he tells this story of gender difference in this way so that his patients will associate these effects of oestrogen 'depletion' with their own experience of the real world: *"bring it down to very much their experience"*. He creates this "*reality*" of menopause for them in this story; indeed he attributes ownership of it to them. This "*reality*" is constructed with an express purpose: to "*try*

to convince them to take their hormone replacement therapy”.

Continuing the hormonal basis of menopause, Dr. F. illustrates the significance of ‘symptoms’ and ‘risks’ to long-term health: they are paramount in this interview and justify the use of hormone replacement therapy both during and after menopause.

*I discuss the treatment of the menopause in three main areas. One is management of symptoms which is flushes and dry vagina and so on. Secondly, prevention of osteoporosis. And thirdly the prevention of cardiovascular disease. I tell the patients those are the advantages. I tell them the disadvantages which are the expense, I suppose, and the fact that if they are taking the hormone replacement therapy to prevent osteoporosis and cardiovascular disease they have to take it for probably fifteen years, we don't really know how long. And that's what they're setting out on. Also I mention the fact that some surveys have shown a slight increase in breast cancer. And I think it's their decision.*

(Dr. F.)

In Dr. F.'s account of three main areas that comprise counselling women about menopause, hormone replacement therapy is presented both as a treatment for menopause as well as having the possibility of preventing long-term illness. The centrality of symptoms, unlike Robert Wilson's earlier writings on menopause, are not used to portray the depleted state of the post-menopausal woman, rather they build a case around prevention that links the lack of

hormones with osteoporosis and cardiovascular disease. Menopause is constructed as a physical condition that could lead to related physical conditions. The changing construction of menopause from one dominated by femininity to one incorporating a discourse of prevention involves risks and choices: the risks of hormone replacement therapy; the risks of menopause to health; that it is the woman's choice to use hormone replacement therapy or not; "*I think it's their decision*"; and, that women are responsible for their long term health. Menopause is risk.

In discussing 'treatment' a linguistic strategy of contrast is used in the presentation of the "*advantages*" and the "*disadvantages*" of using hormone replacement therapy. The advantages, the elements supporting the menopause story and the use of hormone replacement therapy, are unequivocal. Symptoms are 'managed' and 'knowable'. So knowable in fact that only the first couple in a mental list need be articulated. Common knowledge "*and so on*" is called upon to fill in the gaps. Osteoporosis and cardiovascular disease are 'prevented'. The "*disadvantages*", however, are less equivocal. Each disadvantage listed by Dr. F. is accompanied by a qualifier (underlined) which serves to diminish the importance of the 'disadvantage': "*the expense, I suppose*"; "*they have to take it for probably fifteen years, we don't really know how long*", and "some surveys have shown a slight increase in breast cancer". Having thus described a menopause that requires a treatment that has certain advantages and less certain disadvantages the decision about treatment is presented as being the woman's: "*And I think it's their decision*". This appearance of balance, through the presentation of advantages and disadvantages, allows Dr. F. to present her practice as an enlightened and empowering one. This has important

consequences for medical practice and health education related to menopause, which are explored in the discussion in Chapter 7:

The distinction between advantages and disadvantages, risks and benefits and short term and long term effects of oestrogen loss becomes very important in the practices engaged in by general practitioners in relation to menopause and are discussed across the interviews. As observed in the medical literature, this shift has important consequences for the changing rationale for the use of hormone therapy.

The key focus shifts away from menopause as a discrete medical condition to it being the cause of other physical conditions. For this reason the discourse of prevention also serves the function of securing menopause as a medical concern. General practitioner, Dr. B., illustrates this point:

*Well I don't talk about menopause if they don't have symptoms, but I'll definitely talk about hormone therapy in relation to osteoporosis, and heart disease and cholesterol.*

(Dr. B.)

Using a discourse of prevention enables Dr. B. to present an argument for hormone therapy

regardless of the manifestations of hormonal change in menopause. Like Dr. F., the reporting of symptoms is no longer central in Dr. B.'s treatment of menopause. The discourse of prevention enables the construction of a new menopause within medicine which acknowledges differences between women's experiences of symptoms, and the possibility of the experience of no symptoms: *'Well I don't talk about menopause if they don't have symptoms'* (Dr. B.). The discourse, most importantly, continues the relationship between menopause and medicine because all women due to the loss of hormones are 'at risk' of debilitating diseases that require medical attention.

There are parallels in this prevention discourse with the discourse of femininity used in medical descriptions of menopause from the late nineteenth century to the 1960's. In contemporary descriptions of menopause the importance of the experience of symptoms in establishing the consequences of menopause, particularly loss of femininity, is displaced by the concept of long-term risks to health. In each discourse a loss of hormones is presented as the universal biological truth of menopause and is identified as a problem requiring medical intervention. In this way, the effects of hormones appear as if they are inescapable. Feminists and other critics of medical accounts of menopause as symptoms argue that the emphasis on hormones constructs women as a homogenous group who are weak and vulnerable due to the loss of hormones (cf. Mackie, 1992; Coney, 1993; Harding, 1996). A similar criticism can now be applied to the construction of menopause as a risk to long-term health. While the 'menopausal woman', subject to the "vagaries" of symptoms, remains a useful category to bring a woman within the medical gaze, it is not loss of femininity, but the long-term

consequences of menopause that now constitute the inescapable biological 'reality'.

### 5.2.2 Variation: Uncertainty and risk

The association of hormonal decline to symptoms and long term consequences of menopause establishes a rationale for the use of hormone replacement therapy. Variation in the discussion of treatment of menopause includes uncertainty related to these risks. Though it may seem self evident that risk brings with it uncertainty, this is not the predominant meaning used by general practitioners. Dr.s F. and B. above in referring to prevention, present an unequivocal case for the risk-reducing effects of hormone replacement therapy. Dr.s C. and E. are no less certain of the potential of hormone replacement for disease prevention but consider a complex calculation of risk.

*The studies [about breast cancer] are inconclusive at the moment, things emerging about risk of, you know, previous breast problems or family history and that's what you're looking at and..they, ..you know. In the end I suppose they end up saying 'well can you be absolutely sure', you know, 'because we've read this and it must be right'. And then we're saying 'well you can't be absolutely sure about anything. You've got to weigh up the pros and the cons'. And, and that understanding of the fact..that medicine is about pros and cons, its not about absolutes is a difficult one. And they get breast cancer, which they may do anyway, but blame the HRT and you're in the firing line.*

(Dr. C.)

Dr. C. provides an example of variation in the presentation of menopause and the use of hormone replacement therapy in that he describes hormone replacement therapy and its risks in terms of the uncertainty of medical knowledge: "*you can't be absolutely sure about anything*". He positions himself in a dialogue with patients who bring absolute knowledges to the encounter, "*we've read this and it must be right*" contrasting it with his own contingent thinking. Dr. C.'s presents himself as tempering patient certainty with medical uncertainty. By arguing that there are no "absolutes" he introduces a process of decision-making, of weighing up "*pros and cons*". Despite introducing the concept of decision-making he presents this discussion of risk as a difficult one for him because regardless of the risk and cause of breast cancer, "*they may [get it] anyway*", hormone replacement therapy and therefore he will shoulder blame: "*you're in the firing line*". While this is clearly a shift not only from the confident assertions of his contemporaries in this study but also away from conceptions of a knowable and predictable medicine drawn upon by them in their descriptions of menopause and hormone replacement therapy it functions to problematise risk, decision-making and clinical responsibility/blame.

*I don't give them any guarantees. My, I think the last time I talked about [risk of breast cancer] I said 'hormone replacement's been around for a long time, they've done a lot of studies, some studies have shown it slightly increased the risk..but its only been marginal, the other studies have shown a massive benefit from heart disease and..osteoporosis. And I've got my own personal bias that perhaps what's happening is..I say to the ladies well maybe they're not dying of heart attacks at the age of seventy but they're dying of the breast cancer at the age of eighty. But..I think if there's a strong family history..and they really felt*

*uncomfortable I wouldn't push it or..but I know if they still don't believe it well I don't push it onto them anyway.*

(Dr. E.)

Like Dr. C., Dr. E. does not present medical research as incontrovertible fact. She describes the variation in research findings citing the long history of the drug and the equivocal results of numerous studies conducted on its use. Nevertheless she up-plays the benefits and downplays the risk of hormone replacement therapy in her assessment: the "*marginal*" increased risk of breast cancer reported in one study. Unlike Dr. C. description of uncertainty in medical practice, Dr. E. proffers her own epidemiological theory in a risk benefit analysis of hormone replacement therapy and breast cancer risk. Regardless of the range of ways she is able to explain the research results Dr. E. states that she won't "*push*" the use of the drug onto them for three reasons: if they have a "*strong family history*" of breast cancer, the woman feels "*uncomfortable*", or if the women isn't convinced of her explanations "*if they still don't believe it*". The first reason given for not 'pushing hormone replacement therapy is in line with best medical practice at the time of interview. The second and third reasons afford a passive agency to the women: this contrasts with the active agency described earlier by Dr. C.

### 5.2.3 *Variation: Menopause and femininity*

Variation in the deployment of femininity as a characteristic related to menopause is demonstrated by Dr.s. E. and F. who play down considerations of femininity as being



important in menopause

*I know they used to say that the people that went through their menopause, the women felt that they'd lost something and that they were no longer full females and they had lost their re.. But basically I don't think that applies now, because a lot of people who are fifty now, which is about, fifty two or something and that, they've chosen to stop having children fifteen years ago and they've done their tubes tied and that's it. They've done it already. It suits their reproductive life. And also, I mean, a lot of them, its amazing how many people have had a hysterectomy. So that, you know, they get to menopause and they still get symptoms but they don't sort of feel the loss of womanhood or anything. An I think its just, some people are so glad to see the end of their periods and some people its just a hiccup. I haven't got the impression it's a big drama. 'Oh, I'm menopausal now, I'm old'. Fifty two isn't old anymore.*

(Dr. E.)

Dr. E. rejects menopause as the loss of femininity; a femininity constructed in terms of reproduction. This rejection of an earlier construction is achieved by displacing an historical narrative, "*they used to say*" by demonstrating that it is no longer relevant to the reproductive lives of the "*people who are fifty now*". This change away from menopause as the loss of "*womanhood*" is achieved through the separation of menopause, reproduction and femininity. Some women who don't have a uterus because of hysterectomy don't feel this loss of reproductive capacity because the physical site of reproduction has already gone. Other women are glad to see the end of that part of their lives. Menopause remains physiological,

"they still get symptoms", and are therefore open to medical intervention, but it is not necessarily a crisis, "a big drama". Referring again to historical change menopause no longer equates with old age: "Fifty two isn't old any more".

*I suppose people are concerned about getting old and things like that. Certainly there is a concern about menopause if it happens at thirty five, as it does in some women. I think that comes as a bit of a, reminds you perhaps of your feeling of femininity a bit, if you're menopausal at thirty five.*

(Dr. F.)

In talking about those aspects of women experience of menopause that might cause concern Dr. F., as she has done before, uses relative and absolute adjectives to weaken or strengthen her statements. In this way the immediate effects of menopause are reinforced while the attitudes and thoughts about aging are diminished in importance in her version of menopause. Like Dr. E. 'loss of femininity' at menopause is not necessarily problematic. Distance from the notion of 'the loss of femininity' as a consequence of menopause is achieved through Dr. F.'s strong delineation, "certainly", of an association of menopause with femininity as being a "concern" only if menopause is early. Early menopause may result from oophorectomy, surgical removal of one or both ovaries, as part of a hysterectomy or as a result of disease, rarely it occurs spontaneously.

*We've got a group, and I can't quantify them, of women who deny that it happens. And just go into a denial thing and you know. There's a group of women who are absolutely terrified they are losing their womanness or femininity or whatever and they're banging on your door for hormone replacement therapy or something instantly. And one has to assume that that reflects some sort of relationship..difference between their husbands and themselves. And it might be that they're trying to retain some kind of relationship or whatever it might be or appearance, whatever. And there are those who seem to have come to terms with the, realities of physical change and they just come along, very practically and sort of say 'Well now. What's happened to me? What should I do? What are the odds?'*

(Dr. D.)

Dr. D. uses femininity as a tool to describe an ideal or appropriate response to menopause by women. Dr. D. positions women as falling into one of three groups. In contrasting these three groups a judgement is made about the most appropriate, most acceptable way to experience and manage menopause. That ideal menopausal woman is one who puts herself in the medical gaze. This group who he describes as having accepted the "realities" of menopause are presented as taking the appropriate course of action: they are "very practical". 'Practicality' is defined here in terms of seeking the advice of the medical profession, to have that professional define that experience, "What's happening to me?" and seek from medicine a solution to this "reality", "What should I do?". Moreover, having engaged the general practitioner in establishing a woman's relationship to risk they are to seek their general practitioner's calculation of this risk. 'Femininity' here functions to demonstrate, in the

negative, an appropriate response to menopause: one that doesn't include concern about 'loss of femininity'.

This 'acceptable' response to menopause constructs a subject position for the 'menopausal woman' which requires that she seek the knowledge and practices of the medical profession. This acceptable subject position for a menopausal woman is contrasted with those women who either deny menopause or who have too many problems; those who haven't "*come to terms with the realities*". These menopausal women are out of control. Interestingly, this is precisely the subject position constructed for the menopausal woman from the medical discourses of Robert Wilson's 'Feminine Forever' (1966). To be "*terrified*" of the loss of femininity is here not the desirable subject position for the new menopausal woman.

Rejection of menopause as the loss of femininity therefore plays a new role: it enables a continuing medicalisation without resorting to the tactics of the Wilson era. This trend is seen also in the pharmacological advertisements of recent years. The new menopausal woman is active, fit and healthy, no less a woman because of lack of hormones but nevertheless susceptible to their effects. Effects, both short and long term, which can now be controlled, or so the manufacturers claim, with hormone replacement therapy. With hormone replacement therapy the new menopausal woman can conquer her biology.

#### 5.2.4 Variation: A process not an event

While the GPs describe a menopause that clearly goes beyond "*the cessation of menstruation*", the description of the process of menopause above has largely been described as a fairly predictable closed set of events that are the inevitable result of menopause. Avoiding diversity and complexity serves to strengthen the apparent inevitability of this version of the workings of menopause. A construction that eliminates internal contradictions by simple presentations acts to preserve the appearance of the uncontested nature of menopause: of the truth about menopause.

Having a physiological basis the symptoms and consequences of menopause are knowable and predictable in the scientific medical paradigm. The occurrence of these effects is presented as a linear progression, with oestrogen loss precipitating a slow decline. While Dr. E. and Dr. H. consider menopause to be the reduction in hormones which has specific consequences, thus maintaining the construction of the biological hormonal menopause they each consider the progress of this loss a somewhat more complex and less linear process. This is a key variation in description of menopause in medical practice.

*It's a period of time over which the body gets..the ovaries stop functioning, and the body gets used to the ovaries not functioning. And some people get symptoms, other people don't. And the symptoms are basically because of oestrogen withdrawal. The same as any other withdrawal. And ..depending on a..few things, you can do certain things about it. Unfortunately menopause*

*can last one day in some people and it lasts about ten years in other. Because the sort of pre, peri can, you know, they have these perimenopause, periods get up shit creek for some people for about ten years before and they have symptoms for five years after. Other people just wake up one day and say they haven't had a period for a year. [...] Some people go through menopause with no problems and they don't need anything, need to do anything its just they're, the commonest thing is hormone replacement therapy and there's three main reasons people are using that.*

(Dr. E.)

For Dr. E. the clinical presentation of menopause is variable. In contrast to the definitions of menopause in Section 5.2, characterised by hormonal determinism, Dr. E. describes menopause as a period of time rather than an absolute event. The outcome of menopause is the same for her as for the other general practitioners: the ovaries cease to function and the remedy to the effects of this is hormone replacement therapy. The process, however, associated with this cessation of function is one of adaptation rather than decline into 'lack' or 'absence'. Symptoms here are not a response to the 'lack' of oestrogen, rather they are in response to a changing environment in the body. The process of menopause here includes numerous stages and can last a varying time. The experience of symptoms is neither universal nor uniform. This presentation of menopause appears to align itself more closely with those descriptions of menopause given by modernist, second wave feminist as an alternative to the medical constructions of menopause (cf. Greer, 1992). This menopausal body is an active adaptive body rather than reactive, lacking body. It is nevertheless a body in

need of expert assistance. The very variability of this version of menopause provides numerous opportunities for clinical intervention.

While the variability and naturalness of menopause are highlighted here, there is no difference in the solution offered for menopause. Presence of symptoms or clinical signs is no longer a necessary prerequisite for the prescription of hormone replacement therapy. Symptoms may be present but their existence is not required to be inevitable in this construction. The use of hormone replacement therapy is given credence in two other ways. The credibility of hormone replacement therapy is enhanced by the implied acceptability in its "common" usage. Secondly, the three reasons for use are positioned as emanating from the people who use hormone replacement therapy rather than those who prescribe it: "*three main reasons people are using that*". In this way 'ownership' of this medical solution is placed with women themselves, as it was for Dr. A. and Dr. F. above.

*...looking sort of at perimenopause going through, a lot of the symptoms that you get are not because of an absolute lack of oestrogen its because your levels one day are high and the next day are low. And that it's the relative, from one day to the next, the high to the low, that tends to give you a lot of the symptoms. Particularly the hot flushes, the mood swings. All of those sorts of things. Getting towards actual menopause. Once your ovaries are no longer producing any oestrogen whatsoever, you still make a little bit in your fat so you still might be getting a little bit of ups and down but there are some symptoms that are more of a problem when your body is making no oestrogen whatsoever and which is more the dryness in the vagina and the discomfort from intercourse, urinary*

*symptoms, more the dryness in the skin some of those sorts of things. And I tend to tailor that to where the woman is and what symptoms she's actually thinking of.*

(Dr. H.)

Dr. H. has a somewhat different explanation of what is happening. Referring to the relative effects of oestrogen she, like Dr. E., describes a changing environment within the body. For Dr. H., it is this change that creates the symptoms. Despite contradicting the ideal type of the medical model in this way the descriptions of this unpredictability in the varying stages of menopause described here still rely on the hormonal explanation of menopause. Menopause is resolutely physiological. Interestingly this description of menopause as a process with different effects occurring at different times and experienced differently by different women does not as implied in the feminist criticisms close off the opportunities for medicine. In fact it opens the field for the interpretative capacity of the expert to be displayed: Dr. H. is able to construct, "*tailor*", her approach to the particular experience of a woman. While, again, this would appear to lead to a satisfactory solution for feminists, such as Greer and Coney, it does not necessarily do so. This construction of menopause as variable and complex, does not change the outcome for treatment. Rather, variability and complexity provide the expert with additional opportunities for interpretation and the practice of their expertise.

Despite the different strategies used in these descriptions and definitions in the examples



above, 'menopause' remains the same. Whether the consequences of menopause are presented as inevitable or subject to individual variation the solution remains the same. Constructed as a biologically defined and physiologically experienced the 'medical menopause' is a phenomenon that brings with it certain consequences that therefore require medical attention and intervention.

### **5.3 The Informed Menopausal Woman: Prevention and Choice**

The use of a discourse of prevention by medical practitioners changes the position for women by affording them a 'choice' about whether or not to take hormone replacement therapy. The general practitioner's role in the construction of the 'medical menopause' related to prevention is to inform women patients.

*The best, my best way is providing them with information, to make their own decisions. That's, I think that's, I mean of course clinically I do their smear tests and blood pressures and things like that but my other, my other role, I think is to provide them with information. Because I, I mean, basically that, that decision about hormone replacement therapy is their decision not mine.*

(Dr. F.)

In interview, Dr. F. positioned herself as the provider of information. Through repetition this

practitioner emphasises that choice belongs to women, and hormone replacement therapy '*is their decision*', although the definition of that choice and decision-making is structured in relation to whether or not to take hormone replacement therapy. With reference to her roles of clinician and information provider, Dr. F. presents her practice as being separate from the woman's decision-making process.

Being an informed woman in this account is not simply achieved by receiving information. The informed menopausal woman is to use this information, this state of being informed, as the basis for making decisions about her health care at the time of menopause and beyond. The woman is to be empowered by the doctor, through the provision of information, to make such decisions. Specifically, a woman is to make a decision about whether or not to use hormone replacement therapy; it's *her* choice.

*I get them to come back, fill out the chart, look at their score. Talk to them about their symptoms, talk to them about what they're reading, answer any questions they've got. And then talk about, well, do we want to do anything... about this. I mean, you know, basically I try to coin it in terms of it's your choice at this point. I'm not going to say you have to take medication or anything, 'cause there are alternatives. You know, you might say, well, perhaps I want to try it or I don't.*

(Dr. C.)

*Basically our job again is empowering women to make the choice of what they*

*want to do. And they'll do that anyway. Because in my experience if women don't like the answers they get from their GP they'll go to another one. And if, people nowadays are very well advised and they know what they want to do and they go and they basically do what they want to do.*

(Dr. D.)

Dr.s C. and D., like Dr. F. earlier, positioned themselves as medical practitioners whose role it is to empower women to make a choice about hormone replacement therapy. Dr. C. explicitly presents the woman's choice as "*coined*" in terms of "*it's your choice*". Dr. D. reinforces his role as well as the autonomy of patients by stating, '*they'll go to another one*' (GP) if they don't like what you say, '*they know what they want,*' and '*they (women) do what they want.*' In these accounts the menopausal woman is not presented as the 'victim' of medical dominance, women are regarded as well-informed and active participants in their own health care.

### 5.3.1 *Information*

That women need information in order to make decisions about hormone replacement therapy is an important aspect of the construction of this subject position, the informed menopausal women. It is notable that in their discussion of information sources and women's knowledge these doctors systematically dismiss or marginalise sources other than themselves. Information as defined and discussed by these doctors is information about a menopause that is biological and therefore it is also largely information about hormone

replacement therapy. The quality of information about menopause was a key concern to some general practitioners who scrutinised information to determine whether it constituted 'good information.' The main focus was on information that included a balanced, medical perspective about the risks and benefits of hormone replacement therapy, or 'misinformation' which included information from mass media, non-medical health professionals and family or friends.

A major source of women's information is described as being the media. The media is talked about as sensationalist and propagandist, particularly in its coverage of the risks and benefits of hormone replacement therapy. It is, therefore, a highly suspect deliverer of information and would best be placed in the misinformation category.

*Menopause. The choice is the woman's. She can be advised, she can be given the information. I am supportive of hormone replacement because of all the positive advantages. I'm aware of the negative issues. I'm aware of how much they are overplayed in the press. And I'm aware of the great weight that the reporters place on medical opinions given by people without medical training. However, the fact is that there is no scientific evidence to support major dramas as a result of that therapy. And there is good evidence of the positive benefits. And I think people need to see that.*

(Dr. I.)

Having established that a choice needs to be made, Dr. I. differentiates what is or is not legitimate information. Dr. I. presents the informed menopausal woman as a woman who is "advised", has a "choice", and has "information." He presents himself as a practitioner who is aware of many of the sources of information that a woman may be exposed to, and by also identifying the strengths and weaknesses in those sources, someone who has expert knowledge. Information sources, such as the media, where negative issues of hormone replacement therapy, "are overplayed in the press", and how reporters place, "great weight on medical opinions given by people without medical training", is considered inferior to medical, scientific evidence. In consideration of the quality of various types of information, Dr. I. achieves a presentation of hormone replacement therapy as the best choice a woman can make.

Dr. I. builds the informed menopausal woman subject position in this extract by linking the key concepts in that subject position; choice, advise and information. Then in discussing the relationship of media to information he explicitly positions himself as supportive of hormone replacement therapy on the basis of sound evidence. This tactic serves two purposes. It maintains his position as one of balance and undermines the information found in the media. This particular device used to undermine media information also serves to maintain the distinction between medical knowledge and other knowledge by marginalising information given by sources other than medical: "medical opinions given by people without medical training". In so doing it also positions information about menopause as appropriately medical.

Dr. C. is equally concerned about the role of the media in information provision.

*That's what it comes down to and the media wreaks havoc I reckon. [...] I suppose things like breast cancer and the association with menopause. It makes it a very difficult thing to discuss when they've read some headline, you know, 'HRT causes breast cancer, new research from the states' or whatever And they come in and a lot of women get very scared.*

(Dr. C.)

In rural areas access to health care and health information is limited (Franklin et al, 1994; Gay et al, 1995). Women are themselves a source of information, through discussion between friends and family, but are considered a prime source of misinformation. Other health care practitioners are not considered as knowledgeable about menopause and therefore may also be a source of misinformation. This presentation of inadequate non-medical health professionals is achieved by one general practitioner through the device of positioning women as concerned about the qualifications and knowledge of non-medical health care professionals such as counsellors and women's health nurses.

*How qualified are they? You know. A lot of women aren't really prepared to go to [counsellors and women's health nurses] for help because they feel that they're really not much more qualified than they are. So there isn't really a great deal. There is some support available but its not a huge support.*

(Dr. G.)

Using a range of strategies general practitioners position themselves as the preferred source of information. Indeed, rural doctors position themselves as even better sources of information because of their higher standards of health care practice, due to the greater practice of a variety of skills and greater involvement in continuing medical education necessitated by independent practice in rural and remote areas where the range of medical services is limited.

*As you know, the medical profession are involved to a large extent in continuing education. Now, much more so that they were ten years ago... And you now need to do all sorts to keep up you vocational registration. In my experience rural doctors do a lot more than were even required to do as far as that's concerned. Probably two to three times what they need to keep up their skills.*

(Dr. D.)

The information sources relied upon by doctors are positioned as recognised and legitimate medical sources such as academic and professional medical journals. Rural doctors are constrained by time that prevents them from effectively accessing their own sources of information. They nevertheless remain, according to them, the most appropriate source of information. Their dismissal or denigration of other forms and other sources of information maintains this position.

Doctors are both the generator of a need for information and the provider of such information. In this context women are nevertheless positioned as having choice in relation to menopause and the now crucial question of whether or not to take hormone replacement therapy. The informed menopausal woman becomes the woman informed about the dominant medical version of menopause. In this way the discourse of the informed menopausal woman becomes yet another strategy for subjecting women to the discourses of menopause and hormone replacement therapy.

### 5.3.2 Variation

Some variation is evident in the discussion of choice and therapy for women at menopause.

*Whereas two or three years ago I really hammered it very hard, hormone replacement therapy... I'm easing back a little bit ... because more and more women are having hassles on hormone replacement therapy.*

(Dr. A.)

In contrast to other interviewees, Dr. A. states neither 'choice' nor a straightforward medical argument to promote hormone replacement therapy. Dr. A. presents a reflexive position on the use of hormone replacement therapy through a direct reference to his own shift in thinking about whether or not hormone replacement therapy is a good treatment to offer women. He makes an explicit reference to his consideration of women's experiences of "hassles" due to



taking hormone replacement therapy as a basis to modify his practice.

The extracts from Dr. H. and Dr. G. accounts offer contrasting views about women's decision-making and the use of hormone replacement therapy.

*Yeah, So it takes me forever [to discuss issues about menopause and HRT]. I believe in the well informed menopausal woman. So, yeah, I tend to go through all that.*

(Dr. H.)

*The best way I can help them is to offer them hormone replacement therapy.*

(Dr. G.)

For Dr. H., the range of issues about menopause and hormone replacement therapy, the length of consultation time involved, and her belief in the "*well informed menopausal woman*" are all considered to be important to decision-making. Dr. G. simplifies the above points by already having made a decision that offering hormone replacement therapy is the best way to help them. While hormone replacement therapy is brought within each of the general practitioners' accounts as being pivotal to a woman's decision-making process, there are variations due to women's experiences of hormone replacement therapy use, the time

allowed by doctors to consider a range of issues related to menopause and hormone replacement therapy, and the extent to which the decision about hormone replacement therapy has already been made by the doctor.

*[reading from the question guide] 'What do you think is the best way for women to deal with menopause and related health issues?' Find out what is available, find out what the problem is, find out what alternatives they have and then when they understand about the condition and about the treatments available or possible management available if its not specific treatment as such, make an informed decision that they are happy with. And don't be afraid to change their mind if they think they made a mistake afterwards. Of course the same advise could be given to some of the doctors. And what ever the woman decides support her in it. But be prepared to support any change of mind.*

(Dr. I.)

Dr. I. talks about the best way to deal with menopause and related health issues as one in which women make 'an informed decision that they are happy with'. Such a decision is an 'informed' one if it is one where they understand the 'condition' and the possible treatments or management available and this is done through a process of 'finding out'. This 'finding out' is a process of determining 'what the problem is' and ascertaining what treatment or management is available to address this problem. In this presentation of this process menopause is termed a problem. While it could be read that 'finding out' "*what the problem is*" refers to a problem specific to the individual woman rather than referring to 'finding out' the

nature of the condition termed the menopause. The relationship built in that sentence between understanding about the condition and the alternatives available as the basis of making an informed decision, suggests the reading of 'menopause as a problem' is more plausible. The condition of menopause is therefore in this construction problematic.

This interpretation of menopause as a problem needing to be dealt with appears elsewhere in the discussion of discourses of menopause. The ways in which menopause as a phenomenon is talked about by the GP's, that is the construction of menopause as a problem, serves to provide a rationale for treatment. In contrast with Dr. A., who uses such a construction of menopause to 'convince' women to take hormone replacement therapy, Dr. I. directs women to find out what they need to about the problem that is the condition of menopause and to thereby make a decision about the appropriate management or treatment. Which ever action they take women are *required* to take some action just as they are now *required* to make a decision about menopause. Menopause cannot be simply a transition, it is something which is problematic and requires action to be taken. In this case the intervention is to be one chosen by the woman. However, this choice is necessarily constrained, at least from the medical perspective by the value accorded that information. As demonstrated in the discussion of information in the informed menopausal woman discourse above this is a value set which regards medical and scientific information as having a higher value and claim to truth. Dr. I. regards the informed decision as always being open to amendment "*if they think they have made a mistake*". It will always be possible to make a better informed decision.

## 5.4 Conclusion

Demonstrated here in the interviews with general practitioners is a shift in the construction of menopause different to a historical approach primarily focused on symptom treatment incorporating instead the preventive use of hormones which was evident in medical literature described in Chapter 2.

General practitioners in this study drew upon a discourse of hormonal determinism to produce an explanation in which decline or depletion of hormones is the cause of menopause. The descriptions of menopause in these accounts establish a construction of menopause that incorporates four key elements, the end of reproduction, sex, age and hormones. With the shift toward the use of discourses of prevention as a rationale for treatment during menopause it is now the potentially preventable long term consequences of menopause, identified as osteoporosis, heart disease and dementia, that are determined by hormones.

The definition of menopause as biological has a range of effects. The association of menopause with a loss of hormones, particularly oestrogen, provides a rationale for interpreting age-related changes to this biochemical change. In the case of menopause as an end point with the markers of that end point being a loss of the production of oestrogen it is possible to define the lives of mid life women through the inevitability of their biology. The consequence of this particular construction of menopause is that menopause is inevitably

brought within the surveillance of the medical gaze. Being biological, menopause and its consequences are real. Being biological, menopause is an appropriate site for medical intervention.

It is demonstrated in the accounts of these general practitioners that even where the experience of menopause is not described as inevitably one in which a range of devastating symptoms ravage the female body, the construct that hormones are causative in the phenomenon of menopause is maintained. Despite variations in descriptions of the manifestations of menopause, it is constructed as essentially a biological phenomenon. Two general practitioners describe menopause as a process rather than simply an event. This description incorporates diversity, presenting an adaptive menopausal body in place of the body in decline described in medical literature and by other general practitioners. In this way this presentation intersects with critique of feminist literature which refer to menopause as a transition. This shift from menopause as decay does not, however, displace the relationship between menopause and medical practice: the variability of menopause in this description opens opportunities for medical intervention.

With the incorporation of concepts of risks and consequences of menopause and risks related to the use of hormone replacement therapy in the hormonal discourse 'choice' and 'decision-making' are introduced into discussions of menopause. Couched in terms of risk most general practitioners present descriptions of the preventive capacities of hormone replacement

therapy as knowable and predictable. Variation in this description of risk is demonstrated. However, the uncertainty related to risk that emerges for two general practitioners, rather than resulting in questioning of the efficacy of hormone replacement therapy serves to consolidate the shift of responsibility for decision-making about hormone replacement to women.

A key target of feminist criticism in the 1980's and 1990's was the construction that defined menopause as a loss of femininity: a version of femininity bound to cultural notions of youth and beauty. In general practitioner interviews this recourse to femininity in defining menopause is largely absent. Rather femininity was excised from menopause with general practitioners demonstrating that the new 'menopausal woman' overcomes the form of femininity in which women are weak, vulnerable creatures. This absence of femininity functions as part of the shift towards women as active decision-makers.

I identify in this analysis the ways general practitioners positioned women as 'informed decision-makers' responsible for their 'choices' about health care and health outcomes at menopause and beyond. The doctor's role in this reconfigured clinical relationship is one of information provision. This construction is built upon an assumption that empowerment can be effected through the provision of information upon which women are to make informed choices. This is a concept of informed decision-making is common to the women's health movement and called for by some feminist critics of 'the medical menopause' (see Chapter 3). Varying sources of information are considered by general practitioners: legitimate sources

include medical and scientific information, suspect sources include information derived from non-medical practitioners, mass media and from women themselves. The effects of these discourses of menopause are considered in Chapter 7: Discussion.

## **Chapter 6: Menopause in Mass Media: Quantitative Description of the Presentations of Menopause in 13 Years of South Australian Newspapers 1986 – 1998.**

### **6.1 Introduction**

Mass media is identified in feminist literature, discussed in Chapter 3, as a key source of constructions of menopause. According to modernist and postmodernist feminists alike representations of menopause in mass media are almost exclusively negative and predominantly medical. Like criticisms of medical constructions of and medical practice about menopause, feminist critics identify in mass media presentations of menopause constructions that are sexist and demeaning to women and that position women, through a biological definition of vulnerability and illness, as physiologically as well as psychologically weak.

The focus of this chapter is a presentation of the findings of a quantitative description of the breadth and scope of 345 newspaper articles from four South Australian newspapers over a 13 year period from 1986 to 1998. Questions raised in Chapter 3 about the presentations of menopause in mass media texts are asked here in the examination of this example of mass media:

- a) How is menopause constructed in mass media and what are the effects of these



constructions?

- b) Does the shift identified in medical literature in the late 1990's (see Chapter 2) from conceptions of menopause as a disease to menopause as a natural transition, albeit a marker for prevention, alter the presentation of menopause in these media texts?
- c) What are the implications for women of shifts in medical constructions of menopause?

This chapter presents analysis of the categories derived from a content analysis of the newspaper articles retrieved from a search of the Presscom database. Categories were developed through an iterative process, described in Chapter 4. All articles were scrutinised to determine which categories occurred within them. The number of occurrences of the category in each article is not recorded. Where the appearance or distribution of the categories across time changes this is discussed below. Categories were grouped as 'overarching categories' according to dominant, alternative and intersecting presentations of menopause: the 'hormonal menopause' (dominant), 'alternative therapies' (alternative), 'feminism and feminist' (alternative) and 'information, choice and women's decision-making' (intersecting).

## **6.2 Distribution of newspaper articles over time and by type of article**

Table 1 describes the distribution of articles in the four newspapers sampled in this study. All

articles were categorised according to the type or format of the article. The article types 'news', 'feature', letter to the editor' and 'advice' are identified by the Presscom search in the description given to each article by the newspaper concerned. 'News' articles included reports of research, conferences and comments on research or policy. News articles were predominantly derived from press release or syndicated press outlets like AAP (Associated American Press) and Reuters (Chapman and Lupton, 1994). Feature articles included book reviews, special features in health and women's pages and in weekend magazine articles. Feature articles included material collected directly from local health care experts and/or local women about menopause or from interviews and press packs distributed with book releases. Duplication in some accounts of interviews with Germaine Greer in England indicate the use of syndicated articles as the basis of some feature articles. Letters to the Editor includes all letters to the editor featuring mention of hormone replacement therapy and/or menopause. These letters almost exclusively comprise responses to news or more frequently feature articles produced by the paper. Advice articles include all articles featured in sections of the papers specifically designated as advice columns; for example, "Dr. Wright" and "Family Forum". Advice or recommendations are often given in feature articles but these are not included in this typology.

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
Articles included in analysis	24	27	13	12	9	49	28	40	34	26	17	31	17	327
news	8	4	6	6	5	17	8	8	17	10	5	13	6	113
feature	14	18	6	3	3	21	9	24	8	8	7	10	8	139
letter to Editor	2	5	0	2	0	7	0	3	1	1	0	3	0	24
Advice	0	0	1	1	1	4	11	5	8	7	5	5	3	51
Articles Omitted	0	1	0	0	4	2	2	3	6	0	0	0	0	18
All Articles	24	28	13	12	13	51	30	43	40	26	17	31	17	345

Table 1: Distribution of newspaper articles 1986-1998

Table 1 describes the distribution of articles in the four newspapers (The Advertiser, The News, Sunday Mail and Messenger) sampled in this study. In total 345 articles were retrieved in the search of the Presscom database of selected Australian newspapers over a thirteen year period; 1986-1998 using the search keywords, menopause, hormone replacement therapy and HRT. Of the 345 articles 14 were omitted from analysis because their reference

to the keywords was not relevant to a study of media representations of menopause is the mass media. Fourteen omissions result from the use of the term 'HRT' as a keyword in the search strategy: The acronym HRT is used for meanings other than 'hormone replacement therapy', for example 'human resources training' and 'Holden Racing Team' (Holden is a type of Australian car). Four paid advertising features were retrieved in the keyword search. These were omitted because it was not the purpose of this study to study advertising: these articles were produced in a different way and explicitly served a particular purpose, that of selling a product. Omissions do not include use of the term menopause as a metaphor, for example the rock music industry is described as being in its 'menopause' (see below). While not strictly a description of menopause, analysis of the use of the term as a metaphor in this context may be illustrative of the range of representations of menopause.

A peak in articles is seen in 1991 (51) and again in 1993 (40). The volume of material in these years positions them as outliers. The average number of articles related to menopause and hormone replacement therapy is 26.5 articles. The number of articles produced in 1991 is nearly double the average. Gullette (1997) identifies this peak in media interest in North America and refers to these years of the early 1990's as the "menoboom" period (p. 176). In Australia these years coincide with the release of two popular non-fiction feminist accounts of menopause (Greer, 1991 and Coney 1993) and the visit of both authors to publicise their books; this is evident in the comparatively high number of 'feature' articles (21/51 and 24/43 respectively). The year 1994 coincided with increased findings in medical literature and reports of these in mass media concerning an association of hormone replacement therapy

with breast cancer; this is evident in the high number of 'news' articles (17/40) in this year. Peaks in Letters to the Editor in 1987 (5) and 1991 (7) represent responses to one article in 1987 regarded by writers to the editor as misogynist and in 1991 to articles written about Germain Greer and her book "The change". These peaks may indicate an increased influx of letters to the editor in this time but one should be wary about attributing this increase purely to an increase in letters submitted. Many factors influence the selection of letters to be printed in Letters to the Editor columns: not the least being the 'newsworthiness' of the issue.

### **6.3 Dominant Presentation of Menopause: The Hormonal Menopause**

The hormonal menopause is the dominant presentation of menopause in this example of mass media. In this section I describe quantitatively the construction presented in this example of mass media. Two main components of the dominant presentation of menopause relate to descriptions of menopause and to hormone replacement therapy.

#### *6.3.1 Descriptions of Menopause*

The phenomenon menopause is described and defined in this sample of newspapers predominantly in terms of effects or consequences of menopause. Table 2 presents the categories that are used to describe and explain menopause in order of magnitude of their presentation in the media texts examined here.

Categories	Number of Articles	Proportion of total
1. * Osteoporosis/fracture/bones	115	35.2%
2. * Symptoms	101	30.9%
3. * CVD/CHD	78	23.9%
4. Hormone deficiency	48	14.7%
5. Menopause as devastating/term of abuse	42	12.8%
6. Sex	42	12.8%
7. Loss of femininity/youth	21	6.4%
8. Menopause a positive phenomenon	19	5.8%
9. Loss of fertility/reproduction	17	5.2%
10. Myths of menopause	17	5.2%
11. Women now live too long	17	5.2%
12. Diversity of experience	16	4.9%
13. Ageing and decline	14	4.3%
14. Poor relationships	14	4.3%
15. *Alzheimers/dementia	13	4.0%
16. Gender difference	11	3.4%
17. Social aspects of menopause	10	3.1%
18. Wellbeing decreased	7	2.2%
19. Early/surgical menopause	7	2.2%
20. Menopause experiences	7	2.1%

21. Incontinence	2	0.6%
22. Loss of smell	1	0.3%
23. End of life	1	0.3%

Table 2: The descriptions of Menopause in South Australian newspapers

\* these categories appear in both the menopause and hormone replacement therapy categories because they are inextricably linked as part of an explanation of menopause and of the action of hormone replacement therapy

Three categories dominate descriptions of menopause and thereby the definition of menopause in this sample of South Australian newspapers: (i) osteoporosis, fractures and bones; (ii) physical symptoms of menopause, and (iii) coronary heart disease (Table 2, Categories 1, 115 articles; Table 2, Category 2, 101 articles and Table 2, Category 3, 78 articles). These are regarded as the key effects of menopause. The most frequently cited category used in descriptions of menopause is osteoporosis. Unlike other categories the association of menopause and osteoporosis has remained relatively static over the 13 year period: the mode (most frequent number) is 33% and the median is 36% and a 'trendline' (calculated in Excel) showed no relationship; ie no increase or decrease in the number of articles containing this category over the 13 year period. While there is a slight (weak positive correlation) increase in the number of articles containing the category 'symptoms' in descriptions of menopause there is a difference in the types of symptoms attributed to menopause over the 13 year period.

Until the mid-1990's the variety of symptoms reported as being caused by menopause is extensive. A list of symptoms described in The Advertiser on 19 October 1993 in the article entitled 'Picking the common symptoms' is presented in Table 3. This symptoms listed here are found across the media reports of menopause analysed in this study. This article is different only in its exclusive focus on, and therefore its exhaustive list of, symptoms of menopause. In contrast, from 1995 these vast lists of symptoms disappear. Symptoms still form a key part of the description of menopause but symptoms are either not detailed or are described in a more limited fashion. The Advertiser on 14 August, 1997 reports symptoms of menopause in the following way: "night sweats, hot flushes and back and joint aches characteristic of menopause". I identified a reduction in the expansive list of symptoms in Table 3 included in descriptions and explanations of menopause as alternative rationales for the use of hormone replacement therapy, for example the prevention of disease, became available. This change mirrored the increasing co-description of menopause and hormone replacement therapy.



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## Symptoms of Menopause

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Hot flushes  
Night sweats and peeling off layers of clothes  
Sense of losing identity  
Sensation of looking at the world from outside the body  
Difficulty in concentrating  
Light-headed feelings, vagueness and "fuzzy" thinking  
Headaches  
Irritability, moodiness  
Depression, bouts of crying  
Unloved feelings and feeling unappreciated  
Heart palpitations  
Anxiety, feelings of tension, sometimes described as "permanent PMT"  
Mood changes  
Sleeplessness  
Unusual tiredness  
Backache  
Joint pains caused by weakening of the supporting tissue  
Muscle pains  
Irregular and extra heavy bleeding  
Change in appetite  
Periods of acute mental and physical functioning followed by lack of energy  
New facial hair  
Dry skin  
Crawling feelings under the skin  
Less sexual feelings  
Dry vagina  
Uncomfortable intercourse  
Urinary frequency and burning, stinging sensation during urination.

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Table 3: "Picking the common symptoms of menopause" (The Advertiser, 19 October 1993)

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Perhaps the most important category associated with descriptions of menopause does not appear in this table because it is the underlying premise upon which descriptions of

menopause are based and therefore need not necessarily be stated: this is the explanation of menopause as a hormonal phenomenon, specifically a loss of female sex hormones. That this assumption is shared by all articles is evidenced by the absence of any alternative physiological explanation of menopause. Nowhere in these media articles is the relationship of loss of female sex hormones to menopause disputed. Where descriptions of the effects of menopause are presented these are explained in terms of the effects of hormones. In 48 articles explicit reference is made to menopause as hormone deficiency (Table 2, Category 4, 48 articles): there is increasing use of this description over the 13 year period. The most exaggerated description of the hormonal menopause is found in the description of menopause as a deficiency disease, defined either by use of the term 'deficiency disease' or by reference to menopause as a disease or as phenomenon that, like a disease, is 'suffered' and requires medical diagnosis. The explicit description of menopause as a deficiency disease appears only in the years prior to 1991. The term 'deficiency disease' only appears again in critique of the construction of menopause as a disease, for example in 1993 and 1997.

The tenor of the presentation of menopause shifts in these media articles over the thirteen years of the study. The portrayal of menopause as a devastating and debilitating experience in a woman's life is found in 42 articles (Table 2, Category 5). The peak of the portrayal of menopause as devastating occurs in the period 1987 to 1991 with an average of 22% of articles being of this form. The one article describing menopause as the end of life (Table 2, Category 23) occurs in 1987. From 1994 only one or two articles depicting 'menopause as

devastating' appeared in each year, in 1998 no article of containing this category appeared. 19 articles throughout the study period portrayed menopause as a positive phenomenon (Table 2, Category 8). Only one article appeared during the period 1986 to 1990 that presented menopause in a positive light. This portrayal peaked between 1991 and 1993, with the increase in feminist perspectives (See section 6.4), and began to steadily decline towards the end of the period with one, none and one article containing the category 'menopause as positive' in 1996, 1997 and 1998 respectively. Descriptions of menopause were, in 7 articles, presented through the presentation of 'real' women's experiences. Not one of these 'real life stories' portrayed a positive or uneventful menopause. Where the experience of hormone replacement therapy was presented only one experience was described as negative: this was explained as an inappropriate balancing of the hormone levels particularly testosterone. Presentation of diversity in the experience or manifestation of menopause (Table 2, Category 12, 16 articles) increased over the study period, peaking at 20% of all articles in 1993.

In addition to the three key ways of defining menopause, osteoporosis, symptoms and cardiovascular disease three narrative elements appear: 'women now live too long' (Table 2, Category 11, 17 articles), 'gender difference' (Table 2, Category 16, 11 articles) and 'myths of menopause' (Table 2, Category 10, 17 articles). These are presented predominantly in descriptive magazine style 'feature' articles. 'Women now live longer' refers the increasing life expectancy of women in contemporary society. This is used to describe the implications of menopause for women and society. At one extreme women are described as living too long; that women's physiology is incapable of sustaining normal bodily functioning beyond the age

of approximately 45 and that they therefore require hormone replacement therapy. Increased life expectancy is used to highlight potential personal and social impacts as increasing numbers of women experience the 'effects' of menopause. This latter use of the description links to the public health category (described below in Section 6.2.3) and concerns for the cost implications for the society and health care system of women living into their postmenopausal years. This former use of this category, highlighting personal and social impacts, appears predominantly in 1986 and 1988, with the latter, highlighting cost implications for society, emerging in 1991 and 1992, then decreasing in frequency to its appearance in no more than one article from 1993. 'Gender difference' (Table 2, Category 11, 17 articles) presents menopause and the particular manifestation of the wide range effects attributed to menopause as unique to women. The category 'myths of menopause' (Table 2, Category 10, 17 articles) describes the use of the term 'myth' as a strategy employed to downplay or reinforce positive or negative descriptions of menopause: the portrayal of 'menopause as devastating' is described as a myth, as is the portrayal of menopause as an uneventful phenomenon.

A range of phenomena are regularly described as effects of menopause and are included here as categories. 'Sex' (Table 2, Category 6, 42 articles) describes the effects on menopause on libido: until 1997 it is almost exclusively presented in terms of the reduction in desire and quality of sex, from 1997 this category includes discussion of increased libido in postmenopausal women taking hormone replacement therapy.

'Loss of femininity (Table 2, Category 7, 21 articles), loss of fertility (Table 2, Category 9, 17 articles), ageing and decline (Table 2, Category 13, 14 articles), poor relationships (Table 2, Category 14, 14 articles), onset of dementia (Table 2, Category 15, 13 articles), decreased well being (Table 2, Category 18, 7 articles), incontinence (Table 2, Category 21, 2 articles) and loss of the sense of smell (Table 2, Category 22, 1 article) all form part of the description of menopause and its effects that is promoted or criticised. Where 'social aspects' related to menopause are described or criticised these are predominantly presented in terms of gendered social roles; a prime example is in the discussion of the empty nest syndrome (defined as a sense of loss experienced as older children leave home) as the key social context for the experience of menopause.

A key variation in the representations of menopause includes a persistent and extreme discourse of lost femininity at menopause. Though these descriptions appear infrequently and do not constitute a major focus of the 'hormonal menopause' their existence provides an important indicator of the range of possible explanations and understandings that might be brought to bear in practices and perceptions of menopause. The key identifier of these descriptions are presentations of menopausal women as hags or crones who have lost their purpose and usefulness; the use of menopause as a term of abuse; the ridicule of women at menopausal age; 'backlash' against feminist interpretations and alternative approaches to the dominant 'menopause', and descriptions of depleted sexuality (up to 1996) or excessive sexual appetite (from 1997) of mid-aged women.

### 6.3.2 *Hormone Replacement Therapy*

Table 4 presents the categories used in the descriptions and discussion of hormone replacement therapy.

<b>Categories</b>	<b>Number of Articles</b>	<b>Proportion of total</b>
1. * Hormone replacement therapy	265	81.0%
2. * Osteoporosis/fracture/bones	115	35.2%
3. * Symptoms	101	30.9%
4. * CVD/CHD	78	23.9%
5. Cancer	70	21.4%
6. Risk to/not to	68	20.7%
7. Benefits	42	12.8%
8. Research	38	11.6%
9. Side effects/contraindications	28	8.6%
10. Controversy/debate/no consensus	20	6.1%
11. Long term treatment	18	5.5%
12. Diversity of treatment	16	4.9%
13. Increases longevity/decreases mortality	16	4.9%
14. Positive effect on skin/ ageing	15	4.6%
15. *Alzheimers/dementia	13	4.0%
16. Misinformation/myths of	13	4.0%

17. Evidence	12	3.7%
18. Tailoring treatment	10	3.1%
19. Not a cure all	8	2.4%
20. Testosterone	8	2.4%
21. hormone replacement therapy as natural	7	2.1%
22. Men taking oestrogen	2	0.6%
23. Safe	2	0.6%
24. Protects teeth	1	0.3%

Table 4: Hormone replacement therapy in South Australian newspapers

\* these categories appear in both the menopause and hormone replacement therapy categories because they are inextricably linked as part of an explanation of menopause and of the action of hormone replacement therapy

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The key feature of this category is the predominance of hormone replacement therapy in discussions of menopause. In 1986 29% of all articles included mention or discussion of hormone replacement therapy. From 1993 no less than 90% of all articles in each year included mention or discussion of hormone replacement therapy. In 1995, 1996 and 1998 100% of articles about menopause also discussed hormone replacement therapy. Three categories, osteoporosis/bones/fractures (35.2%), symptoms (30.9%) and CVD/CHD (23.9%), discussed above, form a key part of the explanation of menopause and the discussion of hormone replacement therapy. Hormone replacement therapy is repeatedly described as being capable of alleviating or preventing symptoms of menopause, osteoporosis and

coronary heart disease. The association of these phenomena with menopause provides the key rationale for the use of hormone replacement therapy.

Discussion of cancer (Table 4, Category 5, 70 articles), predominantly risks of breast cancer related to the use of hormone replacement therapy, appears in 21.4% of articles. Until 1989 discussion of the risk of endometrial cancer in unopposed hormone therapy also occurs. Articles discussing risks of breast cancer largely appear in the 'news' sections and vacillate between conviction that hormone replacement therapy increases the risk of breast cancer and the assurance that it does not. Headlines shift from "Hormone risks slight, says surgeon" (Advertiser, 11 May 1993), to "Cancer risk warning on hormone treatment" (Advertiser, 21 May 1994) and then, "HRT anxiety 'unfounded' Breast cancer all-clear given" (Advertiser, 6 November 1995). These pronouncement refer to expert opinion, medical research findings and expert commentary on research findings to make their case. Discussion of the risk of cancer rises from 8% and 4% of articles in 1986 and 1987 respectively to a peak of 42% of all articles in 1995, declining in a linear fashion to 17% of articles in 1998. The peak in 1995 coincides with the publication of an article by Colditz and colleagues (1995) in the New England Journal of Medicine reporting findings from a longitudinal study of a cohort of American nurses which found an increase of breast cancer after prolonged use of hormone replacement therapy. This article also drew much attention in professional and academic literature.



Discussion of risks (Table 4, Category 6, 68 articles) and benefits (Table 4, Category 7, 42 articles) and side effects/contraindications (Table 4, Category 9, 28 articles) forms another key component of the presentation of hormone replacement therapy. Benefits of hormone replacement form part of the description and of the rationale for its use. These include prevention of osteoporosis, heart disease and Alzheimer's disease, alleviation of symptoms, positive effects on skin and ageing (4.9%), and latterly (1998), protection of teeth (Table 4, Category 24, 1 article). Reference to the effects of hormone replacement therapy on ageing, particularly the appearance of skin, decreases over the study period. Risks are discussed both as risks of using hormone replacement therapy, breast cancer, and of not using it, osteoporosis, heart disease and Alzheimers. Research (Table 4, Category 8, 38 articles) is used to demonstrate risks and benefits and, from 1995, is referred to in terms of evidence (Table 4, Category 17, 12 articles). This reflects the increasing attention to evidence based medicine in the 1990s.

With the emergence of a feminist critique of what feminists call the 'medical menopause', (discussed in Section 6.4) and the promotion of the use of hormone replacement therapy, discussed below, comes a discussion in terms of the controversy of treatment and the debates surrounding it (Table 4, Category 10, 20 articles). Having first appeared in 1991, two peaks occur in descriptions of hormone replacement therapy as controversial; the first in 1991 coincides with discussion of a feminist critique of hormone replacement therapy that appears in media presentations and the second in 1995, coincides with increased debate about the relationship of hormone replacement therapy with increased breast cancer risk. From 1995

'debate', 'controversy' and 'consensus' or lack thereof become key ways of talking about hormone replacement therapy.

A range of other categories form part of the discussion of hormone replacement therapy. The need for long term treatment (Table 4, Category 11, 18 articles), discussion of increased longevity and decreased mortality (Table 4, Category 13, 16 articles) and of hormone replacement therapy as natural (Table 4, Category 21, 7 articles) and safe (Table 4, Category 23, 2 articles) are used in descriptions of hormone therapy to suggest benefits of using hormone replacement therapy. In 1997 consideration of the benefits to men of taking oestrogen are reported (Table 4, Category 22, 2 articles). In contrast to early descriptions that describe a vast range of potential for benefits (see above) of hormone replacement therapy from 1993 reporting of medical commentators includes statements about the limitations of the drug, specifically that it is not a cure all (Table 4, Category 19, 8 articles). From 1991 treatment with hormone replacement therapy is discussed in terms of the diversity of treatment possible (Table 4, Category 12, 16 articles), and from 1993 the need to tailor treatment to individual women (Table 4, Category 18, 10 articles). The use of testosterone (Table 4, Category 20, 8 articles) as part of the treatment regime is incorporated, though infrequently, from 1991. Discussion of the use of testosterone increases in 1998 with its explicitly association with increased libido in women after menopause (See also qualitative analysis in Section 6.2.5).

### 6.3.3 Public health and menopause

Table 5 presents those articles referring to the categories included in the public health category: that is, those referring to matters of public health services, health care provision and the health of the public.

Categories	Number of Articles	Proportion of total
1. Prevention	31	9.5%
2. Primary medical care	28	8.6%
3. Screening	13	4.0%
4. Women's health centres	8	2.4%
5. Cost to the community	7	2.1%
6. Menopause a public health problem	2	0.6%

Table 5: Public health and menopause in South Australian newspapers

Explicit discussion of prevention in relation to menopause (Table 5, Category 1, 31 articles) decreases over the study period as discussion of hormone replacement therapy, CVD osteoporosis increases. It is possible that these categories take the place of generalised discussion of prevention. Discussion of 'primary medical care' (Table 5, Category 2, 28

articles) and 'screening' (Table 5, Category 3, 13 articles) increase slightly while all other categories decline in frequency (women's health centres, Table 5, Category 4, 8 articles; cost to the community, Table 5, Category 5, 7 articles, and menopause as a public health problem, Table 5, Category 6, 2 articles). Cost to the community and menopause as a public health problem comprised part of an argument encouraging women to use hormone replacement at menopause.

#### 6.3.4 Other Categories

All categories that did not fit within the categories above, but were part of the dominant presentations of menopause, are include here and listed in Table 6.

<b>Categories</b>	<b>Number of Articles</b>	<b>Proportion of total</b>
1. Mention	24	7.4%
2. Celebrity menopause	18	5.5%
3. Male menopause	14	4.3%
4. Environmental oestrogens	3	0.9%
5. HIV/AIDS	1	0.3%

Table 6: Other categories related to menopause in South Australian newspapers

The category 'mention' (Table 6, Category 1, 24 articles) includes all articles in which menopause was mentioned but where menopause was not the primary or major focus of the article. In the majority of these articles 'menopause' was one of a list of issues identified in relation to the primary focus of the article, for example promotion of a health seminar might include menopause in its list of topics to be discuss. Occasionally menopause was mentioned as part of a description of the subject of a television program or documentary. In five instances menopause is the term used metaphorically to refer to decline or depletion. In 1987 'menopause' is used as a metaphor to in an opinion piece to describe the decline of the pop music industry.

*...pop music is going through its menopause. Because of its old age, pop is confused about its identity, unsure of its future and fixated by its past.*

(Advertiser, 25 July 1987)

The menopause experience of celebrities (Table 6, Category 2, 18 articles) is reported throughout the study period but peak in 1991 as examples to prove or disprove Greer's argument are presented. Discussion of male menopause (Table 6, Category 3, 14 articles) is limited but consistent throughout the study period. Environmental oestrogens (Table 6, Category 4, 3 articles) are of concern in 1994 and 1997; HIV/AIDS (Table 6, Category 5, 1 article) in 1990.

#### 6.4 Alternative Presentations of Menopause: Alternative therapy

While hormone replacement therapy is the predominant treatment in discussions of the effects of menopause, alternatives are included in media presentations of menopause. Table 7 presents the categories that define the alternatives to hormone replacement and their incidence in articles about menopause.

Categories	Number of Articles	Proportion of total
1. The existence of alternatives to hormone replacement therapy	34	10.4%
2. Calcium	34	10.4%
3. Exercise	30	9.2%
4. Diet	29	8.9%
5. Drink less alcohol	14	4.3%
6. Vitamins	11	3.4%
7. Smoking	10	3.1%
8. Soy products & phytoestrogens	9	2.8%
9. Alternative pharmaceuticals	7	2.1%

Table 7: Treatment other than hormone replacement therapy in South Australian newspapers

The discussion or mention of alternatives to the use of hormone replacement therapy occurs in 10.4% of all articles and remains less than 10% for all but one year until 1997 and 1998 where the occurrence more than doubles. There is no clear correlate to this increase.

Discussion about alternatives to hormone replacement therapy predominantly take two forms; lifestyle measures - exercise (Table 7, Category 3, 30 articles), diet (Table 7, Category 4, 29 articles), drinking less alcohol (Table 7, Category 5, 14 articles) and giving up smoking (Table 7, Category 7, 10 articles) - and vitamins (Table 7, Category 2, 34 articles and Table 7, Category 6, 11 articles). From 1994 soy products and phytoestrogens are included as alternatives to hormone replacement therapy. From 1993 pharmaceutical alternatives to counter osteoporosis are introduced.

## **6.5 Alternative Presentations of Menopause: Feminism and feminists**

### *6.5.1 Feminism and feminists - quantitative*

The peak in discussion about feminist perspectives on menopause occurs around the release of Germain Greer's book *The Change* in 1991 and the Australian release of Sandra Coney's book *The Menopause Industry* in 1993; the book was originally released in New Zealand, the author's home, in 1991. Table 8 presents categories coalescing around feminist and critical perspectives on menopause and the 'medical menopause'.

Categories	Number of Articles	Proportion of total
1. Critique of medicalisation and hormone replacement therapy	22	6.7%
2. Critique of sexist views of women	12	3.7%
3. Menopause as natural	12	3.7%
4. Menopause is power	9	2.8%
5. Feminism	8	2.4%
6. Critique of media representations	7	2.1%
7. Critique of feminism and feminists	6	1.8%
8. hormone replacement therapy & menopause as exploitation of women	6	1.8%

Table 6: Feminism and feminists in South Australian newspapers

Presentation of critiques of the medicalisation of menopause and the use of hormone replacement therapy directly relate to the release and coverage of books presenting critique of the medical menopause. Peaks in this category (Table 8, Category 1, 22 articles) occur in 1991 with Germain Greer's *The Change*, in 1993 with Sandra Coney's *The Menopause Industry*, and in 1997 with Sherrill Sellman's *Hormone Heresy*. Accompanying these feminist critiques are the categories in which menopause is described as natural (Table 8, Category 3, 12 articles) and embodies women's power (Table 8, Category 4, 9 articles). In the category



'menopause is power' 6 of the 9 occurrences are found in 1991. Likewise, discussions of feminism and feminist perspectives on menopause (Table 8, Category 5, 8 articles) and critiques of feminist perspectives (Table 8, Category 7, 6 articles) predominantly appear in the early 1990's. Discussion of feminism and menopause occurs only once before 1991. Nevertheless, critique of sexist views of women as part of descriptions of menopause (Table 8, Category 2, 12 articles) is found from 1987 to 1995, with the peak occurring in 1991.

Critiques of media representations of women in articles about menopause appear to decrease through the study period. However, caution should be taken in interpreting this trend as numbers are too small to accurately gauge decline or increase. The specific charge that hormone replacement therapy constitutes exploitation of women (Table 8, Category 8, 6 articles) is found in 1993; Coney's argument is referenced in articles about menopause three times in the following four years.

## **6.6 Intersecting Presentation: Information, choice and women's decision-making**

### *6.6.1 Choice*

Articles about Information, choice and decision-making in relation to menopause become increasingly frequent over the 13 years of the study. Table 9 presents six categories defined in this category.

Categories	Number of Articles	Proportion of total
1. Information/being informed	42	12.8%
2. Choice/control/decision-making	33	10.1%
3. Critique of medical practitioners lack of knowledge/information	18	5.5%
4. Education	8	2.4%
5. Right to treatment	8	2.4%
6. Empowerment/independence of women	3	0.9%

Table 9: Information, choice and women's decision-making in South Australian newspaper

The importance of access to information for women is highlighted by the category information/being informed (Table 9, Category 1, 42 articles ). The incidence of this category increases over the study period with peaks found in 1994 and 1998. In the earlier years discussion of information largely accompanies articles that describe or advertise upcoming seminars held by women's health centres and given by prominent medical or alternative health care practitioners. These forms of representation continue throughout the study period. In addition discussions about women's need to be informed are included: initially these from part of critiques of the medical menopause but increasingly from the mid-1990's 'being informed' is integral to medical descriptions of menopause, its effects and treatment.

Accompanying discussion of information is a description of choice and decision-making.

Like the category information, choice and decision making appears first in reports from women's health centres, then in feminist critiques of the medical menopause and from the mid to late 1990's in medical accounts of menopause. In the first three years of the study there is critique of medical practitioners lack of knowledge of menopause *per se* and of hormone replacement therapy and therefore concern that women may miss out on treatment. Later the concern is about medical practitioners lack of understanding or acceptance of the risks of hormone replacement therapy (Table 9, Category 3, 18 articles). From 1991 discussion of education about menopause appears. In 1994 and 1998 the importance of women being empowered and independent in their decision making become part of the discussion of menopause.

## **6.7 Conclusion**

The 'menopause' described here incorporates an understanding of menopause in which menopause is the cessation in the production of female sex hormones and this loss of hormones results in a range of effects, including osteoporosis, symptoms and cardiovascular disease. The 'hormonal menopause' refers to media representations which present medical opinion, may include medical practitioners or authors who are defined as medical experts to present their point. It also includes those articles that do not refer to medical experts but which nonetheless present a version of menopause that holds with the main tenants of the

menopause described by medical practitioners, authors or experts. The key elements of the 'hormonal menopause' are that menopause constitutes an endocrine deficiency. Variation in this description includes the influence of contributory social factors: these tend to be gender specific and assume a woman who has had children but no significant career. The loss of hormones is described as resulting in a range of effects including symptoms and risks of chronic disease. The symptoms described are physical or psychological: there has been a shift in the description of these from extensive and devastating to limited and moderate. Risks of menopause are described as being osteoporosis, CVD and, latterly, Alzheimer's. These risks become co-constructed with menopause in the language used; for example, "post-menopausal osteoporosis". The remedy for the symptoms and risks of menopause is hormone replacement therapy and medical care.

The hormonal menopause is clearly the dominant presentation of menopause in the newspapers analysed in this study. It is dominant in the regularity of its discursive presentation of one particular construction of menopause as the 'truth' about menopause. It is also, demonstrably, by far the most frequent presentation of menopause. For example the key medical treatment, hormone replacement therapy, is discussed, in some form, in 100% of all articles by 1998. In contrast alternative therapies, one of the key alternatives to the hormonal menopause, are discussed, in some form, in approximately 10% of all articles. Discussion of feminist views or critique of the 'hormonal menopause', the second key alternative to the dominant menopause, appears in less than 7% of all articles: Those critiques that do appear cluster around the early years of the 1990's. Nevertheless, the hormonal menopause is not

monolithic or unchanging. Presentation within the 'hormonal menopause' shifts. Moreover, an intersection of the different presentations of menopause occurs in the common discussion of choice and women's decision-making.

This chapter has described the breadth and scope and change in media articles over a 13 year period in South Australia. Questions were raised in Chapters 1 and 3 about mass media presentations in relation to menopause, specifically: 'How is menopause presented in mass media? What constructions of menopause are drawn upon in these media presentations of menopause? Are the shifts demonstrated in the medical and feminist literatures in Chapters 2 and 3 evident in mass media presentations of menopause over the 13 year period from which this example is drawn? and, What are the implications of media constructions of menopause? These questions are taken up in the following chapter, Chapter 7.

## Chapter 7: Discussion

### 7.1 Introduction

General practice and mass media settings were identified in the literature reviews in Chapters 2 and 3 as key settings for the construction of menopause and the subject positions available to women at menopause. Moreover, these are key sites for the examination of power relations. As discussed in Chapter 4, Methodology and Methods, the purpose in this research in examining the production of subjects and power relations in discourse is an expressly political one in that an examination of power relations may be used to highlight possibilities and opportunities for change and transformation. Therefore I set out to ask the following questions:

- a) How is menopause constructed in general practice and mass media and what are the effects of these constructions?
- b) Does the shift identified in medical literature in the late 1990's (see Chapter 2) from conceptions of menopause as a disease to menopause as a natural transition, albeit a marker for prevention, fundamentally change medical practice or power relations between medical practitioners and women or alter the presentation of menopause in these media texts?

- c) What are the implications for medical practice and for women of shifts in medical constructions of menopause as they are played out in general practice or in media texts?

In this chapter I address key aspects of these questions in a review the findings of the Studies presented in Chapter 5, General Practitioner Interviews and Chapter 6, Quantitative Description of the Presentation of Menopause in 13 years of South Australia newspapers. Specifically, I identify and develop a problematic raised by Studies 1 and 2 in relation to the concepts of choice, empowerment and women's decision-making used in the general practice interviews and media texts. In Chapter 8 I subject these concepts to further scrutiny within a framework developed through a postmodern critical analysis of a range of approaches to ethics. I, therefore, introduce discussion of implications of the use of these concepts in medicine and mass media settings here: The discussion is carried out in full in Chapter 8.

## **7.2 The Construction of Menopause**

In Chapter 2 and 3 I traced the shifting discourses of menopause evident in feminist and medical literature and demonstrated a shift in focus in the meanings and descriptions of menopause over the past century and a half. More particularly, the past sixty years has seen a shift from hormone decline and its relation to femininity and symptoms of menopause in the 1960's to the relationship of a definition of menopause as hormone deficiency to long term health consequences of menopause, predominantly described in terms of 'risk'. The process

of change in medical meanings and descriptions of menopause is not simply a linear development of knowledge built on previous evidence and thinking in the field. At various points over the century understandings, and importantly debate, and from other fields inside and outside of medicine appear to intersect with medical knowledge. Feminist and medical literature centred around debates and controversies related to social constructions of menopause and the use of hormone replacement therapy in menopause have contributed to the consideration of potential problems with the use of hormone replacement therapy as well as its potential benefits. Concepts of prevention from public health and health promotion have been drawn into descriptions of menopause; as have concepts of informed decision-making and empowerment from the women's health movement. Equally, development and change of feminist positions are evident the critique by postmodern feminists of the closed arguments produced by some modernist feminist in accounts of menopause couched in terms of anti-medicine / anti-hormone replacement therapy. While the concepts of medicalisation and medical dominance have in the past provided some critique of medical constructions of menopause they do not sufficiently intersect with recent attempts by general practitioners to engage with language about empowerment and women.

The 'hormonal menopause' constructed menopause in terms the loss of hormones and susceptibility to long term health risks as described in medical literature (see Chapter 2) was the dominant presentation of menopause. Nevertheless, in this study, variation from the presentation expected from modernist feminist literature was evident within these general practitioner and mass media accounts. General practitioner accounts included with the



hormonal determinist accounts of menopause were presentations that included variability and diversity. Loss of femininity was not a key strategy for drawing women into medical treatment for menopause. Indeed general practitioners actively avoided this description of menopause. Description of menopause as a process included within it the possibility of the menopausal body as an adaptive reactive body rather than simply as the lacking body described by medical writers in the 1960's (Wilson, 1966) and early 1990's (MacLennan, 1991; Utian, 1990). There is an apparent disjuncture, therefore, in the presentation of explanations of menopause as physiological, in some cases incorporating metaphors of decline and decay, and of women as active decision-makers, discussed below. These seemingly contradictory descriptions nevertheless co-exist. One might speculate that in practice this might produce different practitioner-patient interactions perhaps in different contexts and with different women.

In contrast to recent empirical studies (Carlson et al., 1997; Gannon and Stevens, 1998; Shoebridge and Steed, 1999) of large numbers of media articles over a long period of time, 11, 15 and 10 years respectively, which identify a unitary presentation of menopause in media texts (see Chapter 3), the study presented here (see Chapter 6) identifies multiple competing presentations of menopause. Moreover, not only does more than one reading of menopause compete but the presentation of the available versions of menopause change over time. I argued that this period represents a key time of discursive shift from constructions of menopause as femininity, as in the 1960s, towards discourses of risk and choice and it is therefore important to describe any changes in content across this period. The most notable

of these changes is the shift in the dominant hormonal presentation of menopause from one resembling the presentation of menopause described by modernist feminist authors and Carlson et al. (1997) Gannon and Stevens (1998) and Shoebridge and Steed (1999), including negative portrayals of menopause and menopausal women, to one which incorporates discussion of choice and women's decision-making at menopause. While Carlson et al. (1997) Gannon and Stevens (1998) and Shoebridge and Steed (1999) studies do not include the period in which I identify a key shift towards the discussion of evidence, they do however cover the period in the early 1990's during which an active modernist feminist critique of medicalisation of menopause. Only Mittness's (1983) study, spanning a much longer period in the first part of the 20<sup>th</sup> century, demonstrates a changing representation of menopause (see Chapter 3). Far from presentation of a stable consistent version of menopause in mass media I demonstrate a number of key quantitative and qualitative shifts over the period of the study. These shifts follow broader changes in medical and feminist literature described in Chapters 2 and 3.

Notably, in the interview study described in Chapter 5 general practitioners positioned women as 'informed decision-makers' responsible for their 'choices' about health care and health outcomes at menopause and beyond. In Chapter 6, information, choice and decision making were key ways of presenting menopause. The subject position that is created for women through this presentation of women I have called the 'informed menopausal woman'. It is modelled on the liberal autonomous individual, who makes choices independent of circumstances. At face value this form of medical practice appears similar to the responses of

feminist authors and women practitioners in women's health in their pursuit of the agenda of the women's health movement throughout the 1990's and into the early 21<sup>st</sup> century. That is, to open up the provision of information to women in order that they may take control of the progress of their menopause and thereby be empowered (Worchester and Whatley, 1992). This key response to the medical construction of menopause is also evident in the health information literature emanating from women's health and community health services in Australia, New Zealand, United Kingdom, and North America calling for respect for women's autonomy, the provision of information and the right to choose. Canada's Women's Health Clinic and Britain's Women's Health Information Centre are typical in their employment of an approach aimed at empowering women and their calls to; "encourage women to learn all they can about their health so they can make informed choices" (Women's Health Clinic, 2001) and; "support and promote every woman's right to make her own informed choices about her health" (Women's Health, 2001). This common use of a language of empowerment across practices based on medicine and feminism does not, however, produce identical outcomes because the understandings of what counts as knowledge, and therefore information, and what is included in the context of decision-making are different.

### **7.3 The New Menopause: Woman as active decision-maker**

The breadth of medical, preventive, health promotion and feminist discourses places the woman considering menopause in an invidious position. Leng (1997) and Harding (1997) have identified that dominant medical and feminist positions offer women two opposing options which centre around the technology driving conceptions of menopause; hormone

replacement therapy. To reject the medical position on menopause and thereby refuse hormone replacement therapy is to risk heart disease, osteoporosis and possibly dementia, to accept hormone replacement therapy is to risk breast cancer and to be a 'dupe' of the medical profession and medical power. However, in this examination of menopause in a medical practice setting, I identified a range of ways in which general practitioners' use language from feminists and the women's health movement that is not in opposition to medicine in the same way as work by, for example, feminist writers like Greer's conflicts with medicine. Instead, general practitioners made references to hormone replacement therapy as a 'woman's choice' thereby invoking the individual autonomy of the woman. Based on this observation I argue that women are presented with a *choice dichotomy*. In the language of the women's health movement a choice exists. I do not deny that there still remains the possibility for a choice to be exercised that accepts or rejects hormone replacement therapy and in so doing also accept or reject medical power as this is conceived by feminist writers introduced in Chapter 3. Medicine, of course, similarly offers a choice to accept or reject hormone replacement therapy, based on a different rationale. Thus, the concept of choice is problematic. What my study demonstrates is how general practitioners deploy concepts of choice and key concepts from health promotion and the women's health movement and in doing so produce and constrain options for women.

The medical approach to menopause in the 1990's bears many similarities to the changing focus of health promotion in that decade that assumed a population of rational autonomous citizens who makes informed decisions about health and health care. The subjects of this

health promotion are not passive recipients of health promotion information they are active citizens who are to be supported in their efforts to reach their self-defined health objectives. In the new menopause women are no longer passive victims of a medical dominance they are responsible citizens making 'informed decisions'.

Castel (1991) argues that over the last 100 years there has been a shift in emphasis from controlling dangerous individuals to preventing the emergence of undesirable events such as illness, abnormality and deviant behaviour. By focusing on factors of risk rather than individuals, experts have greater numbers of targets for preventive regulation or intervention and there is less reflection on the social and human costs of these interventions. Castel proposes that new preventive strategies form part of the social management techniques of a neo-liberal society through rational self conduct which is conceived of as a conscious process rather than part of the nature of human beings. It is a form of social control, a power relationship, that does not operate through repression so much as through enticement and the attribution of moral responsibility for the care of the self. The result is that in a neo-liberal society the individual is called upon to enter into the process of self governance through endless self-examination, self care and self improvement. In this schema the individual is constructed as having choice in the maintenance of their physical selves. This individual choice transforms into an expectation a duty of the responsible citizen. A failure to exercise this choice is a moral failure of the self to care for the self.

The responsible citizen is obliged to consult with numerous experts. But different groups have different interests in promoting particular risk factors and there is much disagreement about what constitutes risk, at what levels and how to respond. This results in much conflicting advice as there are rarely coherent sets of norms to which one may defer in the care of the self. The enjoiner to individual choice in this context is hardly an egalitarian step. "Conflicting and changing advice about sources and levels of risk means that the individual consumer of expert advice can never know for certain whether any particular set of advice is more likely to guarantee security than any other" (Bunton and Burrows, 1995: 18) The consumer is nevertheless expected to discriminate among available competing risk messages (though not between competing alternative paradigms) and to be able to make some decision about appropriate preventive action as if some absolute truth about the risk factors can be established. What is evident is that notions of risk and self-regulation that accompanied the emergence of health promotion in the late 1980s also emerge in the changing rationale for the use of hormone replacement therapy in the case of menopause. The discourse of risk and prevention becomes evident in medical literature (Chapter 2), in clinical practice (Chapter 5) and in mass media (Chapter 6) during the 1990's. And with this change menopause is transformed into a risk factor.

However, this individual choice fails to account for differences of power in society, it fails to account for social inequality and social difference. Indeed, it is itself a strategy of power which reinforces these inequalities by bringing a moral force to their existence. To be sick of a preventable disease is morally reprehensible. In some constructs menopause is a disease and

its sequelae are preventable. The association of menopause with osteoporosis and other diseases is, therefore, a strong moral force. In this way the construction of menopause as a risk factor acts as a technology of power. One which is supported and perpetuated through the discourses available through health professionals and mass media. The menopausal woman as a consumer of health information and health advice is left between a rock and a hard place: there exists a moral imperative to choose but the grounds upon which you might do so are continually shifting. Defining menopause through discourses of risk and prevention of disease limits the possibilities for choice outside a medical framework.

The positioning of women as being informed to make a choice and thereby empowered, an autonomous individual and therefore responsible, is adopted by this new menopause and structured through the discourse of prevention. The medical construction of menopause as risk is important in understanding the deployment 'autonomy' and 'choice', because the biological 'truths' of menopause remain central and the language of health promotion is peripheral, or selectively employed. This is unsatisfactory because empowerment, autonomy and choice involve a much broader set of issues than those outlined in the new menopause.

Like Harding (1997), and others, I am arguing that menopause has become increasingly regarded as a risk to health during the 1990's there were antecedents of this in medical literature since at least 1966 (cf. Davis et al., 1966; Nordin et al., 1966). The difference between these periods is the explicit conceptualisation of risk as part of the construction of

menopause. In the 1990s the notion of menopause as risk has been strengthened by the biomedical relationships with disease and ageing. The association of menopause with heart disease and osteoporosis established in the 1980's has been supplemented by associations in the medical literature of menopause with dementia, Alzheimer's disease, urinary-genital problems and bowel cancer in the 1990's (Wren, 1997). Menopause is situated in the 'epidemiological' clinic (Bunton and Burrows, 1995) in which risk is calculated for specific communities. These calculations, a practice of the discourses of prevention and health promotion, are used to explain the new menopause and thereby extend the importance of hormone replacement therapy in contemporary culture and medical practice.

Further problems with the new menopause are found in its relationship with contemporary health practices more generally. The education and promotion of health often assumes that all people regard health as a desirable objective to strive towards. In the Health and Lifestyles Survey conducted by Blaxter (1990) she found that, indeed, health was not regarded as necessarily important, particularly by people facing multiple economic and social problems. The emphasis on individual choice fails to account for differences of power in society and social difference. Employing a language of individual choice and autonomy to decision-making in the new menopause has the consequence of positioning individuals not only as being at risk from themselves (cf. Ogden, 1995), but also responsible for that risk. For women during and post-menopause in choosing not to take hormone replacement therapy they are now also failing to prevent a range of chronic health problems. It is here that morality pervades what have come to be regarded as individual choices to prevent disease.



## 7.5 Feminism, medicine and menopause

Some feminists, for example, Germaine Greer, Sandra Coney and Renata Klein, are critical of medical practice and the use of hormone replacement therapy based on an investment in an alternative reality of the biological menopausal woman; that of the 'natural' woman. This feminist criticism has challenged the consequences of hormonal determinism and the explanation of menopause in terms of idealised femininity, but does not examine the implications of the biological definition of risk. What I argue is that medicine claims a truth about the biological body; that it yields to certain consequences, whereby risk functions as a technology of power within medicine, enabling certain domains to remain unchallenged. In other words, the practices of risk identification, risk reduction, the relationship of risk to biomedicine and epidemiology, maintain and reproduce certain ideas and assumptions about the management of populations. Moreover, these practices offer population level health care strategies that displace broader cultural and social aspects of menopause or try to make them fit within contemporary medical practice. As a consequence, the terms of resistance for feminists are restricted and general practice is able to maintain the most influential ideas about menopause.

Further, similarities are evident, at an epistemological level, between the positions held by these feminist writers and dominant medical ideas (Leng, 1997). Both lay claim to an immutable truth about menopause that rests in an assumption of a knowable, if not universal, reality. In both, an essential subject is produced; one is the 'natural' menopausal woman who

should eschew medical intervention, the other is at the mercy of her hormones. In this way both feminist and medical positions restrict the discursive options available to women. Importantly, neither version accounts for diversity and difference among women, nor for their experiences of menopause given the changing construction of menopause as a long-term risk to health.

The construction of menopause as a risk to a woman's health locates the decision about hormone replacement therapy as necessary and important. The engagement between medical expert and patient is a process of medicalisation of the woman's experience. I do not, as Harding (1997) does, reject the medicalisation argument. Rather by examining it as a constituent element in power relations it is possible to recuperate feminist arguments about medicalisation without the assumptions they bring with them about an essentialised 'natural' woman. The subject position created in the clinical process and in media described above is defined by choice and an ethic of autonomy in women's decision-making which differentiates it from the subject position produced by the concept of 'medical dominance', described by Willis (1983) and some feminist critics (cf. Greer, 1991; Coney, 1993), in that the informed menopausal woman is presented as an active decision-maker in the process. The 'menopausal' woman as active is the key difference in my conception of the medical construction of menopausal subjectivity from either the feminist medicalisation critique described in Chapter 3 or the postmodern critiques of feminist and medical positions: all these assumed to a greater or lesser degree a passive recipient of information and/or advice. By employing the discourses of prevention and health promotion general practitioners have

drawn on language from the women's health movement and some feminist ideas concerning issues of 'choice', 'informed decision-making' and 'empowerment'. These issues were foremost in the establishment of early women's health literature, such as *'Our Bodies, Ourselves'*, by the Boston Women's Health Book Collective (1976; revised British edition 1978), and clinics that engaged a politics of health care (cf. Dorothy Broom, 1993). The language of health promotion has enabled these general practitioners to position themselves as being responsive to long standing calls from the women's health movement about the empowerment of women through the delivery of primary health care and in doing so, to some extent, they circumvent feminist criticism.

Yet, the notion of women's choice presented in this general practice setting is unsatisfactory. The discourse of prevention has changed the terms of menopause from an all encompassing, physiologically and psychologically, hormonally deficient body to a loss of hormones that is problematic because it is the cause of preventable morbidity and mortality. It is this problematic, which appears to remain unquestioned by general practitioners in the research here and in broader medical literature outlined in Chapter 2. Social and cultural explanations of disease causality (cf. Germov, 1998; Hardey, 1998) are absent from these examples of the new menopause despite their being an integral part of the framework of health promotion and the women's health movement drawn on by these general practitioners. Further, the shift of responsibility for health to the individual woman reinforces practice that claims to empower women, but oversimplifies power relations and constructs menopause as a site of self-surveillance. This surveillance occurs within a framework that is constructed by medicine, and

not, as might be suggested by the concept of choice, designed by women themselves.

I have argued that a shift has occurred away from an explanation of menopause in terms of hormones and femininity toward a new menopause in which medicine has incorporated some aspects of health promotion and the women's health movement, albeit incompletely. Further, I argue that this change does not reproduce a 'sovereign' power of medicine employed by practitioners to 'push' hormone replacement therapy onto passive women patients as described by some feminists, rather, power is as Foucault states, 'omnipresent' (1972), it is a diffuse power which provides the possibility for resistance through a matrix of transformation. Changing language use, as observed in our interview study, still maintains power of general practitioners but it affords greater possibilities for resistance and transformation in practices around menopause. At the very least there is variation between medical accounts that demonstrates a shift away from a 'monolithic' power of medicine criticised by some feminists and discussed in Chapter 3. The use of concepts from the women's health movement has created some changes in both the positioning of general practitioners in terms of greater information provision to women and empowerment and positioning of women as having 'choices.'

## **7.6 Conclusion**

The recourse to femininity demonstrated by Robert Wilson, while in part still evident in the medical menopause, no longer dominates its construction. In particular, 'femininity' no longer

serves its original purpose of providing a rationale for the use of hormone replacement therapy. The concept of menopause as a risk to health supplants the overtly sexist manifestations of femininity typified by Wilson's work, nevertheless maintaining the centrality of medical interpretations of menopause. A key shift in medical discourse has occurred away from conceptualisation of female bodies comprising hormones and functions based on sex endocrinology towards an approach in primary medical care based on women's responsibilities and choices. Medicine has added-on aspects of prevention and health promotion discourses while retaining an underlying recourse to biological 'truths' about female bodies.

For feminist critics of medicine and menopause the case for a natural rather than interventionist altered state of women's bodies, while presenting a degree of resistance to the need to intervene with hormone replacement therapy, continues to be limited by the discourses of prevention and health promotion and medical claims to truth. The accounts from general practitioners in this study position women as autonomous individuals who make choices about health care. The problematic site is not necessarily medical dominance over female patients but the ways in which language use about the notion women's choice and empowerment is deployed by general practitioners within the clinical setting that produces and constrains women's health care decision-making.

I argue that changes in the construction of menopause have implications for a feminist

position that examines arguments related to medical management and the 'natural' aging of women. Contemporary primary medical care is not a homogenous, dominant medicine regarding its treatment of women and menopause, but as I have discussed in this article, involves variation that presents a new menopause constructed through discourses of hormonal determinism, prevention, and choice. While general practitioners remain the key professional group in health care delivery for menopause the language of primary care offers an apparent commonality of purpose across primary care and the women's health movement. The material effects of such a new configuration of discourses means that women may well now ask questions about how medicine will broaden, strengthen and maintain a position that claims the empowerment of women as an integral part of health care for menopause.

## **8.0 Chapter 8: Risk, Choice and Agency**

### **8.1 Introduction**

The empirical work in Chapters 5 and 6 and discussion in Chapter 7 raise a number of issues that are unexpected from the perspectives provided by the dominant modernist feminist critiques of a 'medical menopause'. Here I discuss this problematic and then describe the next phase of this thesis and my response to it; ie a postmodern critical analysis of ethical theory about autonomy. I begin by revisiting the problem outlined in Chapter 7 and present a rationale for this further study, I describe the method of the study and I present the findings and argument developed as a result of this study. I identify issues raised by dominant feminist criticisms of the medical construction of menopause and the examination of these in relation to the construction of menopause in general practice (Study 1). I examine, through the lens of a range of ethical theories, the ways in which dominant feminist criticism intersects with medical practice and how concepts that are shared by dominant feminism and the women's health movement are taken up in general practice.

### **8.2 Rationale and method for Study 3**

In Chapter 2 I identified in medical literature and practice about menopause a shift away from discourses of femininity and symptoms and toward the adoption of discourses of prevention and risk. These discourses emerged in the broader context of increasing interest in the 1980's

and 1990's in public health medicine and health promotion approaches to the prevention of illness and disease. In Chapter 3 I identified a consideration in feminist critiques of the importance of the constructedness of menopause. The empirical studies presented in Chapters 5 and 6 demonstrate the way that medical and feminist literature are taken up selectively and intersect to produce the descriptions of menopause proffered in general medical practice and mass media settings. In particular, in medical practice and mass media settings studied here, descriptions of the appropriate response by women and health care professionals to menopause are constructed around concepts of empowerment and choice in women's decision-making.

Chapter 7 described a problematic arising from the review of the empirical findings in Study 1 and Study 2 in terms of medical and feminist literature which takes the form of standard ethical questions about the production of a discourse of choice in general practice and mass media. General practitioners and mass media interpret choice in terms of a simplistic relationship where information equals choice and choice equals empowerment. However, because knowledge is constructed (in language) and information isn't transparent a simplistic recourse to information as choice doesn't deliver emancipatory practice. This is different to the outcome predicted by feminist and women's health literature: general practitioner practice that includes giving information and supporting choice does not produce a non-medical(ised) menopause. Therefore a question arises; if the offer of choice is not a free choice because it is constrained in language and meanings produced in medicine and not by women how then is it possible to negotiate a space for choice?



Given that this problematic is situated around questions of autonomy and choice I turn to theories of ethics. I present a postmodern critical analysis (cf. Hepworth, 1999) examining a range of bioethical theories and feminist ethics to examine the changing conceptualisations of autonomy and choice. Postmodern critical analysis assumes that there isn't, ontologically, a reality or truth in and of itself to be described. However, neither do I assume an extreme relativism in which there are infinite and equally valuable or plausible possible realities. As described in the methodology section of Chapter 4, following Foucault (1982, 1988b) and Potter (1996) I look to the structuring effects of language in the form of explanations and theories and how they structure power relations. Equally, arguments, discourses, epistemologies (all located in language) produce effects. Like Potter (1996) I am concerned not of the reality or otherwise of varying positions and descriptions, rather I am concerned with the effects to which these particular constructions are deployed. In this examination of a variety of ethical positions I look to epistemological differences and I am attentive to the effects of these differences, particularly to the limiting potential of universalistic arguments.

### **8.3 Bioethics and women's decision making at menopause**

Historically, ethics taught in medical schools and drawn upon by medical practitioners falls within what is described as bioethics (Beauchamp and Childress, 1983; Beauchamp, 1999; Gillon, 2001). While ethical practice in medical settings is a more nuanced activity in which "both doctor and patient are engaged in an unbroken continuum of ethical decision making"

(Komesaroff, 1995: 68), 'bioethics' nevertheless functions as a discursive framework for general practitioners. The common version of bioethics draws from an ethics based on Enlightenment ideals combining a mix of utilitarianism and deontology in the application of a limited number of principles, which, if carried out, purports to produce good medical practice. Specifically, these principles include autonomy, beneficence, non-maleficence and justice. Occasionally, neo-Aristotelian virtue ethics (what sort of person/practitioner do I want to be) will emerge. I refer to these as bioethics or traditional medical ethics. The principle of autonomy, while not the only principle drawn on, is of most concern here because of its use by the general practitioners in Study 1 in describing women's decision-making. Bioethics is based on a normative ethics that is built upon the assumption of a universal, gender-neutral self. Autonomy is conceived of as the right to and capacity for individual freedom, including freedom of choice and of consent. The restriction to autonomy comes in the form of the competency of the individual. The standard for the competent individual is the rational individual, designed around a masculine Enlightenment model of the self.

It is the post-Kantian ethic that places the project of autonomy at the centre of Enlightenment ideals. For example, Feinberg's (1989) autonomous individual strives to maintain self-direction in a world populated by "impinging judgements, entangled commitments and complicated by uncertain vision and weakness of will" (p.45). This is a version of the liberal self that is not defined in relation to others because, whilst there are social influences, an authentic self is the source of, "tastes, opinions, ideals, goals, values and preferences" (Feinberg, 1989: 32). Feinberg states; "In normal circumstances ...opportunity is more or less

available to most people; the autonomous person is the one who makes the most of it" (Feinberg, 1989: 32). Traditional moral reasoning used in medical ethics/bioethics is largely characterised by this marginally social stance on the constitution of the self, engendering criticism especially from schools of postmodernist and feminist thought, and which I now briefly discuss.

In Shildrick's (1997) book *Leaky Bodies and Boundaries*, she puts forward a feminist critique of principlism in bioethics pointing to a number of problems with the standard biomedical version of autonomy. Shildrick argues that the privileging of autonomy is most often considered in passive terms; a concern about not overriding consent rather than actively enabling patients' self-determination or sharing responsibility for decisions. Shildrick points out that no one can create autonomy for another and that the very act of entering the doctor's surgery may make impossible the equalisation of power relationships. McGrath (1998) raises the concern that; "...if autonomy is reified outside of the context of discourse, it may only complement the hegemonic power of biomedicine" (p. 516), highlighting the limits and superficiality of the abstract, rationalistic mode of reflection entailed in bioethics. Baylis et al., (1998) are concerned by a principlist ethics that does not account for the social, political and cultural context. Autonomy is conventionally understood as a recognition of the authority of the patient to make choices about their health care (Sherwin, 1998). While general practitioners lay claims to enabling and empowering women and supporting women's choices, they actually limit choice through constructing menopause solely within biomedicine. In other words, by producing knowledge exclusively within a biomedical paradigm, when a woman

enters the doctor-patient consultation these limits are already in place. One way in which this discursive construction of practice related to menopause becomes maintained and reproduced is through medical practitioners' using a range of strategies which have the effect of marginalising knowledge from without this paradigm (cf. Murtagh and Hepworth, Forthcoming, a).

Here, the Foucaultian concept of governmentality and technologies of the self (Foucault, 1988) is useful to elaborate my criticism of bioethics and menopause. Foucault describes relationships of technologies of power "...which determine the conduct of individuals and subject them to certain ends or domination" (1988: 18) and technologies of the self "...which permit individuals to effect by their own means, or with the help of others, a certain number of operations on their own bodies and souls, thoughts, conduct and way of being so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (1988: 18). These technologies exist in a discursive field, and therefore, the form of the technologies are produced in specific, local fields of play.

In his discussion of the invention of the contemporary self Rose (1996) notes that,

...[t]he forms of freedom we inhabit today are intrinsically bound to a regime of subjectification in which subjects are not merely 'free to choose' but *obliged to be free*, to understand and

enact their lives in terms of choice under conditions that systematically limit the capacity of so many to shape their own destiny. Human beings must interpret their past, and dream their future, as outcomes of personal choices yet made within a narrow range of possibilities whose restrictions are hard to discern because they form the horizon of what is thinkable (p. 17). (emphasis in original)

In the case of the modern bioethics and the principle of autonomy a neat reversal of power and freedom occurs. As Rose describes, the principle of autonomy, far from achieving the Enlightenment ideal of freedom, enmeshes the subject within forms of power that operate to produce them as certain sorts of subjects; in the case of women at menopause, an 'informed menopausal woman' based on the individual autonomous being. The management of women at menopause, first using discourses of femininity and more recently discourses of risk and prevention, produce women as subjects of medical and self-scrutiny that acts as a mechanism of control. Clearly there is room for resistance in such a description but when mechanisms of control are constituted in discourse that have previously been set out as the form of resistance, i.e. the women's health movement's concern with women's autonomy and freedom, spaces for resistance are in turn also limited. Rather than ethics as freedom or emancipation in this instance it is precisely the practice of freedom that acts as a mechanism of governmentality.

The problem for feminist ethics related to menopause is thereby illustrated by governmentality

(Foucault, 1988b; Rose, 1996) in that it is the call on autonomy and freedom that is the technique of government. Clearly an ethics that aims to enact emancipation for women in relation to their decision-making at menopause will have to critically engage with foundational ethics. The constitution of self in foundational ethics is therefore significant, and as Rose (1996) suggests, an examination of the ways in which subjectivity has become, "... an essential object, target, and resource for certain strategies, tactics and procedures of regulation" (p.152).

A narrowly defined ethics based on autonomy provides neither a direction for emancipatory health care practice nor an adequate framework for understanding women's decision-making about their health care. Yet, as I describe above, in the women's health movement the concept of autonomy and the association with empowerment and 'informed choice' has underpinned calls for changes to health care practice for women. I turn, therefore, to briefly review selected feminist literature in order to provide a background to feminist ethics and to later examine how discussions of autonomy and subjectivity are developed and relate to menopause.

#### **8.4 Feminist ethics: Autonomy and women's decision-making at menopause**

An interplay is evident between feminist ethics and critique of traditional or Enlightenment ethics in feminist literature. Brennan (1999) notes that:

*Feminist ethics...begins with the claim that mainstream ethics, practised largely by white middle class men, has constructed ethical theories which reflect the experience of this group and leave out, or make impossible to make sense of, the experiences of women and others"*

(p. 861).

Theorists of feminist ethics have determined a range of responses to this problem. An early approach to feminist criticism of traditional ethics as masculinist, the ethics of care proposed a revisioning ethics as 'feminine' (cf. Gilligan, 1982; Noddings, 1984).

Criticisms of the ethics of care are now well rehearsed in the field of feminist ethics (Brennan, 1999); nevertheless it holds an important position in the historical development of feminist ethics. Based on an essentialised construct of the feminine as more capable of care, the ethics of care not only presumes as foundational experiences not lived by all women (for example those of childbirth and mothering) it also provides a rationale which may reproduce practices of care that jeopardise women's autonomy. Equally, in this construction, the autonomy of the cared-for is omitted and may be jeopardised.

Feminist considerations of autonomy and caring include work by Meyers (1989). While Meyers advocates a relational approach to autonomy her essentialised account women and

women's experiences describes an autonomy that is partial and intermittent and neglects the formation of the subject. Meyers women are constrained by and to their socialisation to caring. Meyers' ethics describes a development of autonomy honed by individuals in a process of self-reflection and critical judgement albeit occurring in a social context. Effectively this form of self-reflection is an individualistic practice that leaves unfettered the existing power relationships as the other partner(s) in this relationship does not necessarily engage in this critical self-reflection.

Feminist scholarship following the ethics of care is not necessarily essentialist. Heckman (1985) takes her cue from what she sees as the radical implications of Gilligan's readings of psychological theory. She discerns in Gilligan a call for multiple voices and narratives. In her assessment of the changing notions of agency, Heckman turns to Wittgenstein's use of language games to consider a discursive morality that she feels is better able to describe morality outside of a masculinist frame. She holds that a 'moral voice' produces and is produced in specific social, cultural and historical constitutions of subjectivity and that the voice is never individual but always collective. Heckman (1985) calls for a more reflexive moral account of self-hood. Griffiths (1995), in *Feminisms and the Self: the Web of Identity*, maintains that a reconceptualisation of 'the self', moral and political agency, autonomy and authenticity is necessary. Like Heckman, Griffith's approach conceives of the self as complex, embodied and constituted in complex social and political contexts. The self is relational and dynamic. Additionally, Griffiths account of the self includes a place for experience and personal narratives and the role of emotions in constituting self-conception. Hallstein (1999)



also considers a revised ethics of care, "... a postmodern caring – that offers some possibility for diverse people, who have interpretive capabilities and intentionality to deliberate together across their differences, make choices and be held accountable for those choices in moral reasoning" (p. 32).

In contrast to the attempts to rehabilitate culturally produced 'feminine' values of the ethics of care Walker turns to women's experience and the interrelationships of moral life and social life. Walker (1998), as others (cf. Keller, 1997), conceives feminist morality as a relational process. Critical of the notion of an integrated rational, autonomous self, Walker offers instead a fragmented self of women's experience, although it is nevertheless a self that is constituted in terms of a pre-given identity. Walker (1998) maintains a contrast between an 'expressive-collaborative model' of feminist ethics and an abstract, authoritarian, impersonal, universalistic view of non-feminist moral consciousness. While she acknowledges non-feminist critics of mainstream ethics she maintains that it is only a feminist ethics that relentlessly pursues, "...questions about authority, credibility and representation in moral life" (p. 54) and differences in power inequalities. Critical of the notion of an integrated rational, autonomous self, Walker offers instead a fragmented multiple self of women's experience, although it is nevertheless a self that is constituted in terms of a pre-given identity.

Concern with practices of the self and the embodied self are evident in some postmodern and post-structural revisions of feminist ethics. Shildrick (1997) examines the disciplining practices

carried out by bioethics under the implicit assumption that the purpose of health care is to 'mitigate' the disorders of the body; a body that is defined by biomedicine as fixed and unchanging. She argues that the privileging of patient autonomy is merely a narrow and overdetermined focus on consent. Shildrick envisions a feminist ethics that takes account of diversity and the lived changing body. She does not propose the abolition of traditional ethical concepts such as freedom, rationality and equality; rather she aims to 'enact' ethics in a multiplicity of social relations and an irreducible diversity of individuals. Her ethics is to be understood, not as a, "...systematisation of rules of behaviour," but as, "...no more than discrete instances of better or worse choice" (p. 212). Shildrick argues that what counts in an ethics of the self is, "the degree of reflexivity, the extent to which the actor is self critical in her response to other" (p. 212). However, Shildrick does not effectively address power. Unlike Shildrick, our aim is not to valorize women through a feminist ethics. Although, both Shildrick, in her account of the embodied self, like that of Bray and Colebrook (1998) below, is useful dimension in a consideration of ethics in women's health care by maintaining attention to one of the contexts for decision-making at menopause: the corporeal.

Bray and Colebrook (1998) argue that Deleuze offers feminism, "...the possibility of a positive, active and affirmative ethics", an ethics which is not the imposition of norms, rather "the way in which bodies become, intersect, and affirm their existence" (p.36). In contrast to what they describe as, "a still cripplingly Cartesian" appeal to the body, Bray and Colebrook look to embodiment, the practices and regimes in which bodies are produced, to construct a non-reactive ethics: that is, an ethics which is not defined in opposition to masculinised

representations. It is "A positive ethics of the body [which] would see the body as more than the limit, negation or other of representation" (p.38). This conception makes possible ethics as an analytic; it enables, "...an ethics that examines thought, discourse and reason as themselves bodily events [allowing] an understanding ... in terms of bodily activity rather than in terms of a repressed or negated 'normal' body" (p. 38). Recourse to a 'normal' body is, they say, not possible in this form of ethics. Bray and Colebrook (1998) argue against the universalising of the sexed body in theories of embodiment characterised by Grosz's (1994) call for "new forms of representational practice outside of the patriarchal frameworks which have thus far ensured the impossibility of women's autonomous self-representations" (p.188). Rather, they regard the body as simultaneously the site for analysing socially constituted effects on the materiality of experience and the site for its reformulation. Whilst adopting a position that denies corporeality will be partial at best, affording primacy to the body risks excising practices and relations of organisations and institutions that contribute to the construction of that body.

In these varying revisions of care and considerations of autonomy the self emerges as the rubric around which descriptions of morality revolve and opens spaces for reconceptualising the self: A self constituted not from without, but a self that is plural and relational. This is clearly a distinct step from the abstract yet universal individual of traditional ethics and the essentialising feminine individual of the ethics of care. In the example of the medical management of menopause these approaches to feminist ethics open the possibility to conceive women at menopause as being diverse bringing a social constitution and an

embodied experience to their engagement with the phenomenon of menopause. There are parallels here with the feminist critiques of an historical medical construction of menopause as symptoms that mark a lost femininity, which through the calls for recognition of the diversity of women's experience aimed to demonstrated that the medical construction of menopause was invalid. However, reconceiving the self as social and experience as diverse is not sufficient to counter the discursive construction of menopause as physiological. Similarly, reconceiving the ethical self as plural, embodied and relational may not be sufficient to counter the discursive constitution of bodies and power relations that form a basis for women's engagement with medical health care. In the example of menopause I argue that the examination of the discursive constitution of subjectivity and power relations is crucial. I have already identified how medical constructions of menopause, particularly the subject position of the informed menopausal woman and the ethic of autonomy in women's decision-making intensify of power relations an act as a form of governmentality. Moreover I argue for a politics of women's health, one that employs a feminist ethics not merely as a lens or analytic but as a tool in reconfiguring women's decision-making and health care at menopause.

### **8.5 Subjectivity, power and agency in feminist ethics**

Unlike the feminist ethics of the self and of the body discussed above Abrams (1999) and McNay (1992, 2000) consider subjectivity and power more explicitly in relation to feminist ethics developing transformative (Abrams) and generative (McNay) accounts of agency. The work of feminist legal scholar, Abrams' (1999) refers to feminist theories that reject individualist assumptions in favour of, "a plural social construction of the subject in the context

of intersecting power inequalities" (p. 807). She aims to recuperate enlightenment ideals of freedom by reinterpreting and resituating women's self-determination in terms of an understanding of subjectivity and power relations. In acknowledgement of this reinterpretation she chooses the term agency over autonomy. For Abrams (1999) agency is twofold: self-definition and self-direction; where self-direction may be resistant or, more productively, transformative.

*Self-definition does not occur through a process of excavating the pre-social self or disentangling oneself from social influence ...it occurs, first, by becoming aware of the way that one's self, and one's self conception, are socially constituted ... as norms embedded in social institutions or practices.*

(Abrams, 1999: p. 819).

Abrams concept of agency articulates the collective aspect of the process of self-determination as self-direction; emerging through individual or collective action and interaction it actively engages social structures and power relations.

*...there is a political dimension to this process of recognising and reflecting on the influence of social norms ... that embody negative judgements about women's bodies, women's competence, or women's power in relation to others. [They] are not mere coincidence, [t]hey are a product of, and a means by which, women's oppression is perpetuated in particular settings*

(Abrams, 1999: p. 819).

While self direction may be explicitly or quietly resistant, Abrams' proposes transformative self-direction as a positive model for agency. Transformative agency operates in a context that recognises group-based oppression and positions social transformation as the actor's primary goal. Transformative agency targets institutions and their practices and may incorporate individual or collective action to disrupt social or cultural practices. Her calls for the legal system to "comprehend and respond to a human subject whose self-definition and self-direction have more the quality of feminist agency than of liberal autonomy" (Abrams, 1999: 829) may well be directed to primary medical care. Abrams' agency is pragmatic.

McNay (1992) draws on Foucault in her conception of feminist ethics. For Foucault, "Freedom is the ontological condition of ethics. But ethics is the considered form that freedom takes when it is informed by reflection" (1997b: 284). In her critique of the assumption of a value-free modernist ethic of feminist and non-feminist persuasions McNay (1992) employs Foucault's concept of the practices of the self which he uses both as a tool for analysis and as the basis for conceiving 'a modern ethics' of the self. This is not, she says, an anti-Enlightenment ideal, it is an 'ethics of the self' infused with emancipatory potential linked to the individual's capacity for self-determination and autonomy. Practices of the self, in dissolving the links between consciousness, self reflection and freedom of the abstract, rational individual, "Foucault proposes a way out of this inevitable cycle where resistance is transformed into domination, through a process which involves the adoption of an attitude of self critique and the exploration of new modes of subjectivity" (McNay, 1992: 87). The

exploration of the self is not with the aim of liberation or of uncovering a true or authentic self, rather it is in the obligation that Foucault sees of the perpetual re-invention of the self. A key question for Foucault then is how can the, "...growth of capabilities be disconnected from the intensification of power relations?" (Foucault, 1997a: 317). McNay (1992) argues that a reconstruction of autonomy that begins with Foucault's practices of the self and is attentive to difference produces, she says, an

*ethics of active intervention [which] opens a space for feminists to understand and intervene in the processes through which meaning is produced, disseminated and transformed in relation to the changing configurations of modern power and domination"*

(p.115).

In her recent work *Gender and Agency* McNay (2000) shifts her critique, finding Foucault's account of self-formation suggestive but incomplete as a direction for a concept of agency. She argues that the concept of a coherent subjectivity as discursively or symbolically constructed does not offer a broad enough understanding of the dynamics of subjectification and therefore offers a limited understanding of agency; specifically that it leads to a symbolic determinism and the implicit passivity of the subject. The discursive concept of subjectification appears, somewhat contradictorily, simultaneously determinist and voluntaristic. In the Foucaultian understanding the formation of the subject occurs through a process of subjection (the negative paradigm) and a practice of liberation; the 'practices of the self' described

above. However, the malleability of the symbolic order, implied by the potential for reconfiguring the self, is not necessarily realized as transformative practice: Change in the symbolic order does not guarantee changes in power relations.

*The fetishization of symbolic indeterminacy fails to accommodate adequately notions of structural and institutional inflexibility and can result in naïve accounts of the transformative potential of libidinal practices. The instability of symbolic structures may form a necessary condition for the transformation of social practices, but it is not a sufficient guarantor of change.*

(McNay, 2000: 155-56)

In feminist critiques of medicalised menopause in the 1980's and 1990's an account of the diversity of women's experiences was set against medical constructions of the experience of menopause as universally one of devastating and debilitating symptoms. Implicit in the critique of the universality of menopausal symptoms and in the demonstration of diversity across and within cultures was an expectation that a liberatory (libidinal) transformation in medical practices would accompany a shift in the symbolic construction in medicine of menopause to include a variety in women's experiences of menopause. This did not happen. Rather, as I have described above, the reconfiguration of a woman's subjectivity at menopause to include apparently emancipatory practices operates as a mechanism to intensify power relations.



McNay argues that because Foucault fails to distinguish between practices of the self imposed in a cultural regime and those that are chosen by the self his explanation vacillates between determinism and voluntarism. Determinism constrains the possibility of agency; voluntarism ignores the constraints of both symbolic (cultural) and material (institutional and structural) dimensions of the social world. Neither account enables a conception of agency that accounts for the interconnectedness of the material and symbolic. Moreover, McNay argues that the passivity implied by a determinist negative paradigm does not adequately explain how "individuals are endowed with the capabilities for self reflection and action such that their response when confronted with difference and paradox, may involve accommodation or adaptation as much as denial" (McNay, 2000: 3). This is an etiolated concept of agency. Tensions between determinist and voluntarist accounts of agency and questions raised by a theoretical division between material and symbolic dimensions of agency remain largely unresolved and therefore fails to produce an account of agency that is transformative or emancipatory.

McNay argues for a generative account of subjectification that dissolves the dualism of the symbolic and material. A generative theory of subjectification provides a more dynamic theory of agency through which to examine how social actors may adapt and respond in an active fashion to the uncertainties unleashed in an increasingly differentiated social order. The symbolic and material determinisms that operate in much feminist theory seem to preclude such a generative account of subject formation and autonomous agency. (McNay 2000: 161)

Abrams (1999) and McNay (1992, 2000) bring to bear considerations of subjectivity and power. McNay (2000) argues persuasively that a purely symbolic account of subjectivity limits our understanding of agency. A generative account of subjectivity that is attentive to the symbolic and material dimensions of the social world enables a dynamic theory of agency which is capable of explaining how individuals are able to act in creative and unanticipated ways to complex social relations (p. 161). Employing McNay's generative agency and Abrams' pragmatic agency we may begin to construct an approach towards an ethics of women's decision-making and women's health care at menopause. McNay's generative account of agency would consider the structures and institutions of medical practice as much as the symbolic order as susceptible to change. Abrams' ethics of engagement, in the case of the medical construction of menopause, might include engaging the other partner (e.g. general practitioners) in the negotiation of meaning and power relations in health care practice. Restoration of subjectivity and power relations, thereby, raises important questions about the material implications of 'choice', 'informed decision-making', and 'empowerment' for women's decision-making at menopause as they are currently used in primary medical care and about their possible transformations.

## **8.6 Towards a feminist ethics of women's decision-making and women's health care at menopause**

In discussion of feminist ethics, the revisions of an ethics of care and autonomy is evident in five main areas. First, the reconceptualisation of the self as socially produced; second, the incorporation of 'embodiment' in ethics; third, the importance of an account of subjectivity in a

feminist ethics to enable an analysis of how subjectivity delimits the 'say'able and the 'do'able; fourth, an attention to power that may contribute to a transformative feminist ethics; and fifth a generative logic which reconfigures determinist symbolic and materialist models to produce a creative account of agency that attends to the complex interconnectedness of relations of power. In this chapter I have critically discussed bioethics and feminist ethics in relation to the medical management of menopause. I am not proposing here, nor would it be possible or desirable, to finally resolve what a feminist ethics would comprise. Rather, my aim is to suggest that important questions may be raised about health care issues and women's decision-making at menopause by a consideration of feminist ethics.

Based on this discussion I maintain that an 'ethic of autonomy' and the 'offer of choice' by general practitioners in relation to health care for women at menopause, far from being emancipatory, serves to intensify power relations. The singularity choice, to take or not to take hormone replacement therapy, as currently presented in medical care and bioethics, is *required to be* a choice and is embedded in relations of power and knowledge that produce menopause in medical and popular discourse. Unlike the notion of autonomy that general practitioners use a feminist ethics would necessarily represent the breadth of women's experiences of menopause and choices. 'Choice' based on conceptions of agency informed by Abrams (1999) and McNay (2000) is not an individual act of the woman pursuing her rights and using her will, as previously discussed in relation to bioethics, but is a choice predicated on an active engagement with the relations of power that hitherto were integral to the limitation of her choice to a decision to take or not take hormone replacement therapy. In this

reconfigured concept of women's decision-making hormone replacement therapy is not excluded but is no longer the only (or primary) issue around which choice is exercised. A reconfigured health care for women at menopause would not be limited to reconceptualising the self: It would see health care practitioners, public health researchers and policy makers actively engage with women's meanings and experiences, negotiating health care beyond narrowly physiological parameters of traditional discursive constructions of menopause; it would see health policy regarding women's long term health take account of power relations, social inequalities and the social and discursive context of health.

Feminist writers have identified the resulting problems when modernist, masculine, universalistic, moral reasoning is used as a template for all. I have attempted to illustrate some of these problems in relation to women's decision-making at menopause and identify the need to reformulate bioethics. This review critically discusses various positions in a demonstration of how the modernist, masculine template of ethics is used in medicine and becomes amplified in the area of menopause that primarily concerns women and women's decision-making. Earlier work in feminist bioethics and new reproductive technologies such as Shildrick (1997), discusses some points that are significant to this critique, but does not share the same emphasis on power relations. In relation to the question of what feminist ethics provides for a conception of autonomy for women at menopause, I suggest that an analysis drawn from aspects of postmodern and post-structural feminist ethics discussed above points toward a framework. While not denying there are tensions between feminism and postmodernism, particularly in relation to what Benhabib (1992) calls the strong reading of

postmodernism, I argue that postmodern and post-structural informed feminist ethics engages discourse, subjectivity and power relations in ways that enable us to raise questions about autonomy for women's decision-making at menopause.

In conclusion I propose that feminist ethics is capable of offering a position to women at menopause beyond that which is defined by the use/non-use of hormone replacement therapy. The relations of power inherent in the doctor-patient consultation and the medical management of menopause are based on foundational medical ethics, specifically a principle of autonomy common to traditional bioethics, and the discursive construction of women at menopause which reproduces and ascribes to women a universal subjectivity that is singular and subjugates attempts to represent difference in most forms. The deployment of autonomy in medical practice limits women's decision-making precisely because it is detached from the construction of meaning and the self and makes invisible the relations of power of which it is a part. I argue that moral reasoning about women, menopause and subjectivity, must necessarily be open to the multiple relations of women as other, it must open spaces for active engagement with relations of power from within and without medicine but must also involve a practice that is engaged with transforming power relations.

## Chapter 9: Conclusion

### 9.1 Introduction

In this thesis I have described the shift in medical literature on menopause away from discourses of femininity and symptoms and toward the adoption of discourses of prevention and risk (see also Murtagh and Hepworth, forthcoming, a). These discourses emerged in the broader context of increasing interest in public health medicine and health promotion approaches to the prevention of illness and disease in the 1980's and 1990's. Both discourses of femininity and of risk provide a rationale for medical intervention and specifically the use of hormone replacement therapy. However, in downplaying the effects of menopause on femininity medical writers are able to appear to address some of the concerns of feminists by acknowledging the diversity of women's experience of menopause in terms of risk; which from the medical perspective is equated with the experience of physiological or psychological symptoms. The foundations of the dominant medical descriptions of menopause, that it is first and foremost a physiological phenomenon caused by the effects of hormone loss, is left intact. The construction of menopause as a risk to long-term health maintains menopause as appropriately a medical concern.

This thesis examined the construction of menopause and feminist reflections on this and asked questions about health care for women in this context by examining general

practitioner and media descriptions of menopause and health care for women at menopause. Critically reflecting on these questions from the empirical work and using a postmodern feminist lens, the thesis used ethical considerations around choice, power relations and agency to examine the implications for public health and health care for women at menopause.

## **9.2 Significance of this Research**

### **9.2.1**                      *Social Context and Practice Settings*

While much criticism has been made in feminist and other literature of a 'medical menopause' few studies examined menopause and health care in the medical practice setting (see Chapter 3). In Study 1 I demonstrated that the menopausal subjectivity constructed in the medical setting is unexpected from the perspective of literature critical of a 'medical menopause. I examine the effects of a new discourse of menopause as risk and as a key time for preventive health care for women (see Chapter 5). Discourse analysis of interviews with rural general practitioners demonstrated that the construction and effects of the hormonal menopause discourse used by general practitioners described menopause as the result of the physiological phenomenon of decline in hormone production resulting in a range of physiological and psychological symptoms and specific long-term physiological consequences, namely osteoporosis and cardiovascular diseases. The use of this discourse as a rationale for treatment of women at menopause with hormone replacement therapy is

described. Moreover, it is the construction of choice regarding the technology hormone replacement therapy using concepts of prevention, risk and information that constitutes that is the key approach to clinical practice with women at menopause.

Medical and feminist literature identifies mass media as a key site for representations of menopause. The few existing empirical studies of media representation of menopause largely describe this presentation as a fixed and wholly negative (see Chapter 3). In contrast I demonstrate in Study 2 shifting and multiple constructions of menopause in mass media (see Chapter 6). Content analysis of 345 print media articles from four South Australian newspapers over a period of thirteen years from 1986 to 1998 demonstrated that by the end of this period all discussions of menopause include consideration of hormone replacement therapy. The use and effectiveness of hormone replacement therapy had become so well established by the late 1990's that discussion of hormone replacement therapy could occur in the absence of mention of menopause. This analysis traces the cementing of a relationship between menopause and a range of regularly described physical and psychological symptoms and long term physical consequences of menopause, such as osteoporosis and cardiovascular diseases. Discussion of feminist and anti-feminist standpoints on menopause in the early to mid 1990's is described. An emerging concern with choice, risks and benefits regarding hormone replacement therapy in the mid to late 1990's is described.

Rather than an interpretation of the construction of empowerment, choice and women's



decision-making in general practice and mass media as merely another strategy of medicine to convince women to take hormone replacement therapy (cf. Coney, 1993; Klein and Dumble, 1994) I take seriously the engagement of concepts of choice and subject these to scrutiny within the framework of a range of ethics literature. In this way I examine the potential for a reconfigured health care practice for women at menopause. The construction of menopause as a risk to long-term health in medical practice and the adoption of discourses of prevention have made necessary a decision by women about medical treatment; specifically regarding the use of hormone replacement therapy. However, because the knowledge upon which that decision is made is not produced by women the ethic of autonomy in medical practice about menopause raises important questions for feminists. The rubric around which I engaged this discussion is ethical considerations of autonomy and agency. I examined decision-making at menopause in relation to several approaches to ethics: bioethics, postmodern and modernist feminist criticisms of bioethics, and feminist ethics. Employing Foucaultian concepts of governmentality I identified the "intensification of power relations" (Foucault, 1997a: 317) produced by an ethic of autonomy and examine the ways these considerations inform a feminist ethics of women's decision-making and health care for women at menopause. While this new menopause constructed in medicine and mass media is clearly far from unproblematic, I nevertheless argue that in the discursive shift towards women as active decision-makers there has evolved the potential for a reconceptualisation of health care practice for women at menopause by medicine (see also Murtagh and Hepworth, forthcoming, b). Specifically I argue that conceptions of agency informed by Abrams (1999) and McNay (2000) provide a framework for such a reconfiguration.

### 9.2.2 *Intersection of Knowledge*

In this thesis I also demonstrate the importance of the intersections of knowledge. In Chapter 2 and in Chapter 5 I demonstrate the way medical literature and medical practice, respectively, bring in, adopt, co-opt and amalgamate a range of concepts to develop knowledge and understandings about menopause. Concepts of prevention, medicine and risk are increasingly used as a justification for placing hormone replacement therapy at the centre of a choice that is constructed as part of health care practice about menopause. Yet this incorporation of choice doesn't necessarily change power relations of women and medical practice or improve the health care and public health considerations for women. Similarly in current non-medical literature about menopause the problematic aspects of the construction of choice are reproduced in research and literature about women's decision-making because it ignores power, construction and multiple versions of menopause. Recent research about women's decision-making largely takes a realist position on the experience of women and their stated need to be active participants in making informed decisions about hormone replacement therapy (cf. Griffiths, 1999; Jones, 1999; Bond and Bywaters, 1999). That women's voices are heard and responded to is vital in a feminist politics, be it modern or postmodern. Nevertheless, experience too is constructed in a discursive field. This research is important but it needs to (re-)engage with insights from the critiques of medical constructions of menopause. Particularly an engagement with critiques of the power relations constructed in the subject positions available to women at menopause; for example, the 'informed menopausal woman, described in this research.

In the analysis of the general practitioner interviews and mass media, I demonstrate that multiple of menopauses may co-exist. Different versions of menopause have different effects in different contexts; they are deployed to enact different effects in different contexts. In interview general practitioners deploy a particular version of menopause and health care for menopause to particular effect. I demonstrate that general practitioners construction of menopausal women as active decision-makers positions women as choosing and themselves as informing women and sharing decision-making with women. However this sharing of choice cannot happen because the parameters of choice are constrained. Why does this incorporation of choice and empowerment into descriptions of menopause not work? Because language is situated in power relations and nothing in the power relations of this situation has changed, therefore there is no change. Changing the language without changing the power relations means no change at all.

While a feminist ethics might at first appear to offer a way of understanding the issues raised by general practitioners and mass media about choice, autonomy and agency examining decision-making in the context of menopause demonstrated that the concept of 'autonomy' offered by contemporary health care systems is inadequate. 'Autonomy' is a poor replica for the empowerment or emancipation of women. Choice and autonomy continue to be problematic in current considerations of women's decision-making about health care at menopause because many of the understandings of social construction of menopause and considerations of power have been omitted from these discussions.

### 9.3 Conclusion and Considerations for Future Research

Three key points are made in this thesis that need to be considered in future research drawn from this study. First, the social context in which objects and subjects are constructed, particularly the intersection of knowledge, contemporary power relations and practice settings, is vital to understand health and health care practice. Second, I have identified that the location of decision-making in practice settings brings with it a range of possibilities and constraints. Third, agency is, as I have demonstrated, an important conceptual framework to examine both the context and setting of decision-making.

In this thesis I have demonstrated the ways in which prevention has become intrinsic in the construction of menopause and the use of hormone replacement therapy. The study of mass media is significant because it demonstrates the co-existence of multiple versions of menopause, versions that are often contradictory. The interview study with general practitioners is significant because in the shift in practice demonstrated here is an indicator that includes possibilities for a changed position for women. Possibilities for a reconfiguration of health care practices emerges in the potential offered by general practitioner discussion of choice and empowerment for women and in the fluidity evident in medical descriptions. I have demonstrated that choice and empowerment as currently practised is inadequate but offers the possibility for change. From the critical postmodern examination of bioethics and feminist ethics in relation to the issues of autonomy, choice and empowerment raised by the general practitioners and found also in mass media accounts of menopause I conclude that without a

critical engagement that disrupts taken for granted truths and assumptions about knowledge and power relations it is not possible to construct an emancipatory and transformative practice of health care and preventive health care for women at menopause and beyond.

Choice is clearly constrained when the parameters include only the medical or hormonal menopause. If we are to take seriously the constructedness of the social world then choices too are constructed. Either we determine that choice is itself impossible and therefore must be abandoned, an extreme relativist position, or we acknowledge the constructedness of choice and its parameters and act politically to open spaces for alternatives to be discursively available. A challenge is therefore set to discursively construct an emancipatory and transformative language of menopause. Within the hormonal construct, Martin's (1997) reconfiguration of menopause as an adaptive process, using chaos theory, in place of the current dominant understandings of menopause as failure of a system, clearly provides such an alternative construction. Can we turn also to older feminisms? Greer (1991) has been critiqued for an essentialist feminism that discursively constrains women's options (Harding, 1997; Leng, 1997; Murtagh and Hepworth, forthcoming, a). However, Greer's is the one of few perspectives that offers an alternative outside the hormonal menopause and its consequences. If detached from its essentialism, a reinscription of the alternative subject position proposed by Greer (1991) may provide one of a number of useful referents.

Issues of choice, empowerment and decision-making are far from resolved. Critical insights

and language change have never been translated into practice. Particularly, insights from the social constructionist critiques of power relations and the construction of subjectivity have not been addressed to key questions about the practice of women's decision-making. This is a problem because an understanding of power, difference and diversity in menopause is lost. It is therefore necessary to examine what it would mean to look critically at a 'translation' of insights from the social constructionist perspective into practice. Such reflection may also bear on considerations in broader public health policy as Western countries begin to explicitly engage concepts of patient decision-making and public involvement in decision-making in health care and health care practice (cf. Commonwealth of Australia, 2000; Department of Health, UK, 2001a, 2001b). The concept of emancipatory and transformatory agency appears to offer the possibility of a reconfigured health care that would attend to power relations and social context. I argue that concepts of agency, power relations and social context need to be (re)introduced to discussions of women's decision-making at menopause.

## **Appendix 1: Interview Schedule**

Madeleine Murtagh

Postgraduate Research Scholar

Department of Public Health

23 March 1997

Interview Schedule

**Purpose of the interview**

- a) My organisation and position
- b) 2<sup>nd</sup> year of a PhD – these interviews will contribute to my thesis and to academic papers
- c) My research interests
- d) Confidentiality in this research assured

Are you happy with this?

**Can I take that as verbal consent for your involvement in this project?**

### About the interviewee

1. I've told you about my reasons for doing this study, what would you like to see as an outcome of this study? Is there anything you would like to see achieved by this study? What were your reasons for becoming involved?
2. Tell me about yourself, about your practice here.

### About menopause

3. What does the term menopause mean to you? How would you explain it to a client or patient?
4. From your observation or experience how do you think women feel about menopause? What do you think are their concerns?
5. What do you think are the attitudes of others to menopause: Family, friends partners, the media?
6. Where do you think most women get their information about menopause?

### Health Care Practice

7. In your health care practice how do you determine if menopause is an issue (physical or otherwise) for your clients or patients?



8. What do you think is the best way for women to deal with menopause and related health issues?
9. What is the best way to help or support women in relation to these issues?  
What can/do you do?

#### City/Rural Differences

10. Do you think women in the country would have a different experience than those in the city? How? What, specifically?

#### General

11. Do you have any other comments?

Thank you

## Appendix 2: Transcription Conventions

Both the questions and answers were included in the transcripts, as were short verbal comments such as 'right' and 'really' but non verbal 'um's and 'er's were not included. Pauses and interruptions were also included. Intonations and speed of delivery were not recorded.

The following conventions are used in presenting interview data:

- .. short pause
- word emphasis, louder speech
- [...] text omitted
- [word/s] explanatory notes

**Appendix 3: Distribution of media articles by category and year of publication**

	Year	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	totals
	<b>Number of Articles</b>	24	27	13	12	9	49	28	40	34	26	17	31	17	327
	<b>Description of Menopause</b>														
1	osteoporosis/ fractures/bones	10	10	4	4	3	16	10	8	15	12	3	12	8	115
2	symptoms -	4	2	7	4	2	20	9	12	11	11	6	11	2	101
3	CVD/CHD	6	3	1	3	0	14	6	6	11	14	3	10	1	78
4	hormone deficiency/ change	2	2	3	0	1	8	2	7	5	6	4	6	2	48
5	menopause - negative/ devastating/ term abuse	2	6	6	0	2	11	4	5	1	1	2	2	0	42
6	sex	4	1	2	1	0	8	2	6	4	2	5	3	4	42
7	Loss of femininity/youth	0	0	0	0	0	10	3	4	2	1	1	0	0	21
8	positive	1	0	0	0	0	5	1	4	4	2	1	0	1	19

9	Loss of fertility/ reproduction	1	1	0	0	1	7	4	2	0	0	0	1	0	17
10	menopause - myths of	2	0	2	0	0	6	2	0	2	1	0	2	0	17
11	women living too long	2	1	2	0	0	6	2	1	1	1	0	1	0	17
12	diversity of experience	0	0	1	0	0	1	0	8	3	0	0	3	0	16
13	ageing	0	1	1	0	1	3	2	2	2	1	1	0	0	14
14	poor relationships	0	0	0	0	0	2	0	2	3	1	5	0	1	14
15	Alzheimers/ dementia	0	0	0	0	0	0	0	1	0	3	1	6	2	13
16	gender difference	0	1	0	0	0	1	0	0	0	1	6	1	1	11
17	social aspects of	0	0	0	0	0	1	1	0	5	1	1	0	1	10
18	wellbeing	1	2	2	0	0	1	0	0	1	0	0	0	0	7
19	early/surgical	0	0	0	0	0	1	0	5	0	1	0	0	0	7
20	women's experiences	0	0	0	0	0	0	1	2	1	2	1	0	0	7
21	incontinence	0	0	0	0	0	0	0	0	0	0	0	2	0	2
22	Loss of smell	0	0	0	0	0	0	0	0	0	0	0	0	1	1
23	end of life	0	1	0	0	0	0	0	0	0	0	0	0	0	1

Year	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	totals
Number of Articles	24	27	13	12	9	49	28	40	34	26	17	31	17	327
<b>Hormone Replacement Therapy</b>														
1 hormone replacement therapy	7	14	10	9	6	41	22	36	32	26	17	28	17	265
2 osteoporosis/ fractures/bones	10	10	4	4	3	16	10	8	15	12	3	12	8	115
3 symptoms -	4	2	7	4	2	20	9	12	11	11	6	11	2	101
4 CVD/CHD	6	3	1	3	0	14	6	6	11	14	3	10	1	78
5 cancer	2	1	2	1	1	8	8	10	10	11	5	8	3	70
6 risk to/not to	0	2	1	4	4	11	3	9	8	9	4	9	4	68
7 benefits	0	0	2	2	2	8	3	4	4	5	3	6	3	42
8 research	4	2	0	1	0	3	2	2	2	10	2	6	4	38
9 side effects/ contraindications	0	0	0	0	2	4	2	5	2	3	2	7	1	28
10 Controversy no consensus	0	0	0	0	0	1	3	2	1	6	0	5	2	20
11 long term treatment	0	0	0	0	0	7	1	4	2	3	0	1	0	18

12	diversity of treatment	0	0	0	0	0	5	6	1	1	3	1	2	1	20
13	increases longevity/ decrease mortality	1	1	0	1	2	0	2	2	2	0	4	1	0	16
14	positive effect on skin	0	3	0	0	0	7	0	4	0	0	0	0	1	15
15	Alzheimers/ dementia	0	0	0	0	0	0	0	1	0	3	1	6	2	13
16	misinformation/ myths of	0	0	1	0	0	3	0	1	2	4	0	2	0	13
17	evidence	0	0	0	0	0	0	0	0	0	5	3	3	1	12
18	tailoring treatment	0	0	0	0	0	0	0	0	0	4	0	5	1	10
19	not a cure all	0	0	0	0	0	0	0	3	2	1	0	2	0	8
20	testosterone	0	0	0	0	0	1	0	0	1	1	1	0	4	8
21	hormone replacement therapy as natural	0	0	1	0	1	2	1	1	0	0	0	0	1	7
22	men taking oestrogen	0	0	0	0	0	0	0	0	0	0	0	2	0	2
23	hormone replacement therapy safe	1	1	0	0	0	0	0	0	0	0	0	0	0	2
24	protects teeth	0	0	0	0	0	0	0	0	0	0	0	0	1	1

Year	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	totals	
<b>Number of Articles</b>	24	27	13	12	9	49	28	40	34	26	17	31	17	327	
<b>Public Health and Menopause</b>															
1	prevention	0	4	3	1	2	3	1	7	3	3	2	2	0	31
2	primary medical care	2	2	1	0	0	6	2	1	4	1	4	4	1	28
3	screening	1	1	1	0	1	2	0	1	1	4	0	1	0	13
4	women's health centre	2	2	1	0	0	0	2	0	1	0	0	0	0	8
5	cost to community	2	2	1	0	1	0	0	0	1	0	0	0	0	7
6	public health problem	0	1	0	0	1	0	0	0	0	0	0	0	0	2

Year	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	totals
<b>Number of Articles</b>	24	27	13	12	9	49	28	40	34	26	17	31	17	327
<b>Other</b>														
1 mention	7	6	2	2	0	2	2	2	0	0	0	1	0	24
2 menopause - celebrity	1	1	0	0	0	6	3	2	1	1	0	0	3	18
3 male menopause	2	0	2	0	0	4	0	0	0	1	2	3	0	14
4 environmental oestrogens	0	0	0	0	0	0	0	0	1	0	0	2	0	3
5 HIV/AIDS	0	0	0	0	1	0	0	0	0	0	0	0	0	1



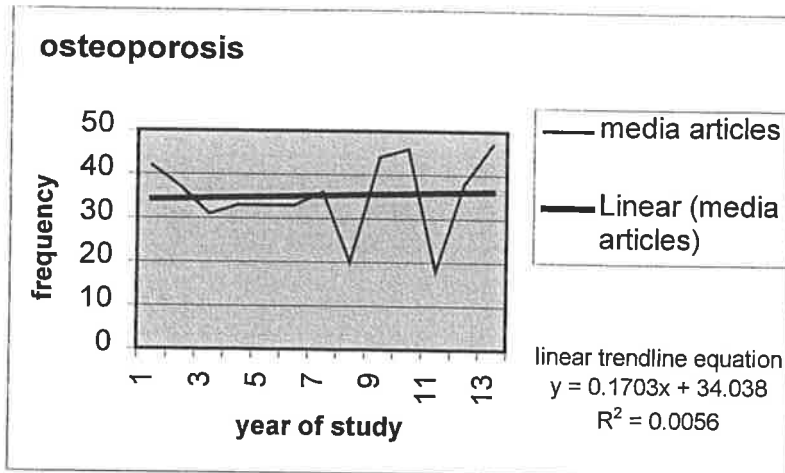
Year	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	totals
Number of Articles	24	27	13	12	9	49	28	40	34	26	17	31	17	327
<b>Alternative Therapy</b>														
1 hormone replacement therapy - alternatives to	2	0	1	1	0	2	3	4	6	1	1	9	4	34
2 calcium	6	4	1	3	1	4	2	2	4	1	1	2	3	34
3 exercise	1	4	0	0	1	5	1	4	5	1	1	3	4	30
4 diet	3	5	0	1	0	4	1	3	2	1	1	2	6	29
5 Drink less alcohol	1	1	0	0	0	2	2	2	1	1	1	2	1	14
6 Vitamins	1	0	0	1	0	1	0	2	1	0	3	1	1	11
7 smoking	0	1	0	0	0	2	2	2	1	0	1	1	0	10
8 soy products/ phytoestrogens	0	0	0	0	0	0	0	0	2	2	0	3	2	9
9 alternative pharmaceuticals	0	0	0	0	0	0	0	1	2	1	1	1	1	7

Year	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	totals	
Number of Articles	24	27	13	12	9	49	28	40	34	26	17	31	17	327	
<b>Feminist</b>															
1	critique of hormone replacement therapy/medicalisation	0	0	0	0	0	10	1	3	1	1	0	5	1	22
2	critique of sexist view of women	0	1	1	0	0	6	0	1	2	1	0	0	0	12
3	menopause as natural	0	0	1	0	0	3	1	2	3	0	0	2	0	12
4	menopause is power	1	0	0	0	0	6	1	0	0	0	0	0	1	9
5	feminism	1	0	0	0	0	4	0	0	0	2	1	0	0	8
6	critique of media representations	2	2	0	0	0	1	0	0	1	0	1	0	0	7
7	critique of feminists	0	0	0	0	0	2	0	1	0	1	1	1	0	6
8	hormone replacement therapy/menopausal exploitation of women		0	0	0	0	0	0	3	1	1	0	1	0	6

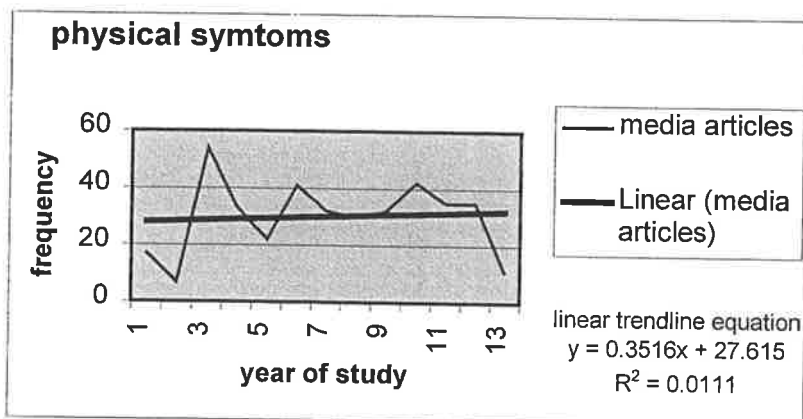
Year	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	totals
Number of Articles	24	27	13	12	9	49	28	40	34	26	17	31	17	327
<b>Feminist</b>														
1 information/informed	1	2	3	1	0	6	1	3	11	4	1	5	4	42
2 choice/control/decision-making		2	1	0	0	3	2	3	4	6	1	9	2	33
3 critique - doctors lack of knowledge/info	3	2	8	0	0	3	0	0	1	0	1	0	0	18
4 education	0	0	0	0	0	1	0	1	3	2	0	1	0	8
5 right to treatment	0	0	1	0	0	1	0	0	0	0	0	6	0	8
6 empowerment/independence	0	0	0	0	0	0	0	0	2	0	0	0	1	3

## Appendix 4: Trends in selected media categories

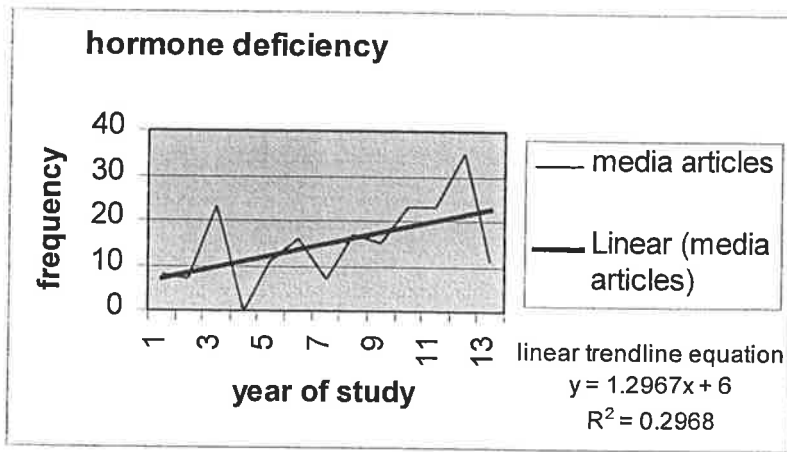
### Osteoporosis



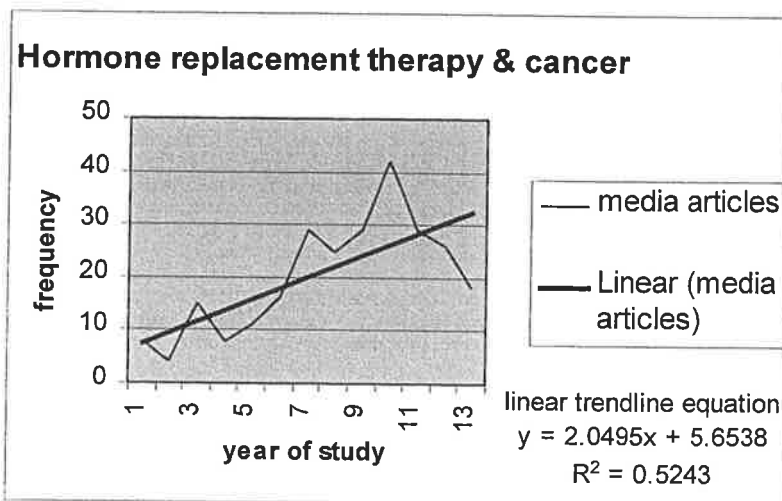
### Physical Symptoms



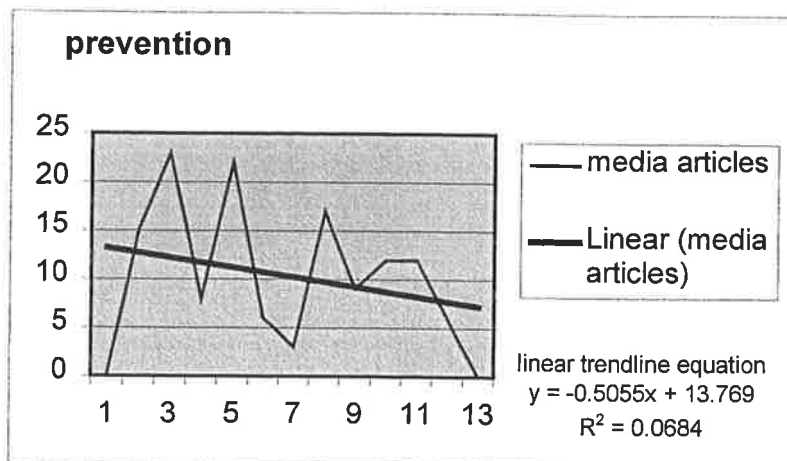
### Hormone deficiency



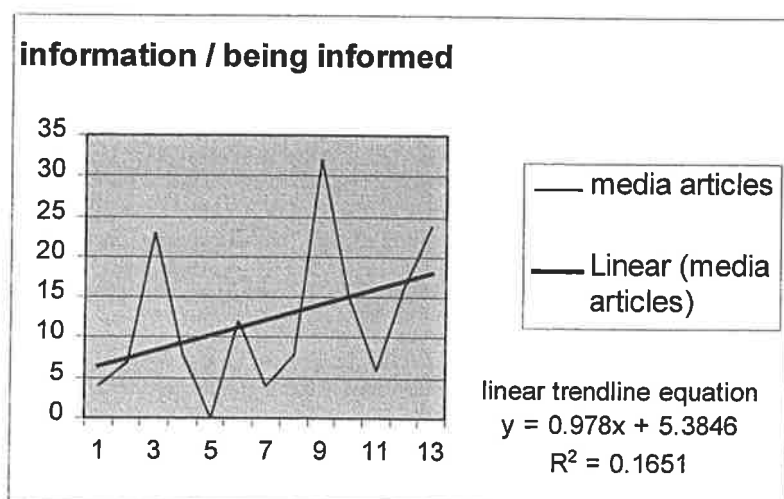
### Hormone replacement therapy and cancer



## Prevention



## Information / being informed



## **Appendix 5: List of Publications and Presentations from the doctoral research**

### *Refereed Publication*

1. Murtagh, MJ & Hepworth, J. 'Menopause as a long-term risk to health: implications of prevention for medicine and feminism' *Sociology of Health and Illness*. Forthcoming.
2. Murtagh, MJ & Hepworth, J. Towards a Feminist Ethics of Women's Decision Making and Women's Health Care at Menopause. *Social Science and Medicine*. Forthcoming.

### *Refereed Conference Paper*

1. Murtagh, MJ & Hepworth, J (1997) 'Implications of Menopause for Public Health' *National Rural Public Health Forum, Book of Papers, 12-15 October, Adelaide, Australia*.

### *Conference Presentations*

2. Murtagh, MJ & Hepworth, J. (2000) 'Feminism, medicine and menopause: Discourses of autonomy and decision-making in general medical practice'. *Gendering Ethics/The Ethics of Gender Conference, 23-25 June, Leeds, England*.
3. Murtagh, MJ & Hepworth, J (2000) 'Medicine, feminism and menopause: Constructing an ethic of choice and autonomy' *Narratives for a New Millenium Conference. 23-27 February, Adelaide, Australia*.
4. Murtagh, MJ & Hepworth, J (1999) 'Constructing the informed menopausal woman'. *Australian Qualitative Research, 8-10 July, Melbourne, Australia*.

5. Murtagh, MJ & Hepworth, J (1999) 'Who is the informed menopausal woman?'. Millennium World Conference in Critical Psychology. 29 April-2 May, Sydney, Australia.
6. Murtagh, MJ & Hepworth, J (1997) 'Is menopause a public health problem or is menopause a problem for public health?' Public Health Association Conference. 5-8 October, Melbourne, Australia.
7. Murtagh, MJ & Hepworth, J (1997) 'Menopause, health and the promotion of risk'. Australia & New Zealand Communication Association Conference. 7-9 July, Melbourne, Australia.

#### *Other Presentations*

8. Murtagh (2001) 'Discourses of menopause in primary medical care and print media: From femininity and decline to risk and choice'. Health Promotion Research Group seminar, 9 May, 2001, University of Newcastle Upon Tyne, UK.
9. Murtagh (1999) 'Public health and the construction of risk', Invited Lecture, 21 October, 1999, Department of Public Health, University of Adelaide, Australia.
10. Murtagh, MJ (1999) 'Menopause and public health' University of Adelaide, Division of Health Sciences Postgraduate Seminar Series, 24 April, Adelaide, Australia.

#### *Conference Posters*

11. Murtagh, MJ (1996) ' Menopause and women in rural South Australia: a qualitative study', International Menopause Congress, 3-7 November, Sydney, Australia.



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