Intervention and (Re)Invention for Women in Menopause: Cultural Norms, Hormone Therapy and Female Subjectivity

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ABSTRACT

Using Michel Foucault’s genealogical approach I analyze the development and promotion of menopausal hormone therapy (MHT). The post-structural genealogy identifies important scientific and social junctures that drove the administration and consumption of the therapy. Findings from randomized controlled trials a decade ago revealed MHT to have greater risks for women than had been known and provided the impetus for this study.

Interviews with fifteen women were conducted in 2007. Nine women were experiencing a natural menopause, two were premenopausal and four had had a hysterectomy although retained their ovaries. Analysis of semi-structured interviews ensued in reference to the following published texts: a popular medical textbook, the US Food and Drug Administration’s (FDA) publications on MHT, and lastly, the Boston Women’s Health Book Collective’s (BWHBC) text Our Bodies, Ourselves: Menopause. Three major discourses in relation to menopause and MHT were isolated: medical and biomedical-science, public health, and feminist discourses of women’s health advocacy.

Analysis was guided by four analytical features using a Foucauldian-inspired approach. The four features comprised the concept of production of beliefs; the significance of sign systems; the nexus of power/knowledge and the discursive practices that govern the conduct of individuals; and lastly, the alignment of the self to discourses and subjectivity.

Deconstruction of the category of the climacteric revealed that medical knowledge has not exclusively occupied a neutral scientific position. Rather, medical construction of the menopause has been influenced by misogyny and ageism, and by the production and reproduction of an intractable dichotomy of the normal and abnormal, leading to menopause being equated with deficiency and thus disease.

Furthermore, truth itself is contested. This thesis finds that Foucault’s expression “games of truth” is recognizable in the contestation, claim and counterclaims about the merits of MHT. Public health and preventative discourses were found to ground the wholesale promotion of MHT.
to well women, alongside commercial imperatives that drove productive relationships between manufacturers and the medical fraternity.

The participants disclosed varying responses and reactions to the complexity that pervaded information on the safety and efficacy of MHT. Whilst women aligned themselves with elements of discourse from all three organizing categories (medical, public health and women’s health advocacy), they also assumed courses of resistance often framed as privileging aspirations to enhance their “quality of life.”

The persistent disputation of truth about the science of hormones, normality and disease, methodological features in research, questions of commercialization, safety and efficacy of therapies, and the conceptualization of mid-life and ageing women were spheres of interest that emerged. Subjectivity was found to be contested. The participants revealed they engaged in self-work to achieve the balance they sought in life, often in a climate of negation and disregard of their interests by those who advised them. These women acted as their own gate-keeper to enhance wellbeing and either resisted or revealed awareness of negative female stereotypes.
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CHAPTER ONE: INTRODUCTION

The discourses that inform the administration and consumption of female hormones are deconstructed in this thesis as an entry to unpacking in a Foucauldian analysis of how the woman as subject is produced and reproduced. The catalyst for this study was the changes to hormone promotion and consumption that followed the release of findings from the first large scale randomized control trial (RCT) undertaken on menopausal hormone therapy (MHT) to determine its safety. The RCT, titled the Women’s Health Initiative (WHI) study, was stopped abruptly after five years in 2002 when it was discovered that MHT was not as safe as had been believed (Writing Group for the Women’s Health Initiative Investigators [WGWHII] 2002). The effects of ending the trial reverberated world-wide affecting many middle aged- women concerning menopause and recommendations about products for symptom relief. My interest was in investigating how this significant revision of thinking on menopause and therapeutic intervention would disrupt common assumptions about menopause as a negative life event and popular beliefs viewing medical intervention in menopause as a norm. Michel Foucault’s genealogical approach is selected as it provides tools to probe the complexity of medical science, ethics, and conceptions of subjectivity and the interplay of power and knowledge on people and systems that are facets of practices concerning MHT at menopause.

Foucault’s approach facilitates investigation of the assumptions about the status and societal positioning of women embedded in traditional and feminist discourses of women and health, involving deconstructing the intersection of those assumptions with how (on what premises) medical science proposed pharmacological intervention for well women. Assumptions of female subjectivity as encapsulated in the biomedical-scientific and pharmacological rhetoric regarding claims about the efficacy and benefits of exogenous female hormones are deconstructed. The sphere of gender thus becomes a major classification to be interrogated in this thesis, as it will be shown biomedical-science knowledge has influenced the construction of female identity and femininity. Foucault’s method was chosen as ideal for this study for the ability to expose the trajectory of juxtaposed ideas that permitted a drug to be widely prescribed without sufficient evidence of its safety over many decades.
Underpinning the analysis are numerous publications presenting the findings of the Women’s Health Initiative Study (WHI) from 2002. WHI studied women with a uterus, between 1993 and 1998, publishing initially in 2002 (WGWHII 2002). The project studied the effects and efficacy of menopausal hormone therapy\(^1\) (MHT) in a large population study and attempted to resolve uncertainty about the safety of MHT. Findings resulted in the United States Food and Drug Administration (FDA) issuing safety warnings and revising advice on MHT to prescribers and the public. Current guidelines recommend the lowest effective dose for the shortest period of time to treat moderate to severe menopausal symptoms with respect to each woman’s unique risk factors (FDA 2010; Hickey et al 2005; National Institutes of Health 2007; Stefanick 2005).

The thesis aimed to unravel how MHT came to hold the place in symptom management that it did for both women and health professionals, how the overturn of past claims about the efficacy of MHT and to what extent these changes effected women post WHI. To achieve the aims the role of professions in advising women, the science of hormone therapy, the marketing of products and the assumption about the subjectivity of women are investigated.

\(^1\) Throughout this thesis the abbreviation MHT for Menopausal Hormone Therapy is the preferred title/acronym used to refer to the cluster of preparations that includes ERT (estrogen therapy), HRT (Hormone Replacement Therapy) and E-P (combined estrogen and progestin therapy). Alternative acronyms are used when other authors use another title/acronym or a reference is made to a product in a time period before later iterations appeared.
1.1 The structure of this thesis

Following this introductory chapter, Chapter Two, “Historical Background,” gives the context for the study and presents a historical overview of the development of the science of human sex hormones, and the development and context of female hormonal medications containing estrogen, concluding with a chronology to the present day.

Chapter Three, “Methodology,” sets out the theoretical underpinning of the thesis, followed by the design and methods used in carrying out the research. At the outset the research question is provided, Foucault’s genealogical method is presented, and the two elements of genealogical analysis, descent and emergence, are outlined. These elements enable the researcher to unpack the relationships and interplay of discourses with respect to Foucault’s power/knowledge nexus. Secondly, under Methods, the approach to discourse analysis is presented, along with the texts chosen as data for analysis, and a description of the interview participants, data collection and analysis, and ethical processes utilized. A framework used for analysis which was informed by Foucault’s genealogical method is presented, accompanied by a descriptive matrix provided at the end of this chapter.

Chapter Four is the first of three chapters comprising the findings and analysis of the data, where published texts and interview data from women participants were analyzed contemporaneously. These three chapters are termed “organizing categories” to reflect post-structural positioning of this thesis. This chapter, “Organizing category one: Medical talk on MHT” analyzes Llewellyn-Jones’ Fundamentals medical text as a representative text on medical discourse of the menopause and related medical intervention. Two editions of the text (1999 and 2005) form the basis of inquiry as they span the period when the interviews were conducted and the recent research discoveries about MHT (Llewellyn-Jones, 1999; Oats and Abraham, 2005).

Public health discourses concerning the efficacy and safety of MHT are the focus of Chapter Five, titled “Organizing category two: Public health talk on MHT.” The publications of the Food and Drug Administration on the Premarin family of drugs are the texts considered alongside the women’s interviews. Discourses about risk reduction, preventative strategies and promoting self-responsibility in consumers are addressed here.
Chapter Six is titled “Organizing category three: Reframing MHT,” and addresses women’s health advocacy perspectives through analysis of the 2006 Boston Women’s Health Book Collective’s publication on menopause. The text is analyzed in conjunction with participant interview data.

Chapter Seven, titled “Fashioning the genealogy of MHT,” completes the genealogy by discussing how we have come to be where we are in relation to MHT and menopause. This large chapter utilizes Foucault’s technique of retracing, disrupting recognizable concepts, identification of discourses and institutional lines of descent. The investigation of historical struggles and events gives insight into the descent of ideas, and in this research to the mechanisms of power affecting menopausal women, how they are perceived and how they conduct themselves. The chapter concludes by outlining a postmodern subjectivity, and considers Foucault’s ethics of the self in relation to peri-menopausal women. The conclusion addresses the thesis in answer of the research question, discusses limitations, and poses recommendations for practice and research.
CHAPTER TWO:  HISTORICAL BACKGROUND

A historical background is provided here to give the context of the introduction of estrogen therapies. These medical interventions became known as estrogen replacement therapy (ERT), later revised to hormone replacement therapy (HRT) and more recently as menopausal hormone therapy (MHT). Firstly, the development of the estrogen drug family is traced, and secondly, the historical events of the licensing of doctors and the advent of prescription medicines provide background information to the legal framework in which MHT evolved. The legal and regulatory context refers in the main to the United States (US), as the most common estrogen product has been manufactured and marketed there and is addressed in this thesis. In this Foucauldian analysis it is essential to consider the scientific emergence of estrogen agents and the context of their use in the light of the development of biological medicine and the institutions that regulated drugs. The content of this chapter provides background information that will be built upon later in the thesis.

2.1 Historical development of female hormone replacement therapy

Menopause has traditionally been a taboo subject. Its representation in literature and scientific writings traverses the very negative to the more balanced (Utian 1997). Aristotle (384-322 B.C.) referred to the cessation of the menses in Greek women at age 40 years. Over the next 2000 years acknowledgement of the decline in fertility is a matter of written record, so that common use of deficit language became well entrenched and is familiar within the framework of biomedicine. Both Greek and Latin origins are attributed to the terms for the menopause (Wilbush 1979, in Utian 1997). The Greek words menos (meaning monthly) and pausis (meaning cessation) give us the modern term for the cessation of the menses, while climacteric in Greek represents steps or the steps of a ladder, introducing the idea of the progression of stages. Early medical writings recorded the indicators or “symptoms” of the “change of life,” and physical manifestations such as the appearance of grey hair, wrinkles, and the loss and decay of teeth (Meigs 1848, in Utian 1997, p.75). In 1777 John Leake linked menopause with vaginal atrophy and altered bladder function. The term “menopause” was commonly used from the mid-nineteenth century (Greer 1991; Utian 1997). With the entrance of medicine in the commencement of the modern era,
medical assumptions based on women’s physiological purposes in life were expressed by Colombat de L’Isere in his *Treatise on the Diseases of Female* (1845). He wrote: “Compelled to yield to the power of time, women now cease to exist for the species, and henceforward live only for themselves,” and continuing he stated, “she now resembles a dethroned queen, or rather a goddess whose adorers no longer frequent her shrine, she retains few courtiers, she can only attract them by the charm of her wit and the force of her talents” (de L’Isere 1845, in Utian 1997, p. 75). Such a description highlights the sexual and reproductive aspects of existence, whilst relegating any other social role contributions, like grand-parenting and matriarchal roles, such as imparting wisdom from a life well lived, to the margins. Towards the end of the nineteenth century Tilt stated that “well localized nervous affection sometimes occurs at this critical epoch” (1857, in Utian 1997, p. 75).

In the latter nineteenth century experimentation isolated the human sex hormones and administration of hormones was seen to reverse characteristics of aging (Brown-Sequard 1889, in Kahn 2005). Experiments on human subjects led to the belief that sex hormones increased vigor and youthful appearance (Kahn 2005). By 1927 estrone was isolated (Utian 1997). This was the discovery that led a decade later to the production of estrogen based products being released and administered to more and more women over the next decades. There appeared to be a prevailing attitude that a “naturally” occurring chemical was not intrinsically harmful. During the ensuing decades research implicated female hormones in breast cancer (Auchincloss and Haagensen 1940; Lane-Claypon 1926; Wainwright 1931).

At a large interdisciplinary scientific meeting, Nancy Krieger and colleagues noted that concerns about cancer incidence in early studies of estrone resulted in questions about dosages rather than questions on efficacy of the drugs per se. Thus the question of legitimacy or advisability of administration of drugs containing estrone was transformed into the more tractable medical question about measurable effects of estrone (and derivatives) on body function, and issues of safety (Krieger et al 2005). Safety was important as without it products would not be marketable. As hormonal pharmaceuticals have widespread effects on the body, for example, reproductive, cell growth and metabolic effects, dose and timing of administration were investigated. Ongoing experimentation led to more precise knowledge of effective dosage levels.

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2 In 2004 following the Women’s Health Initiative trial, a group of historians, epidemiologists, biologists, clinicians and women’s health advocates convened a scientific meeting to discuss “the scientific and social context of and response to the (trial) findings” (Krieger et al 2005, p.740).
Novak and Yui (1936) claimed that estrogen therapy precipitated a pathological hypertrophy of endometrial tissue. In 1936 Russell Marker and Thomas Oakwood formulated the synthetic estrogen called diethylstilbestrol (DES)\(^3\) (McCrea 1983). In 1941 diethylstilbestrol was introduced to the US market after approval by the FDA. James Goodall developed Premarin (a conjugated estrogen manufactured from the urine of pregnant mares) for Ayerst Laboratories who gained approval to produce it in 1942 (McCrea 1983; Watkins 2002). In 1942 Premarin was approved following application by Wyeth-Ayerst Research (FDA NDA 004782). In the same year Greenbalt claimed there were benefits, including the “return of coital pleasure,” to menopausal women of testosterone pellets being inserted under the skin (Greenbalt 1942a, 1942b). In 1947 Gusberg, a New York City cancer researcher at the memorial Sloane-Kettering Hospital and Columbia University, identified increases in endometrial cancer in ERT users in his histological research. His work linked hyperplasia and adenocarcinoma in the female endometrium. Gusberg (1947) wrote that the widespread administration of estrogens to post-menopausal women was akin to human experimentation. Through the 1940s and 1950s, despite growing concern about the safety of hormones, use of estrogen therapy steadily increased, with sharp rises doubling prescriptions in the 1960s and tripling them by 1975 (Stefanick 2005, p.65S). Up until 1962, although drugs were required to exhibit safety, manufacturers did not have to evidence effectiveness of a product. In 1972 the Drug Efficacy Study Implementation (DESI) unit of the FDA released their evaluation of various estrogen products, including Premarin: they stated estrogens were effective in the treatment of menopausal symptoms (FDA 2005).

The most significant development in the 1970s was the discovery, published in two separate studies in the *New England Medical Journal*, that estrogen increased endometrial cancer risk (Smith, Thompson and Herrmann 1975; Ziel and Finkle 1975). In 1978, prompted initially by

\(^3\)Diethylstilbestrol (DES) is a drug once prescribed during pregnancy to prevent miscarriages or premature deliveries. In the U.S.A, an estimated 5 to 10 million persons were exposed to DES from 1938 to 1971, including pregnant women prescribed DES and their children. In 1971, the FDA advised physicians to stop prescribing DES because it was linked to a rare vaginal cancer (Seaman and Seaman 1977). After more than 30 years of research, there are confirmed health risks associated with DES exposure, though not all exposed individuals will experience DES-related health problems. However, it was still widely prescribed until it was demonstrated, in the early 1970s, that women exposed to DES in utero developed clear cell adenocarcinoma (CCA) of the vagina and cervix at a rate significantly higher than the general population (Seaman and Seaman 1977, p. 37). Later it was found that these women also have a higher risk of breast cancers. Patients who are daughter of women who took DES are at increased risk for clear cell adenocarcinoma (CCA) of the vagina and cervix, reproductive tract structural differences, pregnancy complications, and infertility (p. 60).
concerns with oral contraceptive pills and risks of blood clots, the FDA announced the requirement to insert package labeling for estrogens for menopause to warn women about the risk of endometrial cancer, potential risk of breast cancer, gall bladder disease and abnormal blood clotting (FDA 1978).

Through the 1990s, HRT uptake increased again largely because the combined estrogen and progestin preparation was marketed to mediate the risk of endometrial cancers caused by estrogen alone. The emerging picture of the safety of estrogen was complex, as illustrated when two large-scale, prospective studies that commenced in the 1980s (the Framington Heart Study and the Nurses’ Health Study) resulted in opposing conclusions regarding cardiac risks (Stampfer 1991). The Framington study showed increased risk of stroke, blood clots and coronary risk, while the Nurses’ study showed reduced cardiac risk (Stampfer and Colditz 1991; Wilson et al 1985). Grady and colleagues conducted a large literature review and pooled estimates using standard meta-analytic statistical methods from studies to assess the risks and benefits of HRT for asymptomatic post-menopausal women (Grady et al 1992). Grady et al. concluded that evidence showed ERT decreased risk for cardio-vascular disease (CVD), although it must be noted they stated this view arose from observational data and not the more robust data of randomised controlled trials (RCTs). The review found increased risk of endometrial cancers – a finding affirmed by existing findings (Grady et al 1992). In the mid1980s short acting estrogen was introduced for the prevention of osteoporosis (FDA 2009). Claims persisted at this time that MHT would prevent heart disease and osteoporosis (Krieger et al 2005; Stefanick 2005).

In the 1990s the FDA abandoned their long held policy of excluding fertile women from drug trials (Harvard Women’s Health Watch 1999, p. 3). This point is important as the exclusion of women (particularly from cardiac drug trials) had meant they were subject to dosages and prescriptions that had been researched as efficacious in males, although not females (Merton, 1996).

Reliance on observational findings had failed to sufficiently prove the safety and efficacy of estrogen medications for menopause (Krieger et al 2005; Kopera 1990b). Two RCTs, the gold standard of research according to evidenced based medicine (Peto 1993; Sackett et al 1997), were commenced in the late 1990s. In 1998 the Heart and Estrogen/progestin Replacement Study (HERS), with women who had established cardiovascular disease, reported increased
cardiovascular risk and increased risks of breast and ovarian cancers (Hulley et al 1998). The Women’s Health Initiative study (WGWHII 2002) commenced in 1993 published initial results in 2002. The findings of these two landmark studies were the catalyst for practitioners, researchers and women rethinking the function and effects of MHT. Early research into sex hormones identified their association with cancer-causing risks, both of the breast (Auchincloss and Haagensen 1940; Lane-Claypon 1926; Wainwright 1931) and of the uterus (Gusberg 1947; Taylor 1947). When both of these studies confirmed the risks linked to use of sex hormones, Western governments then intervened, warning against wholesale prescribing of MHT.

Krieger et al. (2005) have identified that throughout history hormone replacement therapy use has always been controversial. Indeed, during the twentieth century there were at least three waves of debate about estrogen use predominating in professional and public circles. The first occurred in the 1930s, once laboratory techniques succeeded in making estrogens available as a manufactured drug. During this period, biochemists and endocrinologists conducted animal experiments that provided evidence of the carcinogenicity of sex hormones; however, the hormones were viewed as ‘natural’ and thus not intrinsically harmful. The second wave of debate occurred in the 1960s and 1970s, triggered by new health concerns about oral contraceptives, estrogen only hormone replacement therapy and associated risks of endometrial cancer (Smith et al 1975; Ziel and Finkle 1975), plus the carcinogenicity of tobacco and environmental pollutants. The third wave of debate is currently underway, and involves both concerns about the carcinogenicity of hormone replacement therapy and disputes over its presumed long term health benefits, including its potential to reduce risk of cardiovascular disease. Industry interest in, plus government regulation of, prescription of sex hormones has also intensified over time, with concern typically focused more on preventing harm than establishing benefits of their use (especially long term benefits not detectable without lengthy follow up). Efforts to couch arguments for hormone replacement therapy in terms of chronic disease ‘risk reduction’ are a comparatively recent development. Until recently, clinical guidelines in many countries advocated that physicians counsel women about the use of hormone replacement therapy as standard care for women during and after menopause, but these days physicians have been discouraged from routinely prescribing it.
Prescribing hormone replacement therapy was framed to doctors and women as both curative and preventative – it would alleviate menopausal symptoms and supposedly prevent osteoporosis and cardiac disease. Pharmacological companies had successfully invested large amounts of money in promoting hormone replacement therapy as a normal response to menopausal symptoms and a wise protection against future ill-health. There have been many queries about the ethics of pharmacological marketing strategies, including their role in ghost-writing and effectively obfuscating the results of clinical trials, and concealing of side effects (Gillett 2010; Spielmans and Parry 2010). The prescribing of HRT came under close scrutiny after the release of findings from two long awaited trials: firstly, the HERS study published early results in 1998 (Hulley et al 1998). Secondly, the WHI studied 16,608 post-menopausal women aged 50-79 years with an intact uterus from 1993 to 1998, publishing initially in 2002 (WGWHII 2002). In May 1992 the US Congress Office of Technology Assessment produced a background paper, *The Menopause, Hormone Therapy, and Women’s Health*, stating the need for (1) randomised clinical trials to comprehensively assess the health effects of HRT, and (2) research into the alternative therapies to manage menopause symptoms.

The WHI Randomized Clinical Trial was commenced to attempt to respond to the Congress’ 1992 call (WGWHII 1998). The WHI was funded by the US National Heart, Lung, and Blood Institute and sought to assess the efficacy of MHT via a large scale randomized clinical trial commenced in 1993 to resolve contention surrounding MHT. Premarin was used in the estrogen only arm of the trial, while Prempro (approved in 1995-NDA 020527) was administered in the combined arm of the trial (WGWHII 2002). A decade later the WHI was stopped prematurely. Results showed continuation could endanger the health of participants, as risks for healthy postmenopausal women (with an intact uterus) in taking estrogen plus progestin outweighed benefits (WGWHII 2002). Breast cancer, stroke, pulmonary emboli and cardio-vascular disease events were all elevated in the trial group compared to those on placebo after 5.2 years.

The projects studied the effects and efficacy of HRT in large population groups and attempted to resolve uncertainty about the safety of HRT (Krieger et al 2005; Hulley et al 1998; WGWHII 2002). Below is a brief chronology of events (Table 2.1).
Table 2.1. Brief chronology of scientific, social issues and FDA activities regarding hormones for menopause

<table>
<thead>
<tr>
<th>Decade</th>
<th>Scientific issues</th>
<th>Social issues</th>
<th>FDA activity</th>
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<tr>
<td>1930s</td>
<td>Introduction of hormone, debate on danger of malignancies. Oral preparation sourced from pregnant human then horse urine. Patent-Ethinyl estradiol.</td>
<td></td>
<td>The FDA established in 1931/</td>
</tr>
<tr>
<td>1940-50s</td>
<td>Estrogen &amp; cancer linked (uterine and breast). 1942 Premarin approval and became a commercial success.</td>
<td>↑ use of menopausal hormones.</td>
<td>Expansion of FDA. By 1951 “safety and efficacy” focus of FDA. FDA approves DES for menopausal symptoms.</td>
</tr>
<tr>
<td>1990s</td>
<td>Uptake continues to ↑ PEPI, HERS &amp; WHI trial commence. WHI 1st large scale randomized trial.</td>
<td>Many sectors still question safety - feminists, scientists, advocates.</td>
<td>Abandoned the introduction of generic form.</td>
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Although there is now more information, the context is no less confusing for women. Critiques of these trials and their methods have led to claim and counter claim on the merits and dangers of hormonal medication, in respect of efficacy for symptom relief and in relation to risk, particularly coronary heart disease and breast cancer (Foidart et al 2007; Palmlund 2006; Prentice et al 2005a).
Following the publication of these results, clinical guidelines were hurriedly amended to recommend that before hormone replacement therapy is initiated or continued, women should be advised that use of hormone replacement therapy is associated with increased risk of pulmonary embolism, stroke and breast cancer, and that these risks increase with age and duration of use (New Zealand Guidelines Group 2004). These and similar guidelines, for example, the FDA (Stephenson 2003), suggested that hormone replacement therapy remains an appropriate treatment only for women with moderate to severe vasomotor symptoms of the menopause, and that it has no role in the primary or secondary prevention of cardiovascular or cerebrovascular disease. The consistent advice was that hormone replacement therapy should be taken at the lowest dose for the shortest period of time necessary to control symptoms. The need for continuing treatment should be reviewed at 6-monthly intervals.
CHAPTER THREE: METHODOLOGY

3.1 Introduction
This chapter sets out the epistemology, design, and the methods used in the thesis. My concern in this thesis is to elucidate the consequences of culturally constructed norms and assumptions about women at mid-life that have been given expression in the phenomena of menopausal hormone therapies (MHT) over several decades. The following research question is posed:

‘How have cultural norms about mid-life femininity and health influenced the discursive construction of menopausal hormone therapies (MHT)?’

Answering this question demanded a deconstructive approach. A post-structural Foucauldian genealogical analysis was chosen to unpack the complex web of discourses regarding knowledge, claims to truth about both women and normality, and the utility of exogenous female hormones in the chronicle of MHT. Post-structural analysis critiques the nuances, allegiances, and departures that inform societal and cultural structures, and the complex edifice established by the interface of professions and society that produce knowledge and influence subjectivity. Foucault’s genealogical approach provides the epistemological positioning of this thesis, while Fairclough’s (1992, 1993, 2003) critical discourse analysis (CDA) as methodology provided the tools and techniques to guide analysis of discursive texts, drawn from interviews and selected published material. This process uncovered beliefs, values, knowledge claims, assumptions, categories, representations, crossing points, gaps and elisions in discursive constructs in the data sources. Analysis and critique of the findings led to fashioning a genealogy of MHT for mid-life women. A problematic of this thesis was to critique the apparent homogeneity of menopausal women by analyzing the anomalies that discourse on hormone replacement therapy may illuminate, in the light of the development of medical interventions, treatments, product manufacture, patterns of prescribing and consumption.
The chapter commences by providing a detailed outline of Foucault’s genealogical approach including the analysis of his two important concepts, descent and emergence. The design and methods used in the thesis are then presented.

3.2 Outline of Foucault’s genealogy approach

Foucault’s genealogical approach is post-structural in that it seeks to expose and illuminate ideological drivers and the power platforms that ground structures and institutions in our social and political world. In this section I describe Foucault’s genealogical method and the application of his theories to core discourses constitutive of MHT in the lives of women (Foucault 1971/1984). Broadly speaking, core discourses arising in bio-ethics, medicine, medical science and gender politics are relevant across the period of inquiry from the inception of estrogen therapy to the contemporary era. Foucault’s genealogical method, with its interrogation of the human sciences, subjectivity, ethics and the effects of the power/knowledge nexus on professions and people in general, sheds light on the central issues of this thesis. Analysis is thus focused on femininity and subjectivity, the promulgation of a hormone medication by medicine and pharmaceuticals despite contradictory scientific ‘truths,’ and the emergence of what could be termed a ‘lifestyle’ drug.

Structural analysis locates terms and concepts within a nexus of meaning that allows us to associate things/items with them, to discern what they are marking as characteristic features that form the basis of those distinctions. Post-structural analysis goes beyond that to the contexts in which those layers of structurally related meanings have been generated and are now used (Appendix G in Gillett 2009).

For Foucault, genealogy is not concerned with the discovery of origins of events and human happenings. Such a search is fruitless as it cannot and would not result in uncovering the ‘truth.’ Foucault dismissed grand determinations of history, eschewing the linear development of history articulated by the progressive historians. It was Foucault’s view that words and concepts cannot maintain their meanings across the vagaries of time and culture. Rather, genealogy’s task is to ‘expose a body totally imprinted by history’ Foucault (1971/1984, p. 83). In contrast to the approach of progressive historians, Foucault proposes genealogy as an alternative which ‘opposes itself to the search for origins’ on which supposition history so heavily depends (1971/1984, p.
Although some commentators place Foucault as a historian of ideas, he diverted his audience from such categorization. Writing under the pseudonym of Maurice Florence\(^4\) (1984) he identified himself as a critical historian of thought. Foucault wrote a considerable corpus of material, both published in books and recorded as lectures, interviews and teaching materials. Endemic in Foucault’s polemics was the tendency to offer conceptual proposals and then tender their possible negations. He frequently proffers alternative conceptualizations and avoids claiming a definitive formulation, thus his method is discerned in his own approach to theorizing. Faubion (1994) elaborates on Foucault’s use of the French terms for knowledge that at times have multiple interpretations, *savoir* and *connaissance/connaître*. *Savoir* is to know, to be known and have cognizance. In this meaning Foucault acknowledges that we can ‘know’ by experience, fact and materiality. *Connaissance* is acquaintance, to be acquainted with, and sometimes it refers to cognition and learning. *Connaître* is to comprehend, to have mastered; Foucault uses *connaissance/connaître* in technical applications and with theories of science and deconstruction of the sciences.

Foucault, along with other post-structuralists, has been criticized as an epistemological relativist, that is, one who does not believe anything is true. The feminist postmodernist and bio-ethicist Margrit Shildrick (1997) counters this accusation, explaining that the ‘instability of boundaries uncovered by post structuralism does not inevitably lead to moral indifference (as in moral relativism) but demands from feminists [and post-structuralists] an attitude of high responsibility towards the elaboration of differences and particularity’ to value specific bodies, at specific times, in their unique contexts (p. 139). So the post structural theorist does not deny the facts that women bleed while fertile, or that menses cease with aging. These are material facts that women experience and know (*savoir*). It is the meaning cloaking, and attaching, to these events through disciplinary knowledge, cultural, and social knowledge (*connaissance*) that is the focus of my study.

Crucial Foucauldian works informing this study are his genealogies, the critical *History of Sexuality* in three volumes (1976, 1984, 1985) and the exposé *Discipline and Punish* (1977). Foucault’s genealogical approach to the discovery of knowledge cannot be entirely divorced from

\(^{4}\)Foucault categorizes his work as a critical history of thought in an entry in the *Dictionnaires des Philosophes* (1984, pp.942-944) under the pseudonym of Maurice Florence. The entry was written initially as a retrospective view for the introduction to his book *History of Sexuality* (Vol. II) which takes a genealogical approach to analysis.
his other mode of analysis, archaeology, which is also applicable to this study as it focuses on the professional disciplines in the human sciences. For Foucault, in addition to disciplines (such as medicine, biology and medical sciences) being creators of fields of expert knowledge, they are systems of control. Using archaeology he specifically questioned disciplines ‘in which the subject himself is posited as an object for possible knowledge’ (Florence 1984, p. 942). The process whereby this occurs he called a ‘game of truth’ (Foucault in Rabinow 1994, p. 282). Briefly a ‘game of truth’ concerns the interplay of knowledge and power, where the subject is involved in their own ‘self-formulation’ (Foucault in Rabinow 1994, p. 282). The reciprocal exchange of knowledge and power provides the means to interrogate the relationship of the subject and truth as proffered by scientific disciplines (Foucault in Rabinow 1994). I will expand on this later in the chapter.

Andersen (2003) defines genealogy as seeking ‘by a gaze of disruption, to open up the discursive field through tracing practices, discourses and institutional lines of descent, including lines of connection to different historical conflicts and strategies of control’ (p. 30). Prado posits his interpretation of Foucault’s genealogical analytics of bodies as below:

‘Genealogy, as the analysis of descent, painstakingly exposes the tiny influences on a body, that over time, not only produce a subject of a certain sort, a subject defined by what it takes to be knowledge about itself and its world, but a subject under the illusion that it is a substantial, autonomous unity’ (1995, p. 36).

In Prado’s view, Foucault illuminates that it is disciplinary discourses that shape subjectivity and establish regimes of truth. So now we see that Foucault is interested in subjective bodies and how they are inscribed by events (taken in the broadest sense in which they are always already signified), creating discursive constructs within which our world is ordered.

In his essay titled ‘Nietzsche, Genealogy, History’ Foucault (1971/1984), explains that genealogy utilizes two modes of operandi: the analysis of descent and of emergence. It must be acknowledged that these are not arbitrary and he may not identify the use of one or the other in any given work; nevertheless his strategies of critique and philosophy fall into these modes. Here he notes his indebtedness to Nietzsche, whose work introduced the intellectual platform from which Foucault launched his approach.
Foucault states that the genealogist will discover that ‘behind things (there) is not a timeless and essential secret, but the secret that (things) have no essence or that their essence was fabricated in a piecemeal fashion’ by the interchange of discourses and events (1971/1984, p. 78). As well as examining what has been recorded, the genealogist examines the unrecorded, the gaps and elisions that could tell us about the constitution of bodies, subjects and address the why of historical events.

As alluded to, in genealogy, there is no preset design of the human condition to be uncovered, no origins or essences (such as innate gender differences) that can be isolated as determinants of events or subjects. Rather, origins are refuted and the search for them dismissed, and genealogy assesses the incidences, co-incidences, attempts, tendencies and gaps left silent, tracking complexity and disparities to produce the things that are significant or have value for us that are produced coevally with those assessments of value (Foucault 1971/1984).

Drawing on Nietzsche, Foucault outlines that the techniques/tools of descent and emergence in genealogy are used in analysis and have implications of power. The analysis of descent entails excavating recorded history, and hitherto unknown facts and events, and analyzing linkages or discontinuities to enable ‘recognition and displacement of an empty synthesis’ of the subject and the path of human existence (Foucault 1971/1984, p. 81).

Foucault (1971/1984) elaborates that

‘(t)he traits [genealogy] attempts to identify are not the exclusive generic characteristics of an individual, a sentiment, or an idea, which permit us to quantify them as ‘Greek’ or ‘English;’ rather it seeks the subtle, singular, and sub-individual marks that might possibly intersect in them to form a network that is difficult to unravel from the one traditionally held as ‘true’’ (p. 81).

A genealogical approach necessarily addresses the relationships and interplay between discourses, and embedded in such an approach are four facilities of Foucault’s method(s) that are especially germane to my project: firstly, analysis of power with recourse to the power/knowledge nexus; secondly, production and reproduction as related to ‘normalization’ of subjects; thirdly, the concepts of ‘constraint’ and the clinical gaze; and finally, the subjugation of
discourses and resistance. As discourse analysis is an essential element in doing genealogy it is necessary to define what I mean by discourse.

In the *History of Sexuality* (Vol. I) Foucault (1976/1990) states;

‘it is in discourse that power and knowledge are joined together …we must conceive discourse as a series of discontinuous segments whose tactical function is neither uniform or stable …..we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that come into play in various strategies (p. 100).

Regarding analysis of discourse, Foucault exhorts analysts that

‘it is this distribution that we must reconstruct, with the things said and those concealed, the enunciations required and those forbidden, that it comprises; with the variants and different effects-according to who is speaking, his position of power, the institutional context in which he happens to be situated-that it implies, and with the shift and reutilization of identical formulas for contrary objectives and that which it also includes’ (pp. 100-101).

Furthermore, Foucault claims that

‘(D)iscourse transmits and produces power; it re-enforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. In like manner, silence and secrecy are a shelter for power, anchoring its prohibitions; but they also loosen its hold and provide for relatively obscure areas of tolerance’ (p. 101).

In the above quotations Foucault posits both his definition of discourse and his mode of analysis of discourses and their effects.
3.2.1 Analysis of descent

The analysis of descent is itself a critique of traditional disciplinary approaches and the assumptions underlying knowledge and truth. The subject who is the focus of theorizing in both modernism and humanism is a fixed entity, stable with innate capacities such as autonomy and rationality. To follow Foucault’s approach it is necessary to understand his assessment of the subject as emergent, his negation of determinism and his analysis of the operation of power. Foucault (along with other poststructuralists) challenges the formulation of the subject of liberal humanism and modernity as a unified, self-present, pre-given and transcendent universal subject, with subjectivity understood in terms of stable personal attributes such as capacity for rationality. The subject and object are interconnected as the subject is an object of knowledge, and it is in the conditions that the tensions between true and false (statements or categories) create that the subject comes to be. The problem, for Foucault,

‘…is to determine what the subject must be, to what conditions (s)he is subject, what status (s)he must have, what position (s)he must occupy in reality or in the imaginary, in order to become a legitimate subject of this or that type of knowledge’

(Florence 1984, p. 1).

The subject to Foucault is one of possibilities, multi-centered, not fixed but fluid and emerging, never completely formed. The post structural subject is always in process, constituting and reformulating according to available discourses (Butler1993; Foucault in Rabinow 1994; Grosz 1994). For example, in the History of Sexuality (Vol. I), Foucault critiques the place of sex and its repression in western (particularly European) societies. Rather than it being natural for sex to be secretive and repressed, relegated to the confines of sanctioned marriage, Foucault argues that there was a systematic expunging of sexual activity and open denunciations (language) of sex and sexual practices that composed the social fabric of the period prior to the seventeenth century. Here I cite two examples he used to support his position on the relegation of sex to ‘taboo, nonexistence and silence’ over the next few centuries (p. 5). Firstly, the role of the church became increasingly prescriptive, delimiting speech concerning sex and the limits and conditions of correct sexual behavior, whilst at the same time influencing the passing of laws concerning sexual conduct. Secondly, he analyzed the influence of psychiatry and the repressive hypothesis in denoting the normal from the abnormal, and creating categories of acceptable and deviant
behavior. These two examples display Foucault’s genealogical approach, according to which society’s institutions create the rules for being in society.

Analyzing descent reveals a body which is marked/inscribed and thus signifies the results of regulating discourses in its mannerisms, gestures, carriage, speech and language. Yet the alteration over time and decades (uncovered via genealogy by Foucault) from the freer sexual subject of early times to the constrained sexual subject of the later period disrupts the idea of the subject as stable, thus refuting the necessity for committing to ‘origins’ and a ‘natural’ state of being.

Origins are assumptions underlying the conceptualization of subjects and/or history that give an apparent coherence to events and therefore to claims about them (Foucault 1971/1984). Two examples illustrate this point. Firstly, Augustine’s history is a linear progression of history where the hand of God is behind events in which historical happenings contribute to three phases of the history of mankind: the Creation, the Incarnation and the Last Judgment (Prado 1995). The historian’s task is to identify relationships between events that appear unconnected, relating them within the three pronged progression (Matson 1987). Secondly, the tendency of theories of the modern era is to assume that other things, in addition to the materiality of bodies, contribute to gender differentiation, a principle that is then applied to all people at all times. Attributes of femininity and masculinity, and hierarchies which ensue from them in the social order, are viewed as founded on bodily differences. Such differences are taken as natural because heterosexuality is viewed as a product of the division, thus the atypical male or female and homosexual are maligned and assigned to deviancy (Butler 1993; Foucault 1976; Grosz 1994). A search for origins is invoked when the ubiquitous idea that the subject is stable, indebted and irrevocably dependent on essences of bio-matter imposing uniform, universal subject-hood (regarding, for example, race and gender) is somehow obvious and always self-evident (Butler 1993; Prado 1995).

In short, our understanding of the body is a production of dominant or socially sanctioned discourses, that is, meanings accruing to the material body are discursively produced and therefore fluid and changeable as historical vicissitudes testify. This approach then refutes determinism, a priori theories and thus the idea of a predetermined and stable subjectivity promoted by, for example, anthropology, humanism, and phenomenology. The subject is not static or pre-given; rather, it is evolving, dynamic, fluid, and never formed but always in the
process of forming (Butler 1993; Foucault 1971/1984; Prado 1995). In the passage quoted below Foucault signals his concept of emergence in talking of the discourses on sex:

‘(W)e must not expect the discourses of sex to tell us, above all, what strategy they derive from, or what moral divisions they accompany, or what ideology, dominant or dominated, they represent; rather we must question them on the two levels of their tactical productivity (what reciprocal effects of power and knowledge they ensure) and their strategic integration (what conjunction and what force relationship make their utilization necessary in a given episode of the various confrontations that occur)’ (1976/1990, p. 102).

This passage offers us an insight into the transition from the analysis of descent to the analysis of emergence and the production of subjectivity, particularly when considered in the light of discourses of femininity and the menopausal woman.

### 3.2.2 Analysis of emergence

The analysis of emergence centers on a subject that constitutes itself within relations of power. Foucault turns his attention to the role of authoritative, learned talk, the talk of science and academia. Authoritative discourses have produced the subject, and norms thus articulated are often prescriptive. The subject is shaped and constrained by the forces of hegemonic discourse. Claims regarding disciplinary truth are produced by regimes that both make up the rule book and hold the authority to assert the ‘truth.’ Hegemonic disciplines award the scope of social being (as impermeable absolutes) for particular subjects, thus limiting other possibilities, for example the delineations surrounding gender.

To Foucault it is the interplay between discursive constructs connected to truth claims, and the power/knowledge to enforce them, which creates a regime of truth. Power-relations refer to the generation (emergence) of the cornerstones of society’s values, morals and knowledge that permit and maintain hierarchies and power structures whether of individuals or classes. Emergence is ‘the entry of forces….the play of dominations’ (Foucault 1971/1984, pp. 84-85).
I pose an example here to clarify Foucault’s point and exemplify how this thesis will utilize his genealogical method. I describe early events surrounding the discoveries and usages of ERT/HRT which, although preliminary to the body of the thesis, form a useful example as they give both the background to the problematics of the topic and briefly permit us to gain an appreciation of the application of Foucault’s method. Here two significant discursive constructs and their intersection are important: firstly, the scientific conceptualization of the significance of sex hormones as a disciplinary truth in the bio-medical sciences, and secondly, the ideal of femininity as espoused by gynecology and psychiatry (which mirrored a socio-political view), professions that likewise lay claim to disciplinary expertise in the concurrent historical epoch. The profession of medicine emerged as the proliferation of medical knowledge and the development of formal systems of education (Foucault, 1963/1989) were increasingly formalized across the eighteenth and nineteenth centuries, culminating in the later part of the nineteenth century when medicine sought licensing as a profession. The discovery of germ theory by Pasteur was the critical leap in knowledge which enabled medicine eventually to gain legal status as a protected profession. The legal facility to license medical practitioners was gained by the mechanism of ‘friendly’ licensing5 (Temin 1980). Paralleling the emergence of these events was the strengthening of the scientific method in the sciences, and the political push for women’s suffrage which necessarily disrupted the feminine ideal.

I proceed to present a brief chronology of scientific discoveries illustrating the events which built disciplinary truth within biomedical-science on sex hormones, and, in addition, cite instances where gynecology and psychiatry reveal professional opinion that the menopausal state is ‘dangerous’ and a departure from an ideal of womanhood. Taken together, the effects of disciplinary truths overlaid with the authority of medicine in social structures form examples of Foucault’s ‘game of truth,’ where the claims of an established profession produce a truth that permits the profession to reassert itself as a producer of truths, and the cyclical process of production of truth (knowledge) and reproduction of power based in such truths is set in motion. These elements are excavated genealogically in later chapters. This pattern of reproduction involves Foucault’s power/knowledge nexus.

5 ‘Friendly licensing occurs where a profession monitors itself, rather than the opposite form of ‘hostile’ licensing where regulation is imposed upon a collective body (Temin 1980).
Exogenous female hormones are clustered by biologists and physiologists in a category known as sex hormones (Kahn 2005; Krieger et al 2005; Novak and Yui 1936; Utian 1997). To early scientists seeking to discover the effects of administration of sex hormones there was something of the miraculous involved (Kahn 2005; Utian 1997). Claims were that these chemicals could rejuvenate the aging body, potentially restoring function of the pubertal glands. Tissue and blood products were consumed as tonics by both men and women. In the late nineteenth century, the French physiologist Brown-Sequard explored what he called a replacement therapy. He undertook a trial, injecting into his own arm an aqueous mixture of dog and guinea pig testes, blood and seminal fluid. He had noted declining function in his arm over preceding months (he was 72 years of age) and injected the mixture for three weeks, recording results as improved grip, mental concentration and strength (Brown-Sequard 1889, in Kahn 2005).

In the 1920s animal experiments showed some dramatic youthful appearance in aging dogs. Stimulation of the endocrine glands took different forms, from X-ray radiation to surgery, to promote hypertrophy of sex hormone tissue to increase secretory function, thus avoiding or delaying the onset of senility. Often initiatives were aimed at overcoming the effects of aging in both men and women. In experiments following Brown-Sequard’s early work several European physicians transplanted testicular tissue or testes from animals to humans, in the search for rejuvenation of youthful faculties and strength. Another pioneer in glandular therapies was Voronoff, a Russian surgeon practicing in France who (in)famously transplanted testicular tissue from monkeys and chimpanzees into men in the 1920s (Kahn 2005). Stanley (1922), a physician at San Quentin Prison, California, published results in the Journal of Endocrinology of research on 656 people he transplanted with testicular tissue. His subjects were mostly inmates in addition to 13 physicians, 7 women, and 100 unconfined men. Both Stanley and Voronoff were criticized by other physicians for their experimental and controversial approaches, and even the popular press vilified their work (Kahn 2005). But the stereotype of vigor and youthfulness being dependent on hormones was nevertheless greatly in evidence.

Scientific investigations in this field led to the German scientist Butenandt isolating estrone in 1927 (Butenandt 1930 in Utian 1997). Through the late 1920s and in the 1930s science focused on converting the new discoveries into usable and safe products. However, the carcinogenic property of estrogens was identified by endocrinologists and biochemists as part of the drug
Sexual endocrinology was an emerging medical science throughout the early 20\textsuperscript{th} century, and sex hormones were so labeled, although by function these substances could just as well have been titled growth hormones (Haraway 1991; Krieger et al 2005). Applying Foucault’s method here we could say that medical science categorized the cluster of substances that became known as sex hormones, articulating the possibilities and limitations of their use, and devising therapies and interventions involving their manipulation.

The findings about the biochemistry of sex hormones were soon taken up by medical disciplines involved in research and public commentary regarding women, their femininity and social roles which delineated the normal from the abnormal. Other branches of medicine, such as psychiatry and gynecology, have long associated the climacteric with mental disorders. Samuel Ashwell, a London gynecologist, published \textit{A Practical Treatise on the Diseases Peculiar to Women} in 1855. Ashwell (1855) was an exception in not agreeing that menopause is a time of illness, and he remonstrates with readers to avoid falling into this commonly held mistake:

‘(I)t has become too general an opinion that the decline of this function (menstruation) must be attended by illness; but this is surely an error, for there are healthy women who pass over this time without any inconvenience and many whose indisposition is both transient and slight’ (p. 156).
Thus we are informed that the tendency to view menopause negatively, or as potentially linked to dysfunction and representing the loss of a natural capacity, is well entrenched in the medical profession, and that the evidence for doing so is somewhat deficient. Ashwell’s view, though, remained an anomaly in the medical profession for many years. Emil Kraepelin, the famous German psychiatrist, published on clinical psychiatry in 1896 and 1904, taught medical students, and proposed his method of classifying different forms of mental derangement, which was translated into several languages. He studied various cases over many years, and isolated the disorder *involutional melancholia*, an affliction affecting some women at menopause and men of about 10 years older (Greer 1991). Helene Deutsch (Freud’s protégé) lecturing in 1925, viewed the menopause as a time of neurosis and regression, and named psycho-neurotic events presenting at that age as hysteria (Deutsch 1945). Despite the paucity of evidence, the notion of menopause as ‘the dangerous age’ was promoted in many quarters by medical practitioners.

More than a century after Ashwell published his views, one of the most (in)famous and oft referred to gynecologists, Robert. A. Wilson, author of *Feminine Forever* (1966) on menopause and ERT/HRT, labeled menopause a serious, painful and often crippling disease. He promoted hormone use on the basis of assumptions about what it is to be ‘female.’ Applying Foucault’s genealogy to Wilson’s ideas, it could be said that discourses of normal sex roles for women (based on a normalized biology) were utilized to promote this hormone, which itself was configured in discourse as a sex hormone, despite its wider effects on the body. From a Foucauldian view, Wilson, as an expert, both reiterates a discursive construct on women and femininity while at the same time proliferating a normalized notion of women that has the effect of reproducing the norm. The power/knowledge nexus is thus illustrated when an expert publicizes pronouncements with the authority of disciplinary expertise, thereby producing a ‘truth.’ The crucial thing here in relation to medicating menopausal women with hormones is that well women were *treated* to maintain an equilibrium that medical science had discovered, or rather articulated, about the ideal of women. Foucault elaborates his view on the production of *truths* further:

‘(N)othing can exist as an element of knowledge if, on the one hand, it…does not conform to a set of rules and constraints characteristic, for example, of a given type of scientific discourse in a given period, and if, on the other hand, it does not possess the effects of coercion or simply the incentives particular to what is scientifically validated or
simply rational or simply generally accepted….It is therefore not a matter of describing what knowledge is and what power is and how one would repress the other or how the other would abuse the one, but rather, a nexus of knowledge-power has to be described so that we can grasp what constitutes the acceptability of a system’ (1997, pp. 52-53).

A genealogical approach necessarily addresses the relationships and interplay between discourses. Embedded in such an approach are several facilities of Foucault’s analyses: of power by accessing Foucault’s power/knowledge nexus; production and reproduction as related to ‘normalization’ of subjects; culture and the professional disciplines including the concepts of constraint; and subjugation of discourses and resistance (Foucault 1976/1990). Discourse analysis is used to deconstruct discourses to reveal the assumptions, influences, limitations and effects of discursive constructs.

In this thesis post structural analysis involves particular commitments to deconstruct and critique systems, societal structures and power structures, and social and professional edifices, all of which shape the culture and practices. Gillett (2009) discusses how post structuralism goes beyond structuralism in the way the signified and the signifier are subjectively situated. In structuralism the sign is within a system (of language, knowledge and social interaction), and underpinning this thought is the modernist idea that such a system is stable and recognizable. However, post-structuralism to Gillett

‘acknowledge(s)…the workings of power and the situation of the body in a milieu that inscribes it with skills, techniques, modes of relatedness, positions, institutional expectations, and so on. In the face of such diverse forces acting on the situated subjective body, the thought that there is a substantial essence or core - person at the heart of the psyche is somewhat effaced and so the psychological subject (of much traditional phenomenology and metaphysics) becomes de-centered or problematized and concepts like authenticity and character are, to some extent, deflated’ (2009, p. 388).

Alongside Foucault’s genealogy, feminist post structuralism informs analysis; this approach recognizes female agency and the asymmetry of social structures on gender lines, making the hidden and private visible (Code 1995). Feminist poststructuralists maintain that meanings accruing to the material body are always discursively produced and therefore fluid and changeable (Butler 1993; Cain 1993; Flax 1993; Grosz 1994). Chris Weedon (1987) describes
discourses as constructing multi-various subject positions that individuals occupy or ‘take up.’ A
unitary self does not exist. Rather, the subject is always in process with various and competing
discourses constituting, formulating and inventing the subject. Like Weedon, post structural
philosopher Judith Butler (1993) claims cultures and societies over time shape understanding of
sexed bodies, and thus predetermination imposes meaning on specific bodies. What is
understood as ‘female/male’ (gender) tendencies and the physical/material body are apparently
inseparable and enduring concepts. Effort to separate the raw biological materiality from cultural
markers is therefore inordinately difficult. The ‘raw’ is inculcated with the residue of gendered
discourses, but this ought not restrict how we think about bodies or make us work on the
gendered assumption about particular bodies. Along with Foucault, Butler (1993) does not fall
into the trap of claiming that all matter is rhetoric only.

Methodological and epistemological dilemmas remain contentious even while feminist
researchers attempt to analyze ‘the nature and positioning of would-be knowers and…the sources
of evidence or data’ (Code 1995, p. 39). The process of undertaking analysis of texts requires
attention to the participants’ world and the contexts of their experience. Some of the participants
in this study hoped their experiences would help others not to feel alone in the peri-menopause.

Utilizing genealogy in assessing how this pathologizing of menopause appears ‘natural,’ and
cognizant that the slide from life event to disease is frequently unquestioned, an analysis of
descent would shed light on this phenomenon by reference to Foucault’s methods. These involve
an analytics of ‘games of truth’ in relation to firstly, discourses of discipline and ethics, and
secondly, his technologies of power (normalizing of subjects, constraint, clinical gaze, rendering
subjects-women docile), and the outworking of the technologies of the self. Further, applying the
analysis of emergence would entail unpacking the power/knowledge nexus, examining resistance,
and exploring identity as fluid. Ethical tensions relevant to this inquiry include the ethics of
promotion of therapy for lifestyle, whilst raising the possibility of compromising health with the
ingestion of pharmacological agents. In this chapter I have scoped the theoretical underpinning
of the methodology and analytical approach used to address the aim of the thesis. I have
endeavored to introduce and describe the key concepts on which the analysis depends.
I use the tools of genealogical research to examine the problematic of the apparent homogeneity of menopausal women and to unpack anomalies, which have existed for decades, surrounding hormone replacement therapy.

### 3.3 Design

Qualitative interview material collected from fifteen women, and literature on the administration and consumption of female hormones, were analyzed using Foucault’s genealogical approach as the informing epistemology and design (Foucault 1971, 1977; Prado 1995). Data comprised interview texts and material from three published texts (the Llewellyn–Jones medical text book, 1999 and 2005 consecutive editions), the FDA’s information on the Premarin family of drugs, and the Boston Women’s Health Book Collective’s book *Our Bodies Ourselves: Menopause* (*OBOM*).

The expert texts are chosen as they are ‘prescriptive’ texts whose purpose is to ‘offer rules, opinions, and advice on how to behave’ just as Foucault selected texts for his genealogy *The History of Sexuality* (Vol. II), (Foucault 1984, p. 12). The first set of expert texts chosen, addressing medical discourse (see Chapter 4) were the 1999 and 2005 chapters on the menopause in the textbook by Llewellyn- Jones (Llewellyn-Jones 1999; Oats and Abraham 2005) titled *The Fundamentals of Obstetrics and Gyneacology*. This is a commonly used text in medical education in New Zealand, Australia, the United Kingdom and beyond and includes a section on the medical management of the climacteric. The editions were chosen as they span the period of change in expert opinion on management of the menopause once the HERS and WHI trial findings were released. The second set of expert texts chosen, addressing the public health discourse (see Chapter 6), were the FDA’s releases on the Premarin family of drugs (Premarin was selected as it is the most commonly prescribed menopausal hormone medication). The FDA texts span 1941 to the present, and comprise a set of documents providing advice to prescribers.

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6 The text by the Boston Women’s Health Book Collective’s book titled *Our Bodies Ourselves: Menopause* will be abbreviated to *OBOM* throughout the thesis.

7 Throughout the remainder of the thesis when cited collectively these texts will be referred to as the Llewellyn-Jones *Fundamentals* to differentiate the two consecutive editions from reference to either text individually. Individual citations will be referenced to the named authors: Llewellyn-Jones (1999) and Oats and Abraham (2005). In 2010 the 9th edition of the text was published; I have not included it in the analysis as it was released after the critical period for inclusion, and it is largely the same as the 8th edition.

8 Llewellyn-Jones’ *Fundamentals* is a recommended text (with multiple copies held in the respective libraries, mostly on closed reserve) at the following universities for teaching in medicine: Cambridge, Durham, Glasgow, King’s College & Oxford (UK), Melbourne, Sydney & New South Wales (Australia), and both New Zealand universities offering medicine, Auckland and Otago (NZ).
and latterly patients, scientific evaluations and regulatory statements. The FDA texts have a wide reaching influence as the organization evaluates and approves many pharmaceutical products used worldwide. A third expert text, addressing the women’s health discourse (see Chapter 6) was the Boston Women’s Health Book Collective’s publication *Our Bodies, Ourselves: Menopause* (2006). This publication was written by women’s health advocates from a feminist perspective. It is published by a Collective that has been active in women’s health politics for nearly forty years. The Collective’s publications have gained a reputation as the definitive texts on women’s health issues written from a pro-women stance.

### 3.4 Methods

General critical discourse analysis informed by Fairclough’s (1992, 1993, 2003) approach was conducted to identify key discourses, firstly, in the women’s descriptions of menopause and their decisions on MHT, and secondly within the chosen texts. A general CDA approach was chosen, as while Fairclough relies upon Gramsci’s concept of power, my analysis relies upon Foucault’s theory of power. Nevertheless I find Fairclough’s approach useful as a tool with techniques that guide analysis of discursive texts. Fairclough takes Foucault’s concept of *practices* (Foucault 2002, p. 225), placing it in a framework to permit a systematic analysis of texts. Fairclough’s approach uses a three dimensional framework to critique discursive events. Fairclough explains:

> ‘(E)ach discursive event has three dimensions or facets: it is a spoken or written Language *text*, it is an instance of *discourse practice* involving the production and interpretation of text, and it is a piece of *social practice*. These are three perspectives one can take upon, three complementary ways of reading, a complex social event’ (1993, p. 136).

Taken together the three dimensions provide a mode for substantive analysis, that is, they are interdependent conceptual frames. Fairclough explains it thus:

> ‘(T)he connection between text and social practice is seen as being mediated by discourse practice: on the one hand, processes of text production and interpretation are shaped by (and help shape) the nature of social practice, on the other hand the production process
shapes (and leaves “traces” in) the text, and the interpretive process operates upon “cues” in the text’ (1993, p. 136).

The three dimensions are described below.

Analysis of text

In an analysis of text both form and meaning are deliberated. The interconnection between three attributes of ‘ideation,’ ‘interpersonal’ (made up of two sub functions, identity and relational) and ‘textual’ meanings present in texts are investigated. Investigation of these three attributes involves assessing ‘the representation and signification of the world and experience…the constitution of identities of participants and social and personal relations between them…[and] the distribution of information’ (Fairclough 1993, p. 136).

Discourse practice

Fairclough (1993) explains that discourse practice applies to the ‘socio-cognitive aspects of text production and interpretation’ (p. 136). That is how language is put together, with the deployment of ‘diverse genres,’ metaphors or such techniques that are culturally understood and intertextual sequences that may be apparent.

Social practice

The third attribute, social practice, refers to effects the discourse has on social interface, culture and social structures (institutional, family and/or societal). Social practice involves analyzing the consequences of discourse, noticing continuity, discontinuity, change, or transformation, and how relations are enabled, interrupted or vacillate, affecting exertion/dissipation of power and control (Fairclough 1993, 2003).

Using CDA the texts were analyzed to code and identify emerging discourses and construct themes. Once the detailed components of the texts were identified via CDA, four Foucauldian genealogical questions were applied to the discourses. Figure 1. illustrates the processes undertaken and the relationships. This achieved a multilayered analysis. In a few instances quotations are re-used in different chapters to illuminate distinct points of analysis. The four Foucauldian analytic questions on Production, Sign systems, Power/knowledge and the self with the four questions (see Analytical matrix Table 3.1), are pertinent and intended to facilitate analysis drawing on several of Foucault’s theoretical approaches, including deployment of the power/knowledge nexus (regarding science and ethics), the descent of ideas and emergence,
particularly concerning disciplines and propositions on the production and reproduction of subjects and disciplines. Discourse analysis assessed, for example, language, and whose knowledge is privileged or obscured, dominant and subordinate discourses, how power operated and/or was exercised, and how menopause and MHT were constructed. The women’s testimonies were read alongside and against literature and expert texts. A caution exists concerning interviews, as the possibility is always present that participants’ recall could be inaccurate, or incomplete, yet their narrative is their knowledge of the topic at that point in time. The key findings elicited were the following three organizing categories\(^9\) or discourses titled: Medical talk on MHT, Public health talk on MHT, and Reframing MHT.

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\(^9\) Throughout the thesis I use the term ‘organizing category’ to refer to the major findings; this term captures the complex post structural concept of the interrelated contributing factors in any discourse. The sub-sets in each organizing category are titled ‘object fields’.
Figure 1. The relationship of Foucault's genealogy with CDA and the processes undertaken to extract findings:

- **Epistemology:** Foucault’s genealogical approach
- **Method:** Critical Discourse Analysis
- Application of Four Foucauldian Analytic Features
- **Findings:** identified 3 major discourses
3.4.1 Inclusion criteria - participants

Women participants who were peri-menopausal, experiencing a natural menopause or who had a hysterectomy were included if they had considered taking, were currently taking or had taken menopausal hormone therapy in the previous three years. Hormonal preparations include unopposed estrogen (ERT), estrogen and progestin hormone replacement therapy (HRT), and natural and/or bio-identical hormones (BHT). These products may be oral preparations, injections, dermal patches, vaginal creams or pessaries.

Additional inclusion criteria were that participants spoke English, and had reasonably good general health (that is, were not on multiple medications for advanced or chronic disease(s) or hospitalized).

3.4.2 Recruitment of participants

Advertisements about the study appeared in community newspapers, women’s wellness centres, women’s clubs, and large workplaces in the province of Canterbury, New Zealand, in early 2007. Women opted-in by contacting the researcher by phone. Respondents were screened to ensure the inclusion criteria were met, and the researcher provided information explaining the study and checked eligibility; 15 women aged between 45 and 65 years agreed to participate. All women who consented to the study and met eligibility between March and July 2007 were included.

3.4.3 Data collection- participants

Participants were offered the choice of being interviewed in their own home, a private university facility in the central city or a private location convenient for them. The women chose to be interviewed in their own homes with the exception of one woman who chose a private room at a neutral education facility. Audio-taped semi-structured interviews lasting between 45 and 60 minutes were conducted. Open ended questioning followed a guide and covered the following six areas: consideration of health and lifestyle factors when deciding about taking MHT; receiving professional advice on menopause and MHT; advice during medical monitoring including whether to continue or stop MHT; factors of identity, sexuality and culture during menopause; alternative remedies for menopausal symptoms and sources of information, including media, family and friends. Descriptive statistics (age, ethnicity and menopausal status) and field notes were collected at interview.
An open-ended style of questioning was deployed in the qualitative interviews. By adopting open-ended questions it was anticipated that the women’s narratives (on menopause, their interface with health professionals and the contexts of their menopause experiences) would be expressed in a spontaneous manner. ‘Raw’ narratives in participants’ own words are ideal data for post structural analysis. The inferences, expressions, how an assumption is conveyed and nuances of how participants tell their story, as well as the content, are elements of discourse that form ‘data’ in discourse analysis.

Feminist interviewing and researcher reflexivity

Feminist research attempts to foreground the experiences of women and the unique female perspective on issues as well as the contexts that affect women. Feminist research is orientated to achieving change and is necessarily a political endeavor (Code 1995; Mies 1983; Reinharz 1992). Politics can be seen to shape the research process: identifying a research topic, methods selected and selection researchers and participants. The process tends to be overt whereas the politics behind scientific research are not overt. The commitment to making ‘gender a fundamental category for our understanding of the social order’ (Lather 1986, p. 68) is pivotal in a change agenda.

The positioning of the researcher themselves is important. I am a mid-life woman fitting the age range of the interviewees, as such I was an ‘insider’ sharing the same ‘life-stage’ events around the topic of interview. Additionally I was an ‘insider’ as an academic and registered nurse, a positioning that may have influenced the content of dialogue between myself and the women. They may have sought or offered information that otherwise would not be mentioned due to expectations they held about me given my profile. It would not be unexpected that participants could assume I held a degree of knowledge of the topic and shared elements of their experiences. Feminist strategies have sought to overcome the risk of exploitation of research participants (Finch 1984; Webb 1993). Protection of participants is necessarily a priority to avoid rendering anyone vulnerable. The research process could expose participants to social effects they would not usually encounter, it is acknowledged that research is a political process (Lather 1986, Reinharz 1992). I therefore recruited through workplaces and community newspapers to a method that necessitated women opting-in to avoid coercion.
Feminist qualitative interviewing aims to explore the complexity of experiences that individuals view as their reality. The personal nuances are identified and the local and individual perspective is elucidated instead of the totalizing viewpoints of quantitative approaches (Code, 1995). Reinharz (1992, p. 34) notes that the integrity of research is enhanced by an ethic of commitment feminist researchers’ offer to participants. The interview method entails a relationship built-up over time. The relationship is sustained through first contact between parties, I personally clarified information on selection criteria, arranged and conducted the interviews and offered summaries of findings to participants. Trust is invoked through such a sustained process of building rapport (Hall and Stevens 1991, Lather 1986, Oakley 1981).

In interviewing participants may clearly enunciate some events, or offer partial even ambiguous descriptions, yet the import to each woman is displayed. Both historical and interpersonal contexts affect the narrative each participant produced. The individual sets of information add to the picture gained of the issues under scrutiny. However, Lorraine Code (1995) provides a caution about an acceptance of narratives that appear to leave no room for ‘challenge, interpretation, or debate’ (36), thus acknowledging the difficult path qualitative researchers tread between the two poles, one being the old methods of supposedly objective science which silenced and ignored women and, the new which may contain the trap of unquestioned acceptance of ‘experiences’.

Various researchers have addressed the issues and risks with the interviewing process. The notion of completely overcoming any preconceptions is problematic for the researcher as every project has a raison de entre, in other words some form of agenda, effecting social change, is often an aim of such research as in the case of this study. There can be a negative side in building rapport in face-to-face interviews. Finch (1984) and Reinharz (1992) alert researchers to the risk where a participant may regret sharing some information even though disclosed at the time of interview and under the ethical proviso that they could ask to halt the interview at any time. Hall and Stevens (1991) pose the pertinent question regarding ‘whose interests are being served?’ in the process of interviewing where the relationship has the potential to be uneven. Researchers usually have a different status, most likely more highly educated and are in control of the final product (Webb 1993). Finch (1984) relates that it behoves the researcher to be fully aware and have regard for the sensitive and personal nature of information shared by participants during
interview and as the case may arise that a responsibility to advocate for them is associated with privileged knowledge. I had information on the Health and Disability Advocacy service and contact details for local consumer advocates available to interview participants if they should require it, no participants in this study requested the information (Health and Disability Commissioner’s Act 1994).

Hall and Stevens (1991) outline concepts of rigor that enhance the credibility of qualitative approaches involving systematic documentation of rationale and activities. Auditing dependability is an important concept for researchers to be aware of their own ‘decision trials’, one element is the use of ‘self-reflexivity’ to unpack and be alert to ones’ own assumptions and values (21) and avoid ‘theoretical imposition’ (Lather 1986: 67). In this study the analysis of qualitative interview material was conducted by the author, and then confirmed independently by a supervisor to ensure credibility of the findings. The steps involved author and supervisor reading the full transcripts and discussing the emerging patterns titled ‘object fields’. The author then re-read all transcripts to identify the themes surfacing from the patterns and thus object fields, and the supervisor then read these in a process of affirmation.

3.4.4 Ethical considerations

Ethical approval (see Appendix 1 Ethics approval reference number 06/012) was obtained in June 2006 from the University of Otago Human Ethics Committee before recruitment of participants. Maori consultation was undertaken in October 2005 prior to the ethics application (see Appendix 2). Prospective participants were mailed a written information sheet explaining the study in detail (Appendix 3); opportunity for questions was provided over a two week period, and written and signed informed consent (see Appendix 4) was gained prior to participation.

My participants were informed in an information sheet, before giving consent, of the nature of the study as a supervised PhD project, and additionally, of the limitations of a smaller study and of the possibility that publications in refereed journals and/or conference presentations may ensue from the research. Participants were informed of their right to withdraw from the study at any time, and that they could request the recording be suspended or terminated at any time during the interview.
Participants’ right to privacy was assured by the following measures: a private and uninterrupted place to conduct the interview was guaranteed; participants were informed that only myself, my supervisors and a transcriber, who signed a statement of confidentiality, would have access to digital recordings or transcripts; and the recordings would be returned to them if they wished or otherwise destroyed on completion of the research.

Participants’ names would not be used and some characteristics of their story may be omitted or altered to protect their identity. Participants’ personal and contact details were stored securely on a digital storage device with password-only access. All digital storage devices would be wiped, and hardcopy versions of the transcripts and digital recordings would be destroyed at the completion of the thesis, unless participants identified they would like the audio-recording of their interview returned to them; no one requested a copy of their tape.

All audio-tapes and transcripts were stored in a locked filing cabinet in my office at home, accessed by myself only, the transcriber having agreed to ensure the confidentiality (Appendix 5) of all material in their possession and having returned all material related to the project to me.

I am bound by, and accept the limitations of, several Acts in respect of the participants. The Privacy Act (1993) and its requirements informed the procedures taken regarding confidentiality and anonymity. The possibility that sensitive health information might be shared was considered in planning this study. The Code of Health and Disability Services Consumers’ Rights under the Health and Disability Commissioner’s Act (1994) requires health practitioners to respect patients’ rights; I provided for matters arising under this code by having available information for participants on the channels for complaints under the Code, and the local contact address and phone numbers for the Patient Advocacy Service of the Health and Disability Commission.

The possibility of harm arising from the sharing of distressing experiences was considered, and as researcher/practitioner I was committed to advise as appropriate or recommend referral.
3.4.5 Data analysis

Analysis proceeded by taking Fairclough’s three elements of critical discourse analysis (discourse practice, analysis of text and discourse practice) and applying them as shown in the example using CDA on the vignette by Margaret Gulle in Our Bodies, Ourselves: Menopause (2006) Chapter Eight, p. 126 (see Appendix 6).

An analytic matrix (Table 3.1 below) displays how the methodology was applied to achieve genealogical analysis. The far left column displays the data sources, the second to left column the key categories/discursive constructs identified via CDA. The four columns from the right headed ‘Foucauldian analytic features’ show the four key Foucauldian analytic categories and the questions arising from each category that when juxtaposed to the data, and considering the intersection of discourses, led to the findings. The arrows illustrate the potential cross referencing and flow of information between and across concepts, indicative of permeation of discourses. Three major discourses (findings) were elicited by the analysis (medical discourse, public health discourse and feminist women’s health discourse) following the identification of object fields.
Table 3.1. Analytical matrix that guided genealogical analysis

<table>
<thead>
<tr>
<th>Data source</th>
<th>Discursive Categories elicited via CDA</th>
<th>Foucauldian analytic features</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Production ↓</td>
<td>Sign systems ↓</td>
</tr>
<tr>
<td>Women’s interview texts</td>
<td>← →</td>
<td>← →</td>
</tr>
<tr>
<td>Llewellyn texts</td>
<td>↑↓</td>
<td>↑↓</td>
</tr>
<tr>
<td>FDA texts</td>
<td>↑↓</td>
<td>↑↓</td>
</tr>
<tr>
<td>OBOM text</td>
<td>← →</td>
<td>← →</td>
</tr>
</tbody>
</table>

The analysis of the three major organizing categories (discourses) identified appears in the following three chapters.
CHAPTER FOUR: FINDINGS AND ANALYSIS. Organizing Category One: Medical Talk on MHT

To commence this chapter I provide a brief demographic profile of interview participants. In analyzing the data of both the formal text and the lay women’s texts, I start with a detailed assessment of the Llewellyn textbook’s chapter on menopause. The following areas are investigated: currency of the content; the science informing the material; whose voice is foregrounded; and the positioning of the woman patient within the narrative. I then proceed to analyze the interview data. The deconstructive approach entailed reading the narratives together with and against the Llewellyn-Jones Fundamentals’ texts and other relevant literature. This process elicited four object fields that were analyzed.

4.1 Findings – Demographics of interviewees
The fifteen participants were aged between 50 and 65 years, in the following age bands: 50 - 54 = n4, 55 - 59 = n7, 60 - 65 = n4. One woman identified as Maori, 13 women identified as European/Pakeha NZ, and one woman as Other European. Menopausal status and length of time on MHT are displayed in the following tables.

Table 4.1. Menopausal status

<table>
<thead>
<tr>
<th>Status</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced a natural menopause</td>
<td>9</td>
</tr>
<tr>
<td>Premenopausal*</td>
<td>2</td>
</tr>
<tr>
<td>Hysterectomy (bleeding, pain, headaches, fibroids)</td>
<td>4</td>
</tr>
<tr>
<td>Oophorectomy</td>
<td>0</td>
</tr>
</tbody>
</table>

*Women who reported still menstruating, although may have experienced cyclical and/or volume of blood loss changes.

Table 4.2. Length of time on MHT

<table>
<thead>
<tr>
<th>Duration</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>3</td>
</tr>
<tr>
<td>Less than 1yr</td>
<td>2</td>
</tr>
<tr>
<td>1 - 5 years</td>
<td>4</td>
</tr>
<tr>
<td>6 - 10 years</td>
<td>4</td>
</tr>
<tr>
<td>11 - 15 years</td>
<td>1</td>
</tr>
<tr>
<td>More than 16 years</td>
<td>1</td>
</tr>
</tbody>
</table>
4.2 Introducing the texts

Four object fields contribute to the discourse of Medical talk on MHT. These are:

- Menopause as a medical concern
- Questions of trust regarding doctors’ advice
- Women’s resistance to medical discourses
- Governance of the person-as-patient

Foucault proposed that symptoms (of diseases) were defined in terms related to their visibility. In the practice of medicine empirical evidence was employed to support the existence of disease. Foucault (1963/1989, p. 111) states that:

The formation of the clinical method was bound up with the emergence of the doctor’s gaze into the field of signs and symptoms. The recognition of its constituent rights involved the effacement of their absolute distinction and the postulate that henceforth the signifier (sign and symptom) would be entirely transparent for the signified, which would appear without concealment or residue, in its most pristine reality, and that the essence of the signified - the heart of the disease - would be entirely exhausted in the intelligible syntax of the signifier.

Physical signs are claimed as medical concerns which result in considerable significance attributed to that sign.

The sign announces: the prognostic sign, what will happen; the anamnestic sign, what has happened; the diagnostic sign, what is now taking place. Between it and the disease is a distance that it cannot cross without accentuating it, for it often appears obliquely and unexpectedly. It does not offer anything to knowledge; at most it provides a basis for recognition (Foucault 1963/1989, p. 110).

Menopause – the cessation of menses - is attributed with medical constructions that have anamnestic, diagnostic and prognostic effects. The naming of something as a medical concern does not address, however, issues related to which phenomena are chosen for observation and the meaning that is attributed to the phenomena in the naming process. There is no fixed or essential meaning which reveals itself through observation; rather such meaning is constructed through
language and assigned according to a regime of truth. The interpretation of what is observed is made in relation to medical discourse.

The genealogical approach I have adopted takes the medical text by Llewellyn-Jones titled *The Fundamentals of Obstetrics and Gynaecology* as representative of medical discourses to unravel the conceptualization of menopause and the consumption of MHT at the time the interviews were collected. The seventh edition of the Llewellyn-Jones publication by Elsevier Mosby was in use as a standard text for fifth year medical student education in New Zealand (and medical education internationally as indicated earlier) and thus endorsed as reputable. The intervening years between the sixth edition in 1999, by author Llewellyn-Jones, and the seventh edition in 2005, by authors Oats and Abraham, includes the discoveries regarding safety and efficacy of MHT that led to the introduction of revised guidance to practitioners. Although it is significant to note that both the Llewellyn texts considered here (and the latest 2010 edition) all use the term ‘HRT,’ they have not dropped the ‘R’ for replacement as other medical writers have, to avoid the inference that something that ought to be present is missing (or depleted); (this point is addressed in detail in Chapter 7). My purpose in this section is to analyze the seventh and eighth editions of the text as a lens on the discipline of medicine, alongside the participants’ interviews, to glean the discourses that inform menopause management, treatment choices and recommendations in advising women.

The participants in this study were interviewed in a climate of uncertainty, where previous assumptions on the efficacy of MHT had been eroded by the recent research findings and there were debates in the media about increased risks, about age groups, or those with risk factors, and whether MHT might or might not be considered efficacious. Several discourses were in play, and a potentially confusing set of messages existed for women and their doctors to interpret.

Oats and Abraham (2005) suggest four key actions in the medical management of the climacteric:

1. To provide an explanation (to women) of the changes that are occurring
2. To give advice about nutrition and diet and to answer concerns about weight
3. To recommend that the woman exercise regularly
To discuss the benefits and risks of hormone (estrogen and progestogen) replacement treatment (pp. 333-334).

The last two items had been revised from the 1999 edition which, regarding exercise, recommended thirty minutes three times a week, with the 2005 edition substituting ‘regular exercise.’ The fourth item is altered; where in the 1999 edition ‘benefits’ of MHT were stated, in 2005 the word ‘risks’ was added, with the suggestion being that risks be considered.

The 2005 Llewellyn-Jones text does not include a reference list, while the 1999 edition does contain a bibliography at the end of the chapters. The main differences between the two earlier editions occur where the 2005 edition appears to have incorporated the new guidelines since the release of findings from the WHI trial (although no sources are acknowledged), with unsubstantiated claims deleted and the text altered to moderate advice in line with the guidelines. For example, in the 1999 edition (p. 320) it is stated that ‘observations suggest that estrogen offers some degree of protection against heart disease.’ In the 2005 edition the same statement remains, but with the word ‘suggested’ replacing ‘suggest,’ and the additional qualification that ‘there is no current evidence to support this conclusion (re estrogen as cardio-protective) and HRT does not reduce the incidence’ (p. 333).

The text differs from several published studies about the proportion of the population that can be expected to have severe symptoms of menopause. Both versions state that 40% of women have severe menopausal symptoms (Llewellyn-Jones 1999, p. 319; Oates and Abraham 2005, p. 332). No citation is provided for this statistic. The figure appears exaggerated when compared to published population studies showing less than 40% reporting symptoms at all, and a smaller proportion noting symptoms described as severe (Avis et al. 1993; Bungay, Vessey and McPherson 1980; Dennerstein, Dudley and Hopper 2000; Kaufert and Syrotuik 1981). Dennerstein et al. (2000) compare the findings of their study on incidence of symptoms, The Melbourne Women’s Health Project, with the Massachusetts Women’s Health Study reported by Avis et al. (1993).
Table 4.3 Incidence of women who reported 5 or more core symptoms

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample</th>
<th>Premenopausal women</th>
<th>Perimenopausal women</th>
<th>Naturally Postmenopausal women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avis et al. 1993</td>
<td>N=8050 Random population sample drawn from annual census lists</td>
<td>23%</td>
<td>35%</td>
<td>32%</td>
</tr>
<tr>
<td>Dennerstein et al. 2000</td>
<td>N=172 Drawn from 438(56%) of those recruited in a random population sample.</td>
<td>22%</td>
<td>22%</td>
<td>36%</td>
</tr>
</tbody>
</table>

Core symptoms were derived from the 33 item North American Symptom Checklist (Kaufert 1981). Each symptom was scored on a four point scale: 0 = not present, 1 = symptom causes minor irritation, 2 = symptom interferes with normal life, 3 = symptom is debilitating.

Dennerstein et al. (2000, p. 355) found approximately 10% of their participants reported hot flushes and sweats as bothersome. Reporting on symptom severity the authors noted ‘trouble sleeping ($P < .05$), vaginal dryness ($P < .001$), night sweats ($P < .01$), and hot flushes ($P < .001$) were all increased in late peri-menopause and 3 yrs post menopause. No other symptoms showed any significant change with menopausal status at ($P < .05$)’ (p. 355).

Historically, methodological difficulties have plagued research of the climacteric. In 1981 Kaufert and Syrotuik assessed items listed as symptoms of menopause and found lists had varying numbers of items ranging from one to 41. Such discrepancies could be attributed to lack of agreement between clinicians and researchers about which items were due to the menopause.

Dennerstein (1996) criticized the common practice of recruiting from gynecology clinics where it could be expected that the ill women studied would have a greater propensity for problems than the general population. Clinical samples from such populations would not be representative of other women’s experiences of the peri-menopausal transition and even distorted the experience of women generally. Due to a lack of robust studies to provide adequate data on menopause and
symptoms, several researchers designed population studies (Dennerstein 1996; Dennerstein et al. 2000; Kaufert and Syrotuik 1981). A scale titled the North American Symptom Checklist and adaptations of it were utilized in various studies for consistency and to enable comparison. Parlee (1990) and Dennerstein (1996) outline the various methodological and sampling complexities in identifying symptoms of menopause, and its prevalence and severity in populations. Dennerstein states that most population based data was cross-sectional, and only limited inferences could be drawn due to a lack of longitudinal data and short follow-up (1996, pp. 148-9). Emphasis on longitudinal studies grew over the 1980s and 1990s.

In 1985 controversy ensued as two studies conflicted over benefits and risk regarding cardiovascular outcomes. While the Framingham Heart Study found increased risk of stroke, blood clots and cardiac risk in women consuming MHT (Wilson 1985), the Nurses’ Health Study showed reduced CHD risk (Stampfer 1991; Stampfer and Colditz 1991). The climate of doubt did not halt the rise in use of MHT, particularly as the endometrial cancer risk found from two RCTs in 1975 (Smith, Thompson and Herrmann 1975; Ziel and Finkle 1975) was by then mitigated by the estrogen/progestin combination medication, a fact that was emphasized in marketing (Stefanick 2005). Dissatisfaction with weak and inconclusive studies led to widespread calls for robust RCTs by the 1990s, and the initiation of studies including HERS and WHI.

Best practice evidence guidelines to prescribers state that MHT should be taken at the lowest dose for the shortest period of time to treat moderate to severe symptoms with respect to each woman’s unique risk factors (FDA 2004; Hickey, Davis and Sturdee 2005; MOH 2004; National Institutes of Health 2007; Stefanick 2005). Since MHT is advised where indicated for no longer than five years, it is recommended prevention of osteoporosis is promoted by treatment with calcium regulators (bisphosphonates) and calcium preparations in preference to hormonal therapies (MOH 2004; MHRA 2007; National Institutes of Health 2007; Stefanick, 2005). In reporting on outcomes of the WHI trial on E + P for fractures, Cauley et al. 2003 state: ‘(G)iven the overall unfavorable risk-benefit ratio and the availability of other agents for prevention and treatment of osteoporosis, treatment with estrogen plus progestin should not be recommended for prevention or for treatment of osteoporosis in women without vasomotor symptoms’ (Cauley et al 2003, p.1737). The FDA’s 2002 advice on Premarin warns that ‘when used for the sole purpose of prevention of postmenopausal osteoporosis, alternatives [to E + P] should be carefully considered’ (FDA 2002a, p. 9).
Until 2002, some guidelines continued to recommend estrogen for the prevention of osteoporosis (NZGG 2001), while by 2001 the New Zealand Guideline Group had published their document titled The Appropriate Prescribing of Hormone Replacement Therapy that stated HRT is contraindicated in the prevention of primary cardio-vascular disease (NZGG 2001). The HRT guidelines group acted for Medsafe (a division within the NZ Ministry of Health) and had endorsement from, among other organizations, both the Royal NZ College of General Practitioners and the Royal Australian and New Zealand College of Obstetricians and Gynecologists. One ought reasonably to expect that GPs would have been cognizant of the current guidelines on treating women regarding menopause.

In both Llewellyn-Jones Fundamentals texts, the section titled ‘Contra-indications to the use of HRT’ commences with the statement, ‘[A] few women should not use HRT.’ This statement implies that many can use it. Such a statement could be deemed logical given the guideline advice in the late nineties when the 1999 version contained the following sentence: ‘The current evidence is that the benefits of HRT, even in asymptomatic women, are greater than its disadvantages, and a campaign to persuade women to take HRT would improve women’s health, but must be handled carefully’ (Llewellyn-Jones 1999, p. 321). The sentence appears to show the authors’ partiality to HRT rather than displaying caution. This version mentions the breast cancer risk found in studies, yet comments that other publications have cast doubt on these findings. On the other hand, both the 2005 and 2010 editions state HRT use for longer than 5 years is not recommended, due to the risk of breast cancer. It is reasonable to conclude that the 1999 version is patently pro-HRT, whilst the later editions are clearly more moderate in the light of revised guidelines following HERS and WHI findings, although the texts do not cite any sources.

The 2005 Llewellyn-Jones Fundamentals text (Oats and Abraham 2005, p. 334) states that one compelling reason to prescribe a small daily dose of MHT is to prevent bone loss. This recommendation differs from the current guidelines issued since 2001 by the FDA, who recommend other treatment options (calcium supplements) over MHT to prevent osteoporosis in those assessed as at risk (FDA 2002, 2004; New Zealand Guidelines Group 2002). Interestingly, the United Kingdom immediate advice to prescribers and women stated in 2002 that some HRT products are indicated in the longer term for preventing bone fractures caused by osteoporosis (Medicines Control Agency 2002). A message to health professionals from the Dr Troop,
Deputy Chief Officer of Health stated that ‘combination HRT is only indicated for the treatment of menopausal symptoms and prevention of osteoporosis’ (2002, 1st paragraph).

The language, in relation to advising readers (doctors) on treatment options, referring to women at times signifies women as active participants in the medical encounter, in remarks such as, ‘The woman may choose’ (Llewellyn 1999, p. 321; Oats and Abraham 2005, p. 334) and ‘[A] post-menopausal woman should also consider…’ (Oats and Abraham 2005, p. 336). In the texts medical discourse appears to co-opt elements of feminist discourse on ‘women’s choice,’ albeit in a partial manner. The promise of possibility of choice is created, yet this promise is at the same time foreclosed as the feminist discourse is not fully integrated elsewhere in the text.

In some instances the doctors’ active role is obliterated from the text by placing women as active subjects, although where the text implies women choose they are in fact dependent upon the doctor prescribing a course of action, and additionally largely dependent on the explanations provided by doctors to assist decisions. For example, the following phrase appears in both editions: ‘Should irregular bleeding occur during HRT, the woman should have a transvaginal ultrasound examination of the endometrium’ (Llewellyn 1999 p. 322; Oats and Abraham 2005, p. 334). A later example in Llewellyn-Jones (1999) states: “[A] post-menopausal woman should also consider starting to take HRT, as estrogen effectively prevents bone loss’ (p. 323); this is revised in Oats and Abraham (2005, p. 336) to read: ‘[A] post-menopausal woman with risk factors should also consider starting to take HRT, as estrogen effectively prevents bone loss.’ (NB. The discrepancy in the 2005 version between prevention of osteoporosis and contemporary guidelines was noted above).

The impression given by the authors that women are active participants is misleading. In the shift from viewing women as objects, that predominates in the texts, to one positioning women as active subjects, it is implied that doctors are mere dispensing agents for the ‘authority’ (the woman) who apparently exercises autonomous choice. This move negates the disciplinary power of the authors, attributes power to the patient, and in the same movement absolves the authors and other doctors of the exercise of overt power (a point addressed in my discussion).
4.3 Menopause as a medical concern

As already mentioned, changes in women’s hormonal levels at midlife have been categorized as hormonal ‘deficiency,’ and as such have become a signifier of the phenomena of menopause.

For some participants, their first thought in addressing menopausal discomfort was to go to a doctor. ‘Menopause’ to them was a medical concern, and the doctor was sought for advice and to provide resolution of symptoms by medical intervention.

Ruby recalled her awareness of entering menopause:
Ruby: I felt as though I was disappearing into a puddle of sweat… I would wake up in the middle of the night absolutely on fire… mainly hot flashes: that was really the symptom that I had. (63yrs old, on MHT for 7years).

She decided that she would go to the doctor. Ruby stated her intention to stay on MHT indefinitely. She rationalised continuation as she underwent regular medical monitoring.

Ruby: I suppose realistically I could come off it but her [doctor’s] advice is….I have a regular blood test, to test my liver function, and just a general blood test and there isn’t any…um… blood picture why I should come off it. My liver function is normal and my cholesterol is in the lower limit of normal.

Participant Sylvia states an opposing view.
Sylvia: Being a child of the Pill, I was one of the early people in the 60s taking the very strong contraceptive Pill. I got married at 19, I was too shy to go the family doctor and get fitted for a diaphragm. Someone just gave the Pill to me, no checks or anything. Having been through the ups and downs of hormonal contraception – Depo etc – I don’t think I really wanted to go on HRT for menopause. (65yrs old, postmenopausal, never took MHT).

Medicine has promulgated the menopause as a departure from health and wellness for women over a century. Menopause was referred to as a ‘dangerous age.’ Medical texts address the issue of the menopause by measuring the blood levels of sex hormones (as discussed in Chapter 2). There is the symptom to the woman of change or cessation of menstruation, whilst for the doctor there is the sign of the abnormal. It appears that menopause becomes a medical concern to the profession as it involves the theory of sex hormones with their systemic effects as a branch of medicine.
In the last decades of the twentieth century menopause had been categorized as a deficiency disease by the medical profession. If we dissect the language further, the use of the word ‘therapy’ in the name of the pharmacological regime augments the idea that MHT is treatment of a disease state. Both editions of the Llewellyn-Jones Fundamentals equate menopause with ‘estrogen deficiency’ (1999, p. 320; 2005, p. 333). This point is reiterated by many authors (Coney 1991; Dennerstein 1996; Krieger et al. 2005; Seaman and Seaman 1978), and further cemented into the public consciousness by imagery. Pharmaceutical companies have repeatedly used the image of an aging woman, silhouetted in side view shown progressively bent over, which has become a widely recognized visual symbol of aging women (Coney 1991).

Using a Foucauldian lens it can be seen that the discourse of deficiency has been reproduced through the mechanism of categorization against standardized norms, using the tools of blood tests for hormone levels and comparison against a long established norm regarding the fertile female. As we saw earlier, the dichotomy of the normal and abnormal is a central organizing concept of medical knowledge (Foucault 1963/1989). The woman presents with change in menses of blood flow, regularity of flow, and other changes such as onset of hot flashes and night sweats; these are known as symptoms. The medical practitioner affirms and categorizes the climatic event by taking a history, performing measures, and by comparison with the established norms. The results of this process form the prognostic, anamnestic and diagnostic signs (Foucault 1963/1989). Once categorized and named, the condition is an entity that is produced and is re-produced at every diagnosis.

Each new diagnosis is a reiteration of medical definitions, discovery and conclusions, all of which augment the doctor as the expert. Whilst the doctor is reaffirmed as the expert, the woman is reaffirmed as the patient, the object of investigation. The subject as patient is at once constrained (normalized) and one who presents themselves to the expert for examination, submitting to medical authority and oversight, thereby producing and reproducing the docile patient (Foucault 1977, p. 136).

Foucault’s (2002, p. 58) discussion of the panopticon and its relevance to the medical ‘gaze’ sheds light on how docility and self-discipline may be produced in patients. Initially, I draw upon a more modern example than the prison metaphor that Foucault used to explain docility. The following example is chosen as it depicts a facility and driving philosophy of the twentieth
century that centers on encouraging patients’ recovery and restoration to health. The soldiers’
hospital\textsuperscript{10} at Hanmer Springs in Canterbury, New Zealand, was built in 1916 in the style of a
Swiss sanitarium, and structurally it has the characteristics of a panopticon. It has two octagonal
structures that form the wards leading from a central hall as adjoining wings (Appendix 7). The
octagonal wards each have a central tower with glass windows as the walls (similar to a see-
through lift shaft), and the towers are a window height taller than the roof of the main structure
(Appendix 8). This enables the entry of sunlight and fresh air. The main structure surrounding
the towers has windows forming the upper half of the outside walls. Thus the wards were
flooded with light and fresh air, with views to the mountains, and faced north to maximize
sunlight. A second feature is that the wards were open spaces. There are no internal walls to
partition the octagonal shaped area. A third important feature is that the floor of the towers was
raised two steps above the floor level of the main ward structure and housed the staff observation
stations.

Therefore patients were viewed from the platform, in a well-lit circular space where all patients
were visible to staff, just as in Foucault’s panopticon (based on Bentham’s original design for
prison reform\textsuperscript{11}) (Foucault 1975/1995).

In the prison panopticon the warder is positioned centrally with back-lit prison cells (cell blocks
constructed in a circular spoke-like design) where the warder has an ‘all seeing’ gaze, and for
prisoners, aware of the guards’ presence (but unable to see them), the effect is that they self-
discipline their actions to avoid sanction (whether a guard is actually present or not at any given
time). In the soldiers’ facility, as all patients and staff can view one another, a similar
constraining effect on individuals would be produced. Therefore routines, discipline and

\begin{footnote}
\textsuperscript{10} The hospital was initially a Red Cross hospital housed in a hotel lodge adjacent to the natural hot springs and
bathing pools at Hanmer Springs. In June 1916 The Surgeon-General opened the Queen Mary Hospital for soldiers
recuperating from active service (Ensor 1983). In the 1920s a women’s building was added to the site for treatment
of functional nervous diseases, a V shaped arts and crafts design with individual rooms, each with a sink for privacy
and optimum rest, again facing north for sun and views, but without the architecture of a panopticon. In 1960 the
hospital became an alcohol and drug treatment unit until 2003 (Crawford 2007). The buildings remain on the site
and are used by the local community.
\end{footnote}

\begin{footnote}
\textsuperscript{11} Philosopher Jeremy Bentham (1748-1832) devised the architectural panopticon for the reform of prisons. Foucault
notes in his chapter titled ‘Panopticism’ that ‘the Panopticon must not be understood as a dream building: it is the
diagram of a mechanism of power reduced to its ideal form; its functioning, abstracted from any obstacle, resistance
or friction, must be represented as a pure architectural and optical system: it is in fact a figure of political technology
that may and must be detached from any specific use (Foucault 1975/1995, pp. 195-228).
\end{footnote}
practices that enhance patient recovery would be maintained via constant reiteration and inexorable self-surveillance.

Foucault informs us that discourses emanating from a discipline such as medicine, that constrain our behaviors, produce the panopticon effect in that individuals self-discipline themselves within discursive frameworks, such as medical advice about behaviors that enhance recovery and healing and staying well. Falling in line with a regime of power and discourse that renders one docile (Foucault 1975/1995), in the medical encounter patients are under authority, subject to the medical gaze (a set of technologies in the operation of power). As the soldiers complied with treatment regimes, likewise there is an element of voluntariness in the women participants’ submission to treatment regimes, submitting to physical examinations and providing samples for tests. The patient is enveloped in the medical gaze, through the practices of physical assessment, interviews, monitoring, tests, treatment regimens and documentation on progress. Surveillance of patients has extended in recent years, in New Zealand via the introduction of national screening programs and the awarding of individualized national health index numbers that enable sharing of medical information between various providers (Staples 1997). To Foucault, power operates in a fragmented mode, and the awareness of one’s visibility to others, whether by sight, touch, or specimen or test result, works to constrain behavior, causing patients to comply with dominant discursive formations, and producing the normalized subject.

The conventions of ‘being a patient’ are well known to us and are clearly articulated in myriad and frequent ways. As Foucault tells us, medicine as a discipline ‘engenders …apparatus of knowledge…..[and doctors are] the bearers of a discourse…the code they come to define is not that of law but that of normalization’ (1972/1980, p. 106). Foucault views panopticism operating in three veins: firstly, ‘continuous individual supervision;’ secondly, ‘controls’ accompanied by punishment and compensation; and thirdly, ‘correction molding and transformation of individuals in terms of certain norms’ (2002, p. 70). Individuals constantly, but not always self-consciously, participate in self-surveillance, that is, self-checking and constant amendments of behavior, negotiating the three veins, to achieve normalization. Normalization occurs through complicity with recognizable types, or ways to be. Foucault attributes this outcome to the dispersed operation of power. Power does not radiate from a lofty single locus but through multiple insidious filtrations, disparate in origin, and within which subjects are positioned differentially.
Individuals’ own self-correction and voluntary complicity mean material constraints are unnecessary (Foucault 1975/1995).

The participants acquiesced in their doctor’s directions, although concerns and doubts about their decisions remained.

Willow: I didn’t really know if I was going through it (menopause) or not but the doctor said I was, I was starting and he put me on Hormone Replacement tablets…. I was really worried so I went to the library. My father had a heart attack at 49 and I was really worried because things kept coming in the papers about how bad they were, how bad hormone replacement was. That was the one thing he [doctor] did tell me that it would be quite good for me in that sense because it could prevent a heart attack as such. (54yrs old, hysterectomy with intact ovaries, on MHT for 3yrs, stopped 6 months prior to interview).

Two points arise from this excerpt: firstly Willow’s concerns about risks and benefits do not appear to have been sufficiently addressed in the consultation, and secondly, her doctor’s advice was out of date as the guidelines state there is no evidence of decreased risk of coronary heart disease for MHT users (Australian Drug Evaluation Committee (ADEC) 2004; FDA 2002a; NZGG 2001, 2004; WGWHII 2002).

Scarlett: Family Planning, a GP there. She is not my regular GP. I only go to her for my HRT. She’s taking exactly the same medication herself so that gives me a little bit of assurance that if everything we hear and read about it is bad she wouldn’t be doing it herself. (59yrs old, on MHT 7yrs and at interview).

In this statement Scarlett’s reasoning does not include consideration of individual physiological and medical history that was part of the doctor’s assessment, as she revealed in the interview. The problem revealed here is that the woman, despite the doctor’s reasoning about her treatment, was more reassured by the fact the doctor herself took MHT than the medical rationale. In addition, the participants Cherry, Daphne and Aster also recounted their doctors relating that they themselves were taking MHT. The women took such statements to imply that ‘if it’s ok for my doctor to be on it then it’s ok for me.’ It appears this knowledge mitigated the information regarding risks when the actual risks for the women are unknown. Knowledge that someone else is on the medication ought not provide any reassurance.

In the following instance the woman has a complex medical history, and knowledge that her doctor takes MHT appears to have been a barrier to discussion of her own situation.
Interviewer to Briar: You are really kind of re-evaluating this yourself a lot aren’t you?

Briar: Oh yeah, a day doesn’t go by when I don’t think about, ‘Should I come off it and just go with the flow?’

Interviewer: So have you talked to the doctor about that? Have you talked about what would happen if you decided to come off, how would they help you?

Briar: Not really.

Interviewer: So you haven’t asked that question?

Briar: No I haven’t because I mean my doctor is on it herself, so she thinks it is the best thing. And like she said if she wasn’t on them she wouldn’t be able to continue being a doctor [working as a doctor] so…. (50yrs old, on MHT for previous 15mths).

This woman appeared unaware of risks due to MHT and cardio-vascular events, although she had been advised against going on MHT by her haematology specialist. The four points the Llewellyn-Jones texts (on page 42) recommend be addressed in consultations for menopausal disturbances did not appear to be covered in these instances. The women recalled only that benefits and not risks of MHT were discussed with them. It may be that in retelling events some information doctors may have provided has been forgotten, although it is the information that is retained that is pertinent as decision making in the future relies upon it.

Later in the interview Briar expanded with the following comment:

Briar: I had been told about nothing, my doctor was that keen. I mean I went to see her and she was in her drawer pulling out the HRT, telling me to take it and I said I won’t take it because of my Warfarin and my blood clots. So she never gave me…we never really discussed it. I went back to her when the symptoms got worse, and she gave them to me and I took them basically. I do know there are some doctors that won’t give you HRT. (50yrs old. Consultation in 2005, on MHT for 1.5yrs, on MHT at interview).

Briar needed to discuss options, given her complex history, and it appears her need is unfulfilled yet she is prescribed MHT.

The dilemma posed here is whether on the one hand the female doctors are deploying a cloak of medical expertise (authority) where the women have assumed the doctor has weighed risks (as that is their job) and made a scientifically informed recommendation regarding MHT. Or, on the other hand, possibly these excerpts reveal female doctors taking a sisterly position, evoking shared female experience, implying that what works for them must necessarily work for other women, that is, implying ‘my situation is akin to yours,’ based on the commonality of
femaleness. Either position creates a difficulty for the women as both interpretations are difficult to revisit or confront.

The voice of authority is persuasive in rendering the patient passive. Foucault (in Rabinow 1984) explains how the discursive effects of a profession extend beyond the individual ‘speaker.’ Although the encounters between the participants and their doctors were one-to-one, the operation of power in the difference of status of doctor with patient can be deduced in the interviews. In these instances, the patient is rendered passive. Some doctors were in concert with the medical texts’ advice to discuss benefits and risks of MHT with women, whilst others did not view discussion as a management strategy.

Several women recounted instances when their doctors had spoken about the need to go off MHT (the guidelines suggest a five year limit).

Interviewer: So this tailing down of the doses is something that the doctor suggests or you suggested?

Scarlett: Yes it probably was her suggestion. And also, a close friend of mine, she takes exactly the same thing and she has got herself down to one every three days. Probably she has had more influence on me doing that than the doctor has. (59yrs old, on MHT 7yrs and at interview).

Interviewer: And is she a similar age?

Scarlett: Yes.

Interviewer: So do you see yourself coming off it at all? Do you see this as a goal?

Scarlett: Yes, as I said I have had a couple of goes…but….

Interviewer: So you have had goes at totally going off it?

Scarlett: Yes I have…I remember Easter last year I can remember. I thought I would wait until the cooler weather, because that would always help.

Interviewer: So how long did you try then …did you stop suddenly or did you tail it down?

Scarlett: No I tailed it right down. That was the advice of the doctor was that you tail it off, like you get down to one every third day, then gradually to even say one a week.

Interviewer: How long did you try that?

Scarlett: I can’t remember. It wouldn’t have been any more than a month that I went without it. I just found that the night sweats were back again and… (On HRT for 7 yrs).

These excerpts from the interviews reveal that their doctors have worked to the guidelines and advised women accordingly. It appears not all doctors informed their patients about the need to
stop after five years, as in Cherry, Daphne and Tutu’s interviews they were unaware of (or could not recall) time being mentioned as an issue. The excerpts reveal the struggle women had between the need for symptoms relief and complying with the doctor’s advice. Women who had surgical menopause can be expected to experience more severe symptoms than if their menopause occurred naturally. Surgical menopause occurs when a premenopausal woman has her ovaries surgically removed in a bilateral oophorectomy which is often performed at the same time as a hysterectomy (Hendrix 2005; Rock and Jones 2008) and causes an abrupt menopause (Shuster et al. 2008). Although no participants in this sample reported having had bilateral oophorectomy, four reported having had hysterectomy.

4.4 Questions of trust regarding doctors’ advice

The women’s accounts revealed that a few doctors expressed caution or reluctance about prescribing MHT, and in doing so revealed cognizance of the guidelines following release of the WHI findings.

*Interviewer to Rose: So you felt that her advice was cautionary, she gave you both sides of the debate?*

Rose: Yes, she had always been pretty…honest…you know she didn’t really want me to go on it.

*Interviewer: So she was reluctant?*

Rose: Oh yes very reluctant and this was a real…it was me sort of more or less insisting perhaps…and that is why I was put on that mini, mini dose. It was last resort because I had really got to a stage where I was really sick of being embarrassed for one thing and also the uncomfortableness of it. (55yrs old, on MHT for 3 years, stopped 1 month prior to interview, due to having had a stroke).

Iris: Once when my doctor was away I needed a repeat and saw a locum, the locum gave me the ‘heave-ho’ about it asking, ‘What are you on this for?’ (57yrs old, on MHT for 12yrs, taking MHT at time of interview).

Several participants’ interviews revealed instances where MHT appeared to be prescribed readily despite the guidelines.

Iris: [He said] ‘I just have to make you aware of the fact that we are advised not to keep prescribing them [MHT].’ But he said, ‘You don’t have any particular symptoms or health
concerns that would stop me giving it to you.’ (57yrs old, on MHT for 12yrs, taking MHT at time of interview).

If the woman has recalled the doctor accurately, this doctor’s rationale for intervention negates the important point that the need for caution in advisories is about risks, not symptomology.

Below, the doctor appears to have provided questionable reasoning for continuation of MHT by critique of the sampling approach, dismissing the woman’s concerns and the cautions in guidelines on MHT.

Willow: I did go to him, my GP, and tell him I was really worried because of the articles in the papers. He told me these studies were done in America on unhealthy, oversized women so some of these things are true because they are in such bad shape.

Interviewer: When you were on your patches did the doctor recall you every 6 months for blood pressure and weight and that sort of thing?

Willow: No, I didn’t know you had to. He just kept repeating the prescription. He did do all the tests at first, but he didn’t do it regularly….I don’t think you get enough help. Every time I went to the doctor, no matter what it was for, he would just say ‘Hormones, hormones, menopause, menopause’….That was why I went to the library.

Interviewer: What did you find at the library? Do you remember when you went there?

Willow: I went to the library first about six years ago when I started on HRT. The main thing I found was that it was comforting to see a list of my symptoms in a book that someone else had written. That they were common to other people and I was not going through it alone. You get so scared, you feel like you have cancer or something like that, because you are so unsettled inside you. (54yrs old, on and off HRT over 6 yrs, stopped 6mths prior to interview. Consultation in 2004 after a hysterectomy).

This interview excerpt above reveals a doctor who trivialized the woman’s concerns and whose actions can either be interpreted as paternalistic or misogynic. This is one explicit instance in the interviews which indicates the presence of paternalism despite wide social condemnation.

Ongoing monitoring and review ought to be initiated by the GP and is recommended at least six monthly (FDA 2002a; MOH 2004). Interestingly, the Llewellyn-Jones Fundamentals texts do not mention monitoring as part of management of patients on HRT, although they do advise an initial medical examination before commencement of MHT (Llewellyn-Jones 1999, p. 321; Oats and Abraham 2005, p. 334, Oats and Abraham 2010, p. 325). Given this, it is reasonable to conclude the Fundamentals texts are not complete on advice regarding MHT.
Doctors who have set up businesses to promote bio-identical hormones do not appear to follow the MHT guidelines. Both participants (Daphne and Aster) on prescription for bio-identical hormone were advised to keep taking MHT, and neither considered that bio-identical hormone shared the risks associated with other prescription hormones that were publicized following the WHI studies. In maintaining such a position practitioners are in error as large scale population studies have not been conducted on these products (Boothby et al. 2004; Cirigliano 2007; National Institute of Health 2005a; Stefanick 2005). A lack of evidence about a risk profile does not exempt a product from causing harm (Cirigliano 2007), and biochemists view the risks as similar because the chemical structure is similar (Curcio et al. 2006; Fugh-Berman and Bythrow 2007; North American Menopause Society 2006). There is reason for disquiet when prescribers of BHT espouse the similarity in chemical structure to conventional MHT as a marketing point, while denying that this same chemical similarity would be as likely to hold the same risks for consumers. A fuller discussion of bio-identical hormones appears in Chapter 7.

4.5 Women’s resistance to medical discourses
Several participants recounted instances of doubting their doctor, changing their doctor or ‘doctor shopping’ as strategies when seeking answers to questions about menopause. The women fell into two groups. Either their own research led them to doubt their doctor or they went to other sympathetic practitioners who would provide the course of treatment they strongly believed they needed.

Tansy: He [GP] agreed that I was peri-menopausal and I said that I was having these very irregular periods, I told him all my symptoms and he wrote me out a script [MHT] with no preamble, not a word said to me, just nothing. I left but I was really quite amazed…so I didn’t take it as I did not want to go on HRT. (57yrs old, natural menopause. Subsequently took Remifemin [OTC medication] Consultation in 2001).

This woman had a history of sore and tight breasts and worried about HRT exacerbating her breast condition or increasing her risk of breast cancer.

Sylvia and Holly dismissed medical advice when the doctor appeared to present negative views of aging women and categorized menopause as a deficiency disease.
Under section 5.2 Briar is noted as refusing the MHT prescription due to her history of blood clots.

Briar: I mean I went to see her and she was in her drawer pulling out the HRT, telling me to take it and I said I won’t take it because of my Warfarin and my blood clots.

Flax recounts changing doctors to gain MHT when her usual doctor was reticent and advised against taking it. Cherry was faced with a conflict of information between her own GP (who was pro-MHT) and her neurologist (who was anti-MHT and treated the participant for a chronic condition). This woman had actively sought further information over several years -talking to the doctors, attending menopause seminars, via the web and reading in search of answers for herself, yet she still took the MHT her GP prescribed for 20 years, even as she sought assurance and worried about her health. Flax co-opted a discourse of ‘my body, I’ll choose.’ Flax showed insight into the scientific realities of risk factors, although co-opting ‘a right to choose’ discourse and asserting her choice in the case of MHT did not appear to be in her best interests for long term good health.

Holly recounted that on reaching menopause she had been offered HRT by her doctor as well as the loan of a video on menopause and HRT. As she felt well informed of risks and had weighed her own health status, she chose to view menopause as a natural phase in life, rather than as a medical problem, and dismissed consideration of MHT.

In this object field some participants appear to manifest defiance of their doctor’s advice, although frequently in their accounts defiance is expressed in a covert manner. There is a certain deference to the profession of medicine as they did not tend to confront a doctor head-on but found other ‘subversive’ ways to do what they thought was best. ‘Subversive’ here refers to expressions of resistance in a Foucauldian sense (Foucault 1976/1990, p. 95). At the same time as engaging in resistance the women show deference by default. Those who do recount instances of countering the doctor head-on did so with appeals to science, or from a position where they expressed a confident understanding of their own bodies. The patient/doctor encounter is a social practice where the status quo of power relations is reproduced between parties (Fairclough 2003; Foucault 1972/1980).
Medicine as a discipline claims particular truths of itself, generating a sense of a shared cohesive body of science. Advancing scientific knowledge and the anatomical-clinical method constitute the ‘the condition of medicine that is given [by society] and accepted as positive’-authoritative (Foucault 1963/1989, p. 243). The profession has had profound influence on the course of life through surgery, treating communicable diseases, and healing. Society uses the profession as a reference to every part of life. Gillett (2004, p. 157) notes that medicine ‘is incited to further efforts to expand and use (its) truth from within and without.’

The reiteration of medical authority over aspects of women’s lives other than illness is evident in the Llewellyn-Jones Fundamentals texts. For example, the texts contain the following comment: ‘As women live longer than men, more elderly women have no partner and may seek “permission” from a doctor if they use self-stimulatory methods to obtain sexual pleasure’ (Llewellyn-Jones 1999, p. 321; Oats and Abraham 2005, p. 333; Oats and Abraham 2010, p. 324). The underlying driver to such advice could be that doctors feel invested with authority to know and state opinions based on their concept of what is normal and also to assure women of ‘what is normal.’ In so doing medicine reiterates that it is the vehicle that decides ‘what is normal.’ The presence of this advice in a medical text re-produces such self-awarded authority to all doctors. There is an inherent circularity in the profession instructing itself on definitions of normality, retaining its position, while producing and reproducing itself as an instructor and authority over people’s lives (Foucault 1980).

4.6 Governance of the person-as-patient

This section traces the ideological shift from an early hegemonic persuasion of the status of patients, marked by medical dominance over every nuance of life, to a new hegemonic discourse of care of patients marked by patients being active participants in their own health care.

In reaching a diagnosis no part of a person is exempt from the scrutiny of medicine; every facet and detail (historical, medical, family, social, fiscal, psychological) is to be available for examination (Turner 1992). Traditionally medical authority is thus exercised over the patient. In the relations of power in the dyad doctor/patient, the patient gives themselves over to observation and examination, gives body samples readily and is not under duress. An ever-evolving constellation of techniques form the medical specialist gaze as science extends the boundaries of
knowledge. The classificatory gaze is looking for patterns, sets of identifiers that indicate the presence of particular diseases; it is sifting through signs and symptoms for known archetypes. The patient is only relevant in that what they reveal in history, symptoms and measurements permits identification of disease. Foucault (1963/1989) notes a relentless reciprocity between doctor and patient in the reading and re-reading of the signs in the patient; in the very circularity of assessing there is recognition of disease and healing. The medical gaze, then, is the process of an abstracted searching and evaluating, of discovery, of recording and mapping of the archetype and its variations. Those under medical surveillance become ‘cases,’ and a dossier of information is recorded and held on them. The ability to classify and own people as patients denotes the hegemonic positioning of biomedical science. Foucault notes that while hegemony is attributed, there are ever present subjugated voices resisting such positioning (Foucault 1976/1990). This point is taken up in Chapter 7.

There is evidence in the interviews and texts of women being at times the patient and other times the active subject. It is my claim that via genealogical investigation I show medicine to be beset by discontinuities as a profession. The vacillation apparent in the Llewellyn-Jones Fundamentals texts about how medicine speaks of women subjects tells us the voice deployed is not a uniform voice.

Whilst reiteration of the authority persists in the profession, it does so by the exercise of power in the vein of Foucault’s ‘conduct of conducts… a management of possibilities’ (2002, p. 341). As an orchestra is led, the conductor interprets by selection from many possible alternatives, and conducts the conduct of others in a particular interpretation. The script being followed in the case of the Llewellyn-Jones Fundamentals texts is one of mixed messages. Likewise, the variation of responses by the participants’ doctors in advising the women can be explained with recourse to Foucault’s view of the operation of power relations.

Medicine is itself an unstable entity, as mentioned earlier (see page 47 on authors negating their own disciplinary power), in part responsive to the altered status of patients, influenced by patient rights lobbying and groups, including feminists, over recent decades. Medicine divests itself of authority and yet asserts authority within the same text in ways illuminated by Foucault. Foucault (2002, p. 341) notes that power is a ‘set of actions upon other actions,’ and what an entity has been before, due to its sphere of influence, will shape any action performed presently.
and in the future, and the consequent receipt of such action(s). The voice adopted in the Llewellyn-Jones Fundamentals texts is inconsistent, revealing the nuances of the operation of power; at times the voice is authoritative and even patriarchal; at other times it is has a more contemporary inflection, reflecting the notion of a woman’s right to choose.

The following query was posed to the scientific community, women’s health advocates and society in general in an article authored by Women’s Health Advocates, clinicians, historians, epidemiologists and biologists in 2005 (Krieger et al. 2005, p.746): ‘Why, for four decades, since the mid 1960s, were millions of women prescribed powerful pharmacological agents already shown, three decades earlier, to be carcinogenic?’

Researchers had met in June 2004 to assess the ‘scientific and social context and response’ to the findings of the first rigorous research projects involving large population scale RCTs to determine the safety and/or risks of consuming MHT (Krieger et al. 2005, p. 740). As noted, two crucial studies were commenced in the 1990s. The HERS study reported results in 1998 that MHT, contrary to earlier claims, actually increases cardiovascular risk, and the US study WHI released findings in 2002 revealing that combined estrogen and progestin was associated with increased risk of ovarian and breast cancers, and like the HERS study, it identified that MHT may increase risk of cardiovascular disease. As well as recounting the various groups’ contribution to the development and distribution of MHT, Krieger and colleagues pose a series of challenges about how science and those with interests in consumption of HRT got this so ‘wrong.’ There are methodological, moral, commercial and medico-scientific queries arising from the longstanding ERT/HRT debacle (Krieger et al. 2005). Dissenting voices have existed in tension with promoters of MHT across the decades. There has never been consensus on estrogen’s safety (this point will be addressed within Chapter 7).

In some participant accounts women assumed a passive subjectivity, a position promulgated in the rhetoric of conventional knowledge. Other participants appeared agentic and active in the medical encounter without disruption to the dominant medico-scientific discourses. Some expressed forms of resistance with different impetuses, such as past experience, confidence in their own self-knowledge and information seeking strategies. Further, some women recognized the marketing push and resisted products being offered, based, it seems, on their aversion to entrepreneurial endeavors.
Medicine cannot divest itself fully from its history as authoritative, and having imposed punitive strictures over people’s lives such as harsh regimens and mandatory hospitalization. When the doctor speaks it is with the weight of past action. Tempering that authority by more recent scientific findings, or subsequent modification of practice, with accompanying rhetoric exhorting doctors to be less authoritarian and more conciliatory/advisory, does not entirely negate the entrenched hegemony of the profession. To Foucault (1976/1990, p. 95) ‘the strictly relational character of power relationships’ means that ‘power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategic situation in a particular society’ (Foucault 1976/1990, p. 93). At any time the doctor has at their disposal the appropriation of specialized discursive constructs, ‘a corpus of already formulated statements’ (Foucault 1972/1980, p. 68) that, when inserted into the doctor/patient relationship, as a property of discourse, confers the right to speak, the right to enact particular interventions to which the patient does not have access.

The interview data reveals a picture of doctors who, on the one hand, retained the trappings of authoritarian and patriarchal approaches to their practice, and on the other, incorporated an egalitarian attitude in dealings with patients. At times medical authority was exerted through the use of scientific and epidemiological language by practitioners.

The data is a commentary on the changing state of the profession, where heed to a large degree has been taken of popular, feminist and humanistic commentators who have advocated over forty years for medicine to divest itself of paternal modes of operation that foster exclusivity of knowledge, creating the chasm between lay and profession status. The chasm was breached by patient advocates in many areas like women’s health and the disability and mental health sectors, and all agitated for medicine to be more open, to inform patients of options in a way that promoted choice for patients/clients.

The object fields analyzed arose from text and interview data and provided examples of discourses, effects on subjects and how discourses are reproduced, yet unstable and fluid. Normalization of the menopausal woman was achieved through the constraint of medical discourses.
CHAPTER FIVE: FINDINGS AND ANALYSIS. Organizing Category Two: Public Health Talk on MHT

5.1 Introducing the texts

In applying a genealogical analytic to this second major organizing category of the data on public health discourses, the releases by the US Food and Drug Administration on the Premarin family (Wyeth) of hormone preparations were selected as texts to interrogate. The FDA releases were selected as they represent definitive knowledge on the safety and efficacy of MHT (in the sense of being sanctioned by government within the Administration’s role of regulating drugs for human consumption). The FDA releases permit examination of the public health messages about MHT, and were chosen as they are influential texts in world-wide public health policy and influence the content of health guidelines regarding drug safety of the public. The FDA is currently a section of the Department of Health and Human Services and has broad powers of regulation as a US governmental organization. Therefore, as an arm of the state, the FDA exerts power over populations (in various modes), and particularly via regulatory edicts, regarding the safety and regulation of medical and pharmaceutical products. The FDA’s messages necessarily intersect with medical and lay discourses within and outside the US. It should be noted that there is long established inter-dependency between the FDA and the profession of medicine, in that medical experts and medical researchers are essential on panels advising the FDA\textsuperscript{12}.

Recently controversies about MHT and its efficacy have provoked dilemmas in preventative medicine and epidemiology; preventative medicine has come under scrutiny by its own practitioners, and epidemiological research has had to rethink its foundations (Hernán, 2010). Up until the early 2000s MHT was rigorously endorsed (Llewellyn-Jones 1999; Wilson 1966) as preventative for heart disease and osteoporosis; these recommendations were premised on what many now say was weak science (Curb et al. 2003; Langer et al. 2003; Petitti and Freedman 2005; Prentice et al. 2005a; Prentice et al. 2005b). As noted, often the promotion of MHT was contingent on categorizing natural changes (due to age) as disease processes. However, when those reasons for endorsing MHT were debunked by the results of WHI RCTs, the preventative

\textsuperscript{12} The FDA practice of convening expert panels existed for many decades and was enshrined in The FDA Modernization Act 1997 (FDA Review, 2008).
messages in governmental guidelines changed to limiting use and doses in line with the latest evidence on MHT and its risks profile.

Apart from clinical trials (prior to release of any drug), and before initiation of rigorous population studies and of the HERS and WHI large scale RCTs, recommendations for use of MHT largely arose from observational case control studies and often studies conducted with small populations of women (Dennerstein 1996; Grady et al. 1992). Over the decade prior to the large scale RCTs, some attempts were made to conduct population based studies to gain a fuller understanding of menopause than could be gained from studies that commonly researched women who attended gynecology clinics (Dennerstein 1996). Despite weaknesses in design (identified on page 44) and the distorted data, the information was widely used by preventative health enthusiasts, drug companies and doctors to promote ERT/HRT/MHT and its consumption by women (Barrett-Connor 2002; Krieger et al. 2005; Llewellyn-Jones 1999; Sackett 2002).

Firstly, I provide a brief history of the FDA and its actions regarding the hormone preparation Premarin. Premarin is selected because for decades (and globally) it has been the most widely distributed estrogen product. Prempro (of the Premarin family) followed in popularity as the combined preparation with estrogen and progestins for women with a uterus after the discovery in the 1970s that estrogen alone caused uterine cancers. The FDA, established in 1931, arose from the Bureau of Chemistry formed in 1906 to administer the Pure Food Act (Temin 1980, p. 40). The Pure Food Act (PFA) 1906 was introduced at a time when drugs were sold in much the same way as any other consumer good. The US Food Drug and Cosmetic Act was passed in 1938; this act shifted particular drugs from being commercially available, to prescription by licensed doctors only (Temin 1980), commencing the modern era of regulation.

The post war era ushered in further regulation changes leading to significant growth in the FDA. By 1951, the ‘safety and efficacy’ of drugs were the twin emphases of the FDA (Temin 1980, p. 55). Premarin was established as a commercial success in the 1940s and 50s. In 1961 FDA jurisdiction widened as it became responsible for the surveillance of the introduction of new drugs and drug manufacturing. This move reflected expanded jurisdiction and regulatory activities expressed in the Amendment Act to the Drug Food and Cosmetic Act (1938) in 1962.
In 1942 Premarin was first approved after application by Wyeth-Ayerst Research Division as hormonal treatment for menopause (FDA NDA 004782). The successful application followed the approval of Theelin (FDA NDA 003977) by Parkedale and diethylstilbestrol (FDA NDA 004039) by Lilly.

During the 1960s and 1970s reports implicated Premarin in increased risk of thrombosis, hypertensive problems, thrombolytic events and myocardial infarction. The Coronary Drug Project studied 8,341 men recruited between 1966 and 1969. The high dose estrogen arm was terminated early as the study group showed significant increase in myocardial infarction and an unfavourable trend in total mortality, and the low estrogen dose arm terminated 3 years later due to increases in cancer compared with deaths in the placebo group (Canner et al. 1986).

The approval of generic forms of Premarin had been controversial throughout the decades as scientists could not agree on the active ingredients. In 1972 a mechanism for approval of a generic form was established, although, in 1997, the FDA’s Center for Drug Evaluation and Research (CDER) stated that a generic form of Premarin would not be approved (FDA 2009). In 1972 the Drug Efficacy Study Implementation (DESI) unit of the FDA released their evaluation that Premarin (among other estrogen products) was effective in the treatment of menopausal symptoms (FDA 2005). However, after decades of drug information direct to the public being restricted by the FDA, a turnabout occurred as the need to warn women of the risks of estrogens ensued. Information inserts into drug packaging were introduced, initially in 1971, with the Contraceptive Pill (CP) (Fed. Register, 1970, 35:5962), as the risk of emboli was identified, and then for menopausal ERT in 1976, when evidence of increased risk of endometrial cancers was found (Smith, Thompson and Herrmann 1975; Ziel and Finkle 1975). Both doctors and pharmaceutical manufacturers strongly resisted the plan to include inserts for consumers. The pharmaceutical industry opposed the move because of cost, whilst some doctors’ opposition was based on perceived government interference in the doctor/patient relationship. The FDA produced a 100 word everyday language insert on ERT after a backlash to a longer version (Watkins 2002). By 1975 the annual number of prescriptions for menopausal estrogens increased in the US to 28 million from 15.5 million in 1966 (Kennedy, Baum and Forbes 1985).
Following the discovery of the link between estrogen and endometrial carcinoma in two significant RCTs in 1975 (Smith, Thompson and Herrmann 1975; Watkins 2002; Ziel and Finkle 1975), and a protracted period of consultation, in 1976 the FDA ordered the labelling of estrogens to inform users of the increased risk of endometrial cancers and potential risk of breast cancer, gall bladder disease and abnormal blood clotting (Watkins 2002). In 1978 the FDA mandated all estrogen products contain warnings regarding endometrial cancer and the risk of blood clots (FDA 1978; Stefanick 2005; Watkins 2002). Progestin was then recommended to be prescribed with estrogen to overcome the risk of endometrial cancer in women with a uterus. For a brief period only, consumption waned before increasing again after the combined regimen was available. In 1986 the FDA notified that short acting estrogen is effective for prevention of osteoporosis (FDA 2009).Eight years later the advice was revised, moderating the claimed benefits.

Convening several times over 1989 to 1997, the FDA’s Fertility and Maternal Health Drugs Advisory Committee could not reach consensus on the active ingredients of Premarin. Disagreement persisted, and the FDA’s Generic Drugs Advisory Committee also assessed the active components. In 1997, the CDER announced it would not approve other synthetic generic forms as applicants had not shown their products had the same active ingredients as Premarin (FDA 2009).

Divergent opinion on the likelihood of cardiovascular risk was of serious concern (see detail page 8), as 8 million American women were taking estrogen replacement (Premarin) (Center of Drug Evaluation and Research 1997). The US government led moves to initiate large scale population studies, hence the commencement of the government sponsored Women’s Health Initiative (WHI) randomized control trial in the 1990s (WGWHII2002). Following the cessation of the WHI study, one of the key recommendations issued by the FDA and health departments worldwide was that doctors ought to recall women currently on MHT for review. If women had been on MHT for longer than the recommended maximum of five years, doctors should advise discontinuation by gradual reduction in the dose over approximately three months.

The plethora of public health messages that people encounter can lead to confusion as to risk for them as individuals. The association of risk discourse with all aspects of everyday life can result in all risks being situated as equal, and positioning all aspects of living as a
risk (Beck 1986/1992). The new public health discourse addresses management of risks, quality of life, lifestyle, corporeal control and taking care of oneself. The ‘new public health discourse’ (Lupton 1995; Tulloch and Lupton 2003) can be regarded as a major influence on the use of MHT as a standard practice for the management of menopausal symptoms, particularly throughout the 1980s and 1990s. The idea of prevention of disease in the future hastened prescribing of MHT to ward off osteoporosis and heart disease. Discursive construction of risk as an ever-present interloper in everyday life has the potential to incite increased vigilance and anxiety.

The new public health discourse could be regarded as within traditional medical discourse, but it has specific features that differentiate it, primarily the discourse around risk and lifestyle. As Galvin (2002) has identified, this discourse constructs the ‘good citizen’ as one who actively participates in social and economic life, makes rational choices, and is independent, self-reliant and responsible. Turner (1997) noted the medical profession’s growing emphasis on individual responsibility and self-care rather than population strategies for the provision of health care. In 1995 Lupton stated that ‘the practices and policies of public health and health promotion valorize some groups and individuals while marginalizing others’ (p. 5), for example the non-smoker and the smoker. In a post structural analysis, medical prescriptors direct thought and conduct to produce healthiness and assign unhealthiness, medicalizing all aspects of life, resulting in a ‘disciplined’ society (Turner 1992, 1997). In significant social institutions there is a coercive ability to shape what individuals come to see as their choices or possibilities. Every part of the person becomes medicine’s business; no part of one’s life is exempt from enquiry (Sackett 2002; Turner 1992). The public health discourse is underpinned by a morality based in behavioral culpability: people can ‘choose’ to avoid illness by engaging in healthy thoughts and behaviors. The key components of the discourse are personal responsibility, choice, consumption, autonomy, self-advancement, and the management of risk. Women in particular are exhorted to ‘look after themselves,’ keep well and be physically attractive, as the feminine healthy ‘citizen’ who has a duty to remain healthy to care for others (Petersen and Lupton 1996).
Foucault’s (2002) concept of ‘governmentality’ provides a philosophical exposé of how power operates in society and upon bodies where the state exhorts populations to self-regulating actions and patterns of living as in the new public health discourse. One aspect of governmentality is:

The ensemble formed by the institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of political economy, and as its essential technical means apparatuses of security (pp. 219-220).

The public health politic containing the imperative to be healthy is governmentality in action (Lupton 1995). The ordering of public health messages relies on the ultimate power of the state to enforce, although force is only deployed in emergencies or the presence of epidemics and pandemics. To explore the outworking of public health messages, we can examine a recent example: the legislation on the use of cell phones in cars in New Zealand. Initially, drivers were exhorted by public health message to desist from using cell phones while driving. The health message was aimed at preventing motor vehicle accidents and injury, and when the population failed to follow this advice in sufficient numbers to reduce the accident rate, legislation was introduced with penalties for talking on cell phones whilst driving. Preventing disease or injury has both an individual and a societal benefit. Individually people avoid the morbidity, mortality and suffering of diseases or injury. At a societal level the state and institutions have reduced risk to other road users, and save the costs of treating the injured and other economic impacts of mortality, long term injury and disability. Public health then becomes a moral regulator articulating imperatives about healthiness, and thus a science-cultural artifact subject to ‘political, economic and other social imperatives’ (Lupton 1995, p. 4).

A forerunner of public health discourses as we recognize them over recent decades involved dietary management. The proper feeding of babies and families brought medical knowledge into the home, co-opting women as the ones to turn the instructions into everyday practices (Turner 2008, p. 145). The promotion of good health through proper diet was effected through the alliance between medicine and mothers/housewives. Medicine had (and has) the function of policing the health of individuals and populations, and as Foucault (1972/1980) states:
[It] arguably concerns the economic-political effects of the accumulation of men. The greatest eighteenth-century demographic upswing in Western Europe, the necessity of co-ordinating and integrating it into the apparatus of production and the urgency of controlling it with finer and more adequate power mechanisms cause ‘population,’ with its numerical variables of space and chronology, longevity and health, to emerge not only as a problem but as an object of surveillance, analysis, intervention, modification, etc. The project of a technology of population begins to be sketched: demographic estimates, the calculation of the pyramid of ages, different life expectations and levels of mortality, studies of reciprocal relations of growth of wealth and growth of populations, various measures of incitement to marriage and procreation, the development of forms of education and professional training. Within this set of problems, the ‘body’ - the body of individuals and the body of populations - appears as the bearer of new variables, not merely between the scarce and the numerous, the submissive and the restive, rich and poor, healthy and sick, strong and weak, but also as between the more or less utilizable, more or less amenable to profitable investment, those with greater or lesser prospects of survival, death and illness, and with more or less capacity for being usefully trained. The biological traits of a population become relevant factors for economic management, and it becomes necessary to organize around them as an apparatus which will ensure not only their subjection but the constant increase of their utility (pp. 171-172).

As a labor force nurses are an example of such organization, as the cheaply trained public health nurse could visit homes and enforce rules of health behavior. The mother was the person targeted for the health message. Women were invariably encouraged to look after their health to protect family members as, they were portrayed as having a duty to and responsibility for others. Advertisements for estrogens reflected that it was through others that women were important, with the subtext being that they themselves were less
important (Coney 1991). Sandra Coney’s book titled The Menopause Industry (1991, pp. 216-217) reproduces several pharmaceutical companies’ advertisements for treating menopause, spanning three decades from the 1950s. One in particular, Menrium, by Roche, depicted a smiling middle aged couple and states, ‘Menrium treats menopausal symptoms that bother him most’ (Coney 1991). This advertisement is not alone in subsuming the woman’s health concerns as secondary to the husband’s. Encapsulated within the advertisements is the long held association of the menopause with mental illness (Deutsch 1945; Wilson 1966). Menrium (now discontinued) contained chlordiazepoxide (anti-anxiety medication) and estrogen.

The discourses of science, medicine and individual autonomy have shaped the subject of public health practice. In turn public health discourse constitutes the subjectivity of individuals whilst taking a population approach. The bounds of normality and health are clearly articulated as standards to be attained, with behaviors that do not lead to their attainment being discouraged and even regulated. The probability of risk is used to produce self-regulation, and in instances such as pandemics or severe earthquakes to justify legal restriction of risky behavior and actions.

The above section has introduced the texts, showing how the institution of public health is articulated by authoritative professionals appealing to populations, using rational science about health risks to promote self-responsibility in citizens for their protection. The ‘reading’ of the public health texts in concert with the interview data (presented below) led to identification of the following object fields.

- Taking personal responsibility
- Adopting a risk management approach
- Weighing own individual risks
- Prioritizing quality of life

At interview, seven women indicated their doctors were cautious in talking with them about MHT, appeared cognizant of the recent warnings regarding MHT and were risk averse, while six doctors appeared to promote MHT despite the guidelines, and two women reported their doctors were dismissive of the current guidelines. Some women reported on the views of more than one doctor. It is concerning that such a proportion of the doctors consulted by the women appeared
not to be applying the guidelines. Although the women’s memories of consultations may be a factor methodologically, nevertheless, the impression recalled by the participants can be considered to have had an impact on their choices. Three women had other chronic medical concerns that would potentially affect the advice they were given. In one instance, Briar’s GP’s advice to take MHT conflicted with that of her haematology specialist who advised her to go off MHT (see p. 54).

5.2 Taking personal responsibility

The interview excerpts below reveal the women as active in maintenance of their own health, conveying the sense of responsibility they assume for their health and well-being.

Scarlett: I probably tend not to read the popular press. I probably read texts and I did that initially probably before I reached menopause. I listen to information that is a bit current, news. Often in listening to it you can pick up flaws when it is focussed on one direction only. Usually if I am prescribed medication I look it up on the Internet, do a search on it, look at the pros, cons and you know…there is a word for it….you know how it reacts with other things….contraindications….yes that’s it. (59yrs old, on MHT 7yrs and at interview).

Scarlett’s narration reveals she anticipated the next ‘stage’ before entering it, displaying a watchfulness and selectivity alongside the desire to be well informed.

Sylvia: I am very interested in health matters, what we eat and supplements we take. I have a very supportive GP and I felt that she wasn’t very keen to prescribe a vaginal cream because they still get absorbed into the body. I think you have to weigh up – my GP and I talk and things and we choose, I make an informed decision for myself – like I choose not to have mammograms and that is my decision. It is not that I am against all things medical I just like being informed. I have all my Pap smears. (65yrs old, postmenopausal, never took MHT).

A reciprocity between Sylvia and her GP show the doctor’s respect for her decisions with mutual respect appears to be part of the relationship. Again the idea of weighing information resulting in considered actions is apparent.

Briar: I wasn’t going through menopause then…well it took a little while to get over the heart attack of course…and then I…I have been back to the gym since and you know I’ve always watched what I eat. But….um…so I never ate unhealthily and I exercised. (50yrs old, on MHT 15months and at interview).
Ruby: I do eat a lot of cheese, quite a bit of yoghurt, I don’t drink a huge amount of milk but I do have a lot of cheese and a bit of yoghurt so I figure that that...[a good intake of dairy] ... will be fine. I don’t go overboard about it, we do have skim milk but that is the fat level not the calcium. I haven’t ever had a broken bone, and neither did my mother, and I gather this is somewhat familial….I think it’s all part of that attitude to take responsibility for your own health, and if there is something that you can do which will benefit your health then OK, if it has negative side effects you look at those and weigh them up but if you perceive the benefits to be greater then you might be happy to be on it. (63yrs old, on MHT for 7 years and at interview).

In the last two quotations the women reiterate the messages about eating well and exercising as steps they take in self-help, and again the watchfulness is present. These excerpts demonstrate how the women have taken health promotion messages into the everyday practices of their lives: ‘doing the right thing’ orders their eating, activities and the degree of health monitoring they participate in.

With the emergence of the new public health discourse, emphasis on MHT moved from taming the rapacious female body (as argued by Robert Wilson (1966) and others) to self-regulation of one’s body and the consumption of hormones to prevent diseases, such as osteoporosis and heart disease. The dominance of preventative health messages emphasizing one’s social responsibility to achieve optimal health by control of the body intersected with arguments fostering a certain type of femininity (Petersen and Lupton 1996). The sense of a need to control the body is constructed as evidence of the imperative contained within the public health discourse for self-responsibility and taking care of oneself. One is required to be an active participant by public health discourses in self-restraint and self-regulation, whether it be to wear a seat belt in cars, to present oneself for health screening, to obey the many exhortations to avoid a fatty diet, to exercise or eat vegetables and fruit. Such discursive constructs come into dominance by what Foucault (1976/1990) termed ‘polymorphous techniques of power,’ as the public health message of self-responsibility permeates the clinical encounter, our airwaves, television broadcasts, and school health education, ‘in order to reach the most tenuous and individual modes of behavior’ (p. 11). The body has become the focus of the public health arm of the state.
Being self-responsible is rewarded, as the responsible patient is endorsed as a ‘good’ patient. With constant reiteration the public health messages are part of societal and cultural values and norms and therefore coercion is not necessary. Rather, patients submit voluntarily to regimens and monitoring in their own best interests. The word ‘regimen’ has a double meaning. On the one hand, it applies to government of the body, and on the other hand, government of citizens due to its origins as ‘rule’ or ‘regere’ (Turner 2008, p. 142). The populace (citizens) are ruled by proscribed regimens of daily life and behaviors.

Foucault (1976/1990) postulates technologies of the self as constraints that the person exercises to understand themselves and to mould themselves to fit normative expectations. Foucault (1994/2000) defines ‘technologies of the self’ as techniques that permit individuals to ‘effect, by their own means, …operations on their bodies, souls, thoughts, conduct…so as to transform themselves, to attain a certain state of perfection, happiness, purity, wisdom, or immorality’ (p. 225). Although the quotations above show the assumption of self-responsibility, it is often within normative modes. Prohibitions configure and generate the normative. In public health discourse prohibitions are iterated on overweight, sedentary lifestyles, and risky behaviours. These prohibitions proscribe how to be. Individuals are complicit in ways that Foucault describes as exercising technologies of the self. The women have enacted self-surveillance and been vigilant, tailoring their activities to meet a norm. As with any discourse, the public health discourse in Foucault’s words ‘transmits and produces power’ (1976/1990, p. 101), constraining individuals and eliciting their co-operation and complicity. Briar, Sylvia and Ruby’s comments reflect how they calibrated their actions (food choices, exercise regimes, participating in screening programmes) to ‘fit’ public health expectations in myriad ways. Foucault describes two types of discipline, the extreme version with repression, physical restraint and imprisonment, and the lighter version termed the ‘discipline-mechanism’ which is functional or productive and where generalized surveillance leads to a disciplined society (1975/1995, p. 209). Where normality (on which public health discourses depend) is articulated, the individual is exhorted to behave in ways that will align their bodies to the norm and maintenance of the norm through which the desire to align oneself is kindled.

Sylvia selectively resists the dominant discourse on prevention and screening, exercising a counter-investment as she refuses some screening tests and participates in others. So power relations are both strengthened and weakened through mechanisms, described by Foucault.
(1976/1990) such that ‘focuses of resistance are spread over time and space at varying densities, at times mobilizing in a definitive way’ (p. 96). Here taking self-responsibility is seen in acts of compliance and resistance. The watchfulness described by the women indicates the potential for resistance is ever-present.

5.3 Adopting a risk management approach

The quotations from three women below reveal that they took a risk management approach in considering potential risks against relief of symptoms.

Cherry: But when you listen to the TV, to me it is scaremongering. It is like a media hype and then everybody goes off it [MHT]. Of course, millions of women stop taking it...and I am sorry...but I have to die of something...if it is not the radio mast next door, the radiation a couple of paddocks away, it will be this [MHT]. But I am not stopping it and that is all there is to it. I feel really, really good on it. I have much more energy than friends of my own age...I don’t tell anyone [friends] I’m on it, they’re negative. (62yrs old. Hysterectomy 21yrs ago. On MHT for 20yrs and at interview.)

Aster: I mean I am looking at 5 years on HRT...but you do have to look at the quality of your life and [menopause] affects your mood, what problems you have and weigh it all up I think. (53yrs old. On Bio-identical hormones for 3yrs, and at interview.)

Tutu: Actually...um... I didn’t really want to know...I had to keep working. Well being aware that there were risks. And then I decided that well I had no family history of cancer, heart disease and it [HRT] was going to keep me sane. I would die with breast cancer or a heart attack sane and that was enough for me. (57yrs old. On MHT for 6yrs and at interview.)

The type of willingness to gamble on risk taking referred to by these women may be based on a variety of possibilities: perceptions of the self, knowledge or lack of knowledge, perceptions of their own body’s capacity and desires (Tulloch and Lupton 2003). The women have developed a degree of trust in the MHT product, and they appear willing to take the chance of any new risk they know about, given their experience of meeting a personal need in symptom relief. The five year time frame mentioned by several participants correlates with the ministerial health advisories (MOH 2004), and the women reveal they aim to be guided by the advisories, although at the same time they have calculated that possibly certain benefits outweigh risks to a point where maintaining their quality of life is a key personal concern. Although the women’s narratives reveal awareness of disease prevention discourses, yet resistance to deploying
preventative measures is expressed on emotional planes and in desires that rely upon different motivations or discourses.

Daphne and Aster, who were taking bio-identical hormones, dismissed the guidelines, believing they were exempt from risks due to taking compounded preparations despite this being refuted by several researchers and experts (Curcio et al. 2006; Fugh-Berman and Bythrow 2007; North American Menopause Society 2006). Bio-identical hormones are marketed to replace the mainstream medical hormonal solution. The idea of the post-menopausal state as deficiency disease is perpetuated as the basis on which to suggest ‘natural’ therapies to women.

The term ‘bio-identical hormones’ (BHT) is applied to compounds that are structurally indistinguishable from human endogenous hormones. They are derived from plant extracts. Compounds are most likely to include estriol, estrone, estradiol, testosterone, micronised progesterone and sometimes dehydroepiandrosterone (DHEA) (Cirigliano 2007). Customizing for individual doses of BHT for women, based on blood or saliva tests for hormone levels, is commonly performed by compounding pharmacists. Proponents claim that these compounds are a safer alternative to conventional therapy and better tolerated (Boothby et al. 2004). The promoters of BHT utilize three angles in their marketing to appeal to women: firstly, the idea that their products are natural; secondly, a strategy designed to make the customer believe that their products are special and unique to the individual woman; and thirdly, they claim that their products are safer.

Let us deconstruct the concept of ‘natural’ as it is applied in the case of bio-identical hormones. The term ‘natural’ may be applied to substances derived from natural organic sources, and equally to native human hormones naturally occurring in the body, as well as chemical substances that are not synthetic or manufactured. As a descriptor of BHTs the word ‘natural’ carries the connotation that BHTs are unadulterated naturally occurring plant extracts, somehow harmonious with the body and enhancing chemical balance (Lee et al. 2002). Further, the marketing for acceptance of substances claimed to be natural draws upon knowledge arising out of traditional remedies. The claim of those supporting natural remedies is that in refining material to produce pure elements/substances, goodness can be lost. To produce a protein from wheat, by refining grains the naturally occurring fibre in whole grains is discarded, thus goodness is lost to the consumer. Practitioners promoting bio-identical hormones signal a reference in the
public’s mind to all that is attractive in the naturalist discourse. Yet in contrast, they also draw upon the scientific discourse of the benefits of pure substances, highlighting their products as being the exact molecular structure of human female hormones.

Proponents of bio-identical hormones deploy the second strategy in a specific way, as they claim their product will be individually dosed for each woman, based on female sex hormone concentrations in saliva. This approach to dosages is refuted by medical scientists with expertise in pharmokinetics. In 2005 the American College of Obstetricians and Gynecologists (ACOG) alerted the public to appreciate that hormones do not belong to a class of drugs suitable to individualized dose therapy. In addition they stated, ‘there is no evidence that hormone levels in saliva are biologically meaningful’ (p. 1140). Furthermore, to give stat doses (that is, administered immediately) based on a one-off saliva test when it is known that hormone levels in the blood fluctuate is not a valid way to proceed. Cirigliano (2007) and Boothby et al. (2004) critique the individual dosing idea. Influences such as time of day, diet, secretion rates, storage processes and the hormone being tested can mean results of salivary testing are not necessarily accurate (Boothby et al. 2004). In contrast to those advocating individualized compounding, who claim particular symptoms relate to saliva or blood sera levels of estrogens, Cirigliano (2007) states that no-one has published peer review research findings that support their position. In the past it was thought that theoretically saliva would be amenable to testing for unbound concentrates of estrogens; however, Marder, Joshi and Mandel proved this not to be the case in 1979. Proponents of BHT persistently claim that ‘natural’ hormones are different from conventional therapies, yet this is not entirely accurate, as they are identical to some commercial pharmaceutical preparations (Fugh-Berman and Bythrow 2007).

This antithetical dyad can be deduced when we look closely at the way bio-identical hormone promotional materials illustrate the exact molecular structure of their hormonal substances. Here we can see the deployment of a scientific argument alongside its oft times opponent, the naturalist position, being co-opted and utilized in tandem in the selling of bio-identical products. Such promotion is carried out without reference to the fact that many preparations of conventional hormones have exactly the same chemical structure as so-called natural hormones, and that bio-identical hormones are not special or unique in their chemical composition (Boothby et al. 2004; Cirigliano 2007; Fugh-Berman and Bythrow 2007).
‘Mother nature’ is usually thought of as an apolitical concept, devoid of bias and vested interest. Yet once this concept is utilized as a marketing tool in a discourse of productivity and meritocracy, it becomes a tool of commercialism and thus politicized as one sector strives competitively with another sector in a marketplace. In today’s world, recourse to naturalness could be viewed as relying on a green, eco-friendly message. Cirigliano (2007) explains that all progestins arise from plant derivatives and therefore are natural (p. 612). Seeking to restore a balance that is naturally declining as part of natural aging is antithetical to the course of nature. Thus these naturalists are shown, most ironically, to also buy into the medical model with its deficit discourse, based on a bio-functional specification of the essence of womanhood as firstly and always about reproductive capacity.

In relation to bio-identical hormones being portrayed as safer than conventional medicine, there is no evidence to support such claims as rigorous trials to prove safety have not been carried out (Boothby et al. 2004; Cirigliano 2007; National Institute of Health 2005; Stefanick 2005). For women, health professionals and nurses working in women’s health, there is an attraction in the possibility that there could be ‘safer’ products when a treatment of many decades has become far less available due to evidence based recommendations arising from the large scale studies (Cirigliano 2007). Boothby et al. (2004) capture this point, stating: ‘in the absence of [scientific] data, advocates promote use of alternative methods of hormone supplementation, not based on scientific data but instead seizing upon the negative publicity generated by the results of the WHI’ (p. 358). Cirigliano (2007) reiterates this message, noting, ‘an absence of evidence of harm due to the lack of clinical trials [on BHT preparations] does not make an unproven therapeutic safer than another product’ (p. 623). Furthermore, researchers in the field state the risks in taking either conventional HRT or BHT are similar (Curcio et al. 2006; Fugh-Berman and Bythrow 2007; North American Menopause Society 2006).

In their product materials, the Menopause Institute of Australia (MIA), who market BHTs, include statements that imply the products create dependency and patients require weaning to come off them. This impression is misleading because hormones do not fit into classes of drugs which cause dependency. As a final comment on marketing per se, it is curious to note that the MIA operates a membership benefits scheme to retain and encourage women’s long term custom (Menopause Institute of Australia 2006). One has cause to ponder that having sowed the seed of
potential dependency and then offering incentives for long-term use, the approach expresses a thoroughly commercial interest in securing patient loyalty.

The Australian incident was not an isolated event. In 2008 the FDA released policy statements warning about the risks of bio-identical hormones for professionals and consumers (FDA 2008). At the same time they sent warning letters to seven compounding pharmacy companies regarding violations of federal law and FDA regulations where bio-identical hormone products were concerned (Inspections, Compliance, Enforcement, and Criminal Investigations (ICECI) 2008). For example, the letter to Panorama Compounding Pharmacy, Lake Balboa, California, cited several violations of the Federal Food, Drug and Cosmetics Act, including false labeling, unsubstantiated claims of efficacy, unsubstantiated superiority claims, unsubstantiated ‘bio-identical’ claims, and the marketing of an unapproved new drug (ICECI 2008).

Another hormone often prescribed with bio-identical products is dehydroepiandrosterone (DHEA). The consensus statement of the NIH National Institute of Health State-of-the-Science Conference on Management of Menopause-Related Symptoms (2005, p. 17) reported that claims about the drug’s efficacy cannot be supported as findings are not generalizable to the population.

In the surging uptake of alternative products, doctors, pharmacists and business owners have played roles that in a Foucauldian analysis fall under the concept of the ‘political economy of truth’ (Foucault in Rabinow 1984, p. 73). Foucault espouses that persons who occupy specific positions (as those above in relation to promoting bio-identical hormones), ‘whose specificity is linked to the general functioning of an apparatus of truth’ (p.73), in this case scientific discourses and associated disciplines (medicine, pharmacy and economics), become the bearers of ideological and universal values. This is a struggle about the ‘status of truth and the economic and political role it plays’ (p. 74). Aggressive marketing ensures their message is persuasive, repeatedly appearing in multiple media outlets, and playing on the inconclusiveness of the ‘truth’ of rigorous science, a ‘truth’ enmeshed in power, and thus politicized truth.

In adopting a risk management approach, women balanced future health risks with maintenance of their lifestyle and the immediate need for symptom relief, where achieving at work, social relationships and mediating the impact of symptoms were uppermost for them. As we have seen, some were prepared to rely on alternative, though largely unproven therapies.
5.4 Weighing own individual risk

Several women individualised the information on MHT, considering their own particular circumstances and individual state of health. They sought a balance in the various messages about health keeping practices.

Sylvia: Menopause decisions started to come about in my 40s and I was currently going to Family Planning. I remember my 40s as being a time of tiredness. I would be kinder to myself now. My GP at the time said you should think about HRT, I can hear her words-osteoporosis is an awful illness. At that time they were also saying it would be good for your heart – like most New Zealanders at that time I had raised cholesterol. I was shocked, because I was still in my 40s….. and they were saying I should be thinking about menopause. (65yrs old, postmenopausal, never took MHT).

Ruby: And now I am on half [dose of remifemin] and I have been on half for…ages. I suppose realistically I could come off it but her [Consultant] advice is… I have a regular blood test, to test my liver function, and just a general blood test and there isn’t any…um… blood picture why I should come off it. My liver function is normal and my cholesterol is in the lower limit of normal. (63yrs old, on MHT for 7years and at interview).

Interviewer to Tansy: So the doctor gave it (HRT prescription) to you and you decided not to have it?

Tansy: Yes, that’s right. I remember …when the doctor gave it [MHT] to me it was about 2001. Then there were two studies released in quite close proximity to one another…for as long as I can remember I seem to have had this connection between HRT and breast problems and that probably is because I had had a lot of breast problems and I had always sort of tuned into that one aspect. (57yrs old, on Remifemin for 7yrs and at interview).

These women have weighed their personal health picture with the information about the effects of aging and the effects claimed about MHT. Sylvia and Ruby share how they consulted with the doctor to arrive at a decision. Flax, on the other hand, dismissed concerns her doctor raised against long term consumption, as she believed MHT dampened, in her words, an ‘over-active sex drive.’ She did not wish to stop taking MHT and invite struggles with a high sex drive. In the instance Tansy recalled, discussion with her doctor appeared limited, and she had a prescription she was not willing to take. Having breast changes and having read of the breast cancer risks associated with MHT she decided against taking it.

The above quotations display the women having levels of self-knowledge and self-care. To Foucault, care of the self, a practice of the self, depends upon self-knowledge, and furthermore
self-care is a self-technology that is transformational (Foucault 1994/2000, pp. 282-287). Applying principles and taking sound counsel are facets of caring for oneself. The subject is constituted as one actively engages in practices of the self (p. 291). The engagement with dilemmas for these women about how to best care for themselves reveals how they evaluated information and knowledge to reach a decision.

5.5 Weighing disparate information

It was clear from interviews that some women, although having sought information and listened to their medical practitioners, struggled in judging the information and their best interests.

Briar: I have read a lot of books about menopause….I mean my heart medication and my Warfarin I have got to take, I can’t do anything about that. But this one here…like…it is also my choice. I mean my doctor has given it [MHT] to me but it is also my choice to say ‘yes’ or ‘no,’ where I have no choice about the others. I also wonder whether I am doing the right thing. And I am not under my cardiologist anymore, he has cleared me so I have never, ever been able to talk to him about it either to see what his theories are on it. You have to trust your doctor…I mean…I would never take it long term. Five years I am happy to take it but after that no way. (50yrs old, on MHT for 1.5yrs and at interview. Has had heart attack and is on warfarin to prevent blood clots).

Willow: I mean I have read about [MHT] at the library and that. That is where I am picking things up. I would come out [of the library] with armloads [of books] trying to figure out what was going on. I still don’t really know. What is estrogen and things. (54yrs old, on MHT 3 years, stopped 6 months prior to interview).

Willow’s GP had prescribed her HRT and she had attended regular doctor’s visits, although she never felt her questions were answered sufficiently.

Valerie: It was a specialist consultation and I had to pay for it because our health insurance only covered surgery so it was my decision. So she weighed me and ran tests um…basically her advice was that I should take HRT. It was at that time there was an awful lot of controversy about whether HRT was good or was it bad. My doctor had put me on it briefly and I had taken it for about a month and then all this other stuff was…information in the paper made me think. No, I don’t think I am prepared to [take it]. I decided no I was really not comfortable about this HRT and what the newspapers were saying about it. So I tried Remifemin, which is a naturopathic that I brought at a health food shop. I tried that for a couple of months and quite frankly it didn’t make much difference. And then I think I… I am trying to think what else I tried. Basically I just continued with …um…Rescue Remedy when I was feeling anxious or stressed, that seemed to be most helpful….About one year later I actually decided that it possibly wasn’t menopause that was causing those things, depression etc. I started getting counseling. (61yrs old. Never took HRT, natural menopause).
Such narratives reveal gaps in medico-scientific knowledge for the women. Although they may have made considerable effort to gain information and understanding, a gulf existed to be bridged. It seems medical practitioners have ‘talked past’ the women, or their searching for answers has not been satisfied. Although a lot of information may be available, this gives rise to frustration if it is not tailored to individuals and mediated by those with expertise.

The dilemmas the women faced highlight Foucault’s descriptions of the struggles over truth. He applies the concept of the power/knowledge nexus to explain, understand and signal ways to possible resolution of such struggles (Foucault 1972/1980, 2002). Expertise is contestable, and we could ask, ‘Is the expert an expert due to their knowledge (grounded in supposed truths) or is one an expert due to their education, registration in a profession and social recognition?’ Foucault believes it is the relationship and interplay of the operation of power that holds the key to answering such a question. The veracity of science is a ‘problem of the regime, the politics of the scientific statement’ influenced by the symbolic in culture, or the field of signifying entities and tactics, alignment and the use of contestation that opens fractures, fissures and their opposite interconnection (Foucault 1972/1980, p. 112). The women are subjected to multiple claims regarding ‘expertise,’ sometimes in concert, at other times in competition, conflict and variance.

It appears Valerie was offered HRT for issues she presented which ought to have had specific treatments proposed, as MHT is not deemed a remedy for depression. Briar seemed unaware that she could request an appointment with a cardiology specialist through the GP. Discussion on truth, knowledge and power is further developed in Chapter 7.

5.6 Prioritising quality of life

Ruby, as a graduate in human biological sciences, sees no reason to stop taking MHT as she is monitored regularly. She believes that as long as monitoring reveals no adverse effect she can continue on MHT despite her knowledge of epidemiological evidence on population risks.

Ruby: Yes…and of course that’s the other thing too…if it is not broken don’t fix it. So if (HRT) is working for you and your health is good and you don’t have side effects …um… how much of that is due to what you are taking and if that is the case why stop it? (63yrs old, on MHT for 7 years.)
Briar: Yes because I had blood clots...I didn’t go to him when I went on it...I had blood clots years ago in my lungs and so now I am on Warfarin because I am Factor 5, that is why I got the blood clots. I said to my doctor about it and she said, ‘Well you are on Warfarin, you are hardly likely to get a blood clot if you are on Warfarin.’ So I just thought well at that time the quality of lives... I mean I can’t lead my life if I don’t get something for this menopause.

**Interviewer:** So the GP saw the fact that you are on Warfarin was sort of counterbalancing any problems with HRT?

Briar: Yes but I do worry...I worry every day.

**Interviewer:** Do you...so what is bothering you [woman’s name], tell me what is going on for you, what you are thinking?

Briar: Um...well I had a heart attack two years ago coming this Xmas. Yeah, out of the blue, because I am very fit, I had been to the gym for an hour that morning, I was extremely fit and I used to run up to [name of mountain] and back...um... I have always watched my diet, but I had a heart attack. (50yrs old. On MHT for 1.5yrs, on MHT at interview).

It seems Briar had considered herself ‘protected’ by following health maintenance regimes (keeping fit, taking care with her weight) to attain the best quality of life. Then having suffered a heart attack she has felt cheated and is bewildered by the outcome in her case. Having followed the regimes that ought to have offered ‘protection,’ she faces the dilemma of dealing with those moral judgments (both her own and other people’s) that are directed at the ill in a climate of health promotion and disease prevention discourses.

Some individuals feel their own unique circumstances put them on the fringe or even outside a discursive construct (or common recipe for maintaining wellness), resulting in feeling exempt from the ‘healthism’ discourse (Lupton 1995). It may be perceptions of ethnicity, gender or chronic disease status that produce this upshot. The public are exhorted to assess their own risk then to make choices and behave in ways that contain/limit the potential for disease to develop. Lupton (1995) describes one aspect of risk discourse as a consequence of ‘lifestyle choices made by individuals, and thus places the emphasis on self-control’ (p. 77). The case of MHT raises a dilemma where medicine has caused harm by persisting in promoting a therapy that was not sufficiently safe, and women have been exposed to iatrogenic disease (Burrell 2009; Krieger et al. 2005; Sackett 2002). Sackett (2002) admonishes his peers, stating preventative medicine has been ‘aggressively assertive, pursuing symptomless individuals and telling them what they must do to remain healthy’ (p. 363).
Quality of life is framed for us in some senses by the public health discourse (Lupton 1995), and in another sense it is discursively constructed as attained via individual fulfillment of any desires, for good health, drive for accomplishment, wealth or possessions. In this sense it is self-defined.

5.7 Professions and politics of MHT
This section discusses the mechanisms deployed to promulgate a discursive construct using the hegemony of science (anchored to the professions) and yet at the same time science is selectively dismissed. A new wave (a second wave) of ‘aggressively assertive’ medical practitioners has persisted with promoting MHT, despite health departments the world over advising prescribing the smallest dose possible for the shortest time possible for symptom control only. Shapiro (2007) of the International Menopause Society (IMS), when assessing epidemiological methods and results of recent studies, concludes that the response to the initial 2002 WHI and HERS study findings was an overreaction. He makes this claim based on his view that there is inconclusive evidence to prove various indices regarding risk. Shapiro calls into question the findings of WHI and the Million Women Study (MWS), although he concludes his article by suggesting that any future studies would need to explicitly confirm risk or benefits. Therefore he is not able to resolve the questions and issues around existing results and calls for further research. In his view, however, unless the issues of concern to him are attended to, the findings of the large RCTs (WHI and MWS) that have been published cannot be dismissed.

Interestingly, Shapiro’s conclusion contrasts with an article in the British newspaper, the Daily Mail, where Sturdee (also of IMS) is quoted as regretting a dramatic drop in HRT prescriptions since 2004, lamenting clinicians’ caution in the light of advisories (Hope 2007). The article states that the IMS is opposed to current guidelines, a position that minimizes and dismisses the warnings that governments and other scientists stress. Sturdee is quoted in the headline of Hope’s article ‘One million women “have needlessly abandoned HRT.”’ It can be interpreted that Sturdee’s position blames women for being cautious whilst working to distance doctors from responsibility for no longer prescribing HRT to many women (Hope 2007). There are several issues to note here. Firstly, there appears to be inconsistency in the position of IMS on the issues, including the weight accorded to evidence-based medicine, its use and whose interests are being served by it. Secondly, given the IMS have labeled governmental advisors ‘scaremongers’ for offering what they consider conservative advice, the public is left to wonder ‘who are the
scaremongers? when internationally prominent organizations take such a stance. Thirdly, the IMS asserts a position in which women are assigned responsibility for no longer taking the therapy (having responded to advice following revised guidelines), and fourthly, the loss of large numbers to medical oversight for HT is lamented (Hope 2007).

Although similar organizations exist in OECD countries, the FDA has regulated the use of the most common estrogen products, Premarin and Prempro. Using Foucauldian analytic features (see page 39) it is useful to analyze the role of the FDA as an example of a state apparatus in the regulation of MHT. As described earlier, the FDA is an agent in pursuance of public health imperatives set by US legislation on the safety of drugs and medical devices. As such it proposes acts to regulate medicine and medical devices, expounds policy, issues regulatory statements, and disseminates advice to health professionals and the public. The FDA’s mechanisms of operation are the creation of regulations and guidelines, providing approvals and rescinding approvals, and the dissemination of warnings and advice to practitioners and consumers. Therefore it is involved in the production of discourses of drug safety, risk reduction and avoidance, therefore molding public health discourses.

The FDA deploys various tools and apparatus to achieve its goals. Consensus decision making is one technique of the FDA in formulating policies and guidelines. Consensus meetings follow evaluation, where manufacturers supply information via ADAs and NDAs - expert panels review trial outcomes and technical scientific data, to make decisions on the efficacy and safety of products.

The public health discourses are reproduced and repeatedly signaled via codification systems, health professional and patient inserts accompanying products, practitioner information, and black box warnings. Other signs that cement and reproduce public health discourse are the use of incentives as a form of coercion, and lastly the FDA’s ability to institute regulatory mechanisms and pursue criminal proceedings to ensure public safety and the efficacy of products. As noted, other countries have set up similar systems to protect their populations.

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13 EMA, MOH NZ, Medicines and Healthcare Products Regulatory Agency(UK), German Institute for Quality and Efficiency in Health Care, Australian Drug Evaluation Committee.
Applying the third analytic feature of the power/knowledge nexus to the FDA’s role in public health discourses, the sciences (population health, epidemiology, pharmacology, science of experimentation) and health professions are foci. The scientific method cited within recognized disciplines with its own measures for proof, efficacy and evidence govern conduct. The rigor and conformity to the method produces affirmation in others. The discussion below on the present crisis in epidemiology that arose from research on MHT evidences my point. The discipline of health ethics is a discursive practice which operates at all levels of the MHT saga, where clinicians, scientists, feminist researchers and public health advocates have questioned practice and debated issues (note the earlier discussion on bio-identical hormones and Krieger et al.’s (2005) critique on the uptake of MHT). The stance the FDA took in regard to providing black-box warnings (inserts) on oral contraceptives directly to consumers, despite complaints from both drug companies and doctors, can be viewed as driven by ethics.

The objects of public health discourse are populations, individuals, and professionals. Public health messages become moral regulators for individuals. The participants regulate themselves and doctors iterate regulation of the self. The self in public health discourse is disciplined in diet and exercise, participates in preventative measures and monitoring, and is knowledgeable about their genetic traits/tendencies regarding potential for disease. As noted earlier, the subject, in a post structural conception, is capable of resisting discourses. The subject is betwixt and between many competing, complementary and divergent discourses, and is therefore continually positioned and repositioning itself in this dynamic mesh of moral imperatives, fulfillment of desire, and knowledge of their bodies and inherited characteristics (Foucault 1976/1990).

5.8 Crisis in epidemiology.
Not only is the plethora of conflicting information and views on MHT and its effectiveness confusing for women, but it has created discussion, even consternation and reconsideration of methods for epidemiologists and bio-statisticians (Hernán 2010; Pettiti and Freeman 2005; Prentice, Langer, Anderson and Barad 2005a). Discussion on statistical adjustment, the hazard ratio and clinical trial monitoring methods have been reconsidered in the light of the Women’s

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14 See discussion of insert warning on page 65. In 2003 the FDA issued the ‘black box’ warnings on estrogen products, and revised prescriber and patient information and warnings (FDA 2011).
Health Initiative randomized clinical trials and observational studies. Seven commentaries (Barrett-Connor 2004; Kuller 2004; Lawlor 2004; Petitti 2004; Stampfer 2004; Stampfer and Colditz 2004 #529; Vandenbroucke 2004) appeared in the International Journal of Epidemiology (Vol. 33) in 2004, all concerned with the methodological dilemmas raised by the study of MHT. Researchers for the Women’s Health Initiative presented two detailed discussions of their concerns on statistical issues and methods in 2005, although the papers had been submitted for publication in 2004 (Prentice, Pettinger and Anderson 2005). Their paper in the American Journal of Epidemiology, submitted in September 2004, concerned discrepancies between their observational and trial data (Prentice et al. 2005b). The papers followed the publication of the findings of the trial after its early termination due to safety concerns. Differences in outcomes due to research design were the catalyst for heated debate on statistical rigor and interpretation of results for both RCTs and observational studies. Clinicians and researchers took a hard look at their past activities as the ethical aspects of prescribing MHT were questioned. Several far reaching meetings of minds took place as the issues of MHT were grappled with, and collaborative efforts were initiated to offer guidance in the confusing milieu surrounding menopause.

Firstly, in June 2004 the Radcliffe Institute for Advanced Study, Massachusetts, convened the seminar titled ‘Hormones, women and cancer risk: professionals and activists facing “miracle molecules”’ (Krieger et al. 2005). The group comprised academics, researchers, lay women’s health advocates, historians and clinicians, and they traced the events and trends from the discovery of estrogens to the contemporary period, starting with the thesis that despite it being known and reported repeatedly that ‘biological, clinical and epidemiological evidence emphasized risks’ and discounted ‘purported benefits,’ prescribing estrogens surged over the decades (p. 741). The seminar attempted to resolve the question of why a product known to be carcinogenic since the 1930s was promoted for decades from the 1960s. The seminar found that the influence of politics and values on scientific discoveries cannot be understated and has had detrimental effects on people’s health. Their final warning is that there are no shortcuts to safe therapies (p.746). Secondly, the Agency for Healthcare Research and Quality (AHRQ) commissioned a technology Assessment (Number 120) into the management of menopause related symptoms (Nelson et al. 2005) to reassess the evidence on estrogens. The purpose of the report was to guide the development of clinical practice guidelines. It was prepared for the National Institute of Health State-of-the-Science Conference on Management of Menopause-
Related Symptoms, held in March 2005, which compiled a consensus statement on the topic (NIH State-of-the-Science Conference Statement on Management of Menopause-Related Symptoms 2005, March 21-23). The consensus statement encourages researchers to utilize the same standardized measures when studying menopause, as the inability to pool results from many years of studies of disparate design has polluted knowledge. The debate has not abated with Hernán raising further comment in 2010.

Some proponents who were cynical about safety warnings and seized on the climate of controversy (for example, as detailed above) to undermine the messages about risks and are not deterred from continuing to promote MHT. At times they have taken small aspects of the issues under debate and used them to promote their own view, for example, as Willow recounted her doctor saying ‘these studies were done in America on unhealthy, oversized women,’ implying that the results did not apply to women in general. It is a gross leap to simply dismiss the study findings (with an inaccurate judgment on the sampling strategy), and on this basis give advice contrary to health departments worldwide. It appears some doctors promote their personal views in the guise of ‘science-talk’ that inevitably has the power and weight of the profession, subsuming the woman’s own knowledge and the complex consideration which are needed in informed decisions. How are women to discern the difference between a personal view as opposed to a professional view? In a consultation it is only reasonable that patients believe that a professionally agreed position is being recounted to them by their doctor, not some casual comment that is out of step with professional opinion.

From the analysis of the object fields in this chapter it appears Public Health Talk holds many imperatives that people feel pressure to follow. The women’s narratives echo some of them; to be the healthy citizen, to be engaged in preventative activities to lower risk factors, and to be vigilant and self-responsible. The narratives revealed the considerable thought and effort women put into meeting these imperatives, despite the obstacles about the trustworthiness of information and the diversity of opinion to navigate. The quality of life discourse had an apparent synergy with these imperatives. Striving for ‘quality of life’ held its own imperative for some women who placed meeting health imperatives and life imperatives as complementary.
CHAPTER SIX: FINDINGS AND ANALYSIS. Organizing Category Three: Reframing MHT

Forty years’ worth of feminist theorizing and activism has successfully dissected the social cultural milieu in every area of women’s lives. Participants in this study were part of a generation affected by the women’s health movement – a movement characterized by a desire for health information, reproductive politics, activism, and effecting change toward equal rights for women. Where discourses of aging and menopause have been negative and stereotypical (often mediated by the biological sciences and medicine), advocates within the women’s health movement have sought to disrupt and counter the culturally embedded negation of the older woman (Bell 1987; BWHBC 1971, 1973; Coney 1991; Greer 1991; Sampselle et al. 2002; Shildrick 1997).

Shaped by Foucault’s view of subjective bodies and how they are inscribed by events (taken in the broadest sense in which they are always already signified), and by discursive constructs which order cultural and societal structures, in this chapter I apply feminist post-structural perspectives in the genealogical tracing of discourses and practices informing peri-menopausal women about their health. I explore connections to historical signs, contested authorities and strategies of control regarding women’s bodies (Andersen 2003).

In this chapter two data sources (text and interviews) are analyzed. A discourse analysis of the Boston Women’s Health Book Collective’s (BWHBC) publication in 2006 titled Our Bodies, Ourselves: Menopause (OBOM) is interwoven with analysis of the participant interviews.

6.1 Positioning the text - Our Bodies, Ourselves: Menopause
The preface states the aim of the OBOM book was to provide women with the latest scientific information that ‘they can understand and use’(2006, p. vii), and expresses the Collective’s desire to place the event of menopause in both a social context and the context of the shared experience of women’s lives, not see it as an isolated event. The mild reference to ‘social context’ belies the unapologetic way the authors critique elements within the health establishment, from US government departments, insurance and medical practice, to the pharmaceutical industry. The authors rapidly establish the point that menopause is a natural
process and not a disease. The introduction informs readers that the book is about women, for women and written primarily by women (BWHBC 2006, p. x). The authors made a deliberate choice to use the inclusive ‘we’ as a counter to the third person adopted in medical references to women, thus ‘rejecting the distancing voice of some medical texts’ (BWHBC 2006, p. x). The notion of the ‘patient’ as an object to be written about is dismissed in favor of the all-inclusive women as ‘we.’ The authors inform the reader that by using ‘we’ the diversity within womankind is acknowledged by inclusiveness, although in doing so, using ‘we’ can be seen to imply a homogeneity that may not be present.

The early BWHBC publications (1971, 1973) were overtly those of a radical group, reacting to the medical and doctor orientated material that wrote about women and not for women. The BWHBC expressed their reaction by being proactive, producing Our Bodies, Our Selves: A Book by and for Women. The propensity of the BWHBC to promote themselves as ‘women writing for women’ co-opts a women’s standpoint approach as defined by Alison Jaggar (1988). In the first instance, the approach is decidedly ‘feminist,’ and secondly, the position taken re-conceptualizes knowledge and ideas to, in Jaggar’s words, ‘reflect the interests and values of oppressed groups and so constitute a representation of reality from an alternative to the dominant standpoint’ (1988, p. 370). In the conclusion to her exploration of feminist thought, Rosemarie Tong positions standpoint feminism within socialist feminism, concurring with Jaggar that it is a workable theory from which women’s causes can be advanced (Tong 1989). Although this position is useful and later I draw upon it as an explanatory lens, there is the post-structural objection that cannot be ignored, explored by Jane Flax (1990), that standpoint theory ‘rests on problematic and unexamined assumptions….including the optimistic belief that people act rationally in their own interests and that reality has a structure that perfect reason (once perfected) can discover’ (p. 56), an idea which itself rests upon a unified conception of the social subject ‘woman’ that aims to confront male domination from essentialist position. The authors of OBOM tend to write as though readers will make rational decisions in the best interests of staying well and maintaining health.

The Collective’s work generated a women’s alternative to male dominated medicine that in the Collective’s view (in the early 1970s) produced a knowledge and science of women and women’s bodies that was aimed at medical and pharmaco-scientific professionals as opposed to women themselves. The BWHBC sought to make women visible and legitimated as the audience of
references and depictions about women and women’s bodies. This move is in contrast to the artifice of medicine that asserted its authority over all things bodily by claim to its expertise, an endeavor elucidated by Rose (1996) as ‘legitimation of social power through claims to possess esoteric knowledge and technical capacities not available to others’ (p. 84).

Women’s standpoint position (or lens on the world) is not uniform or even agreed, although the concept does encompass the phenomena of female solidarity, the entity of a sisterhood, and the initiation of women-only organizing (Jaggar 1988). Therein is captured the idea of an alternative to the male dominated societal structures and organization, and an alternative from which resistance to oppression arises. Where liberal feminists seek change within existing systems, and Marxist feminists seek change through overthrowing a gendered class system, standpoint feminists seek change through asserting the standpoint of women to counter the exclusiveness of the male domain of medical and social expertise. The authors do express commitment to the marginalized and underprivileged by addressing poverty and critiquing the American health and insurance system, coaching readers on ways to organize collectively to overcome fiscal and systemic disadvantages.

A group of women formed the Collective after attending a women’s conference in 1969 in Boston, ‘one of the first gatherings of women meeting specifically to talk with other women’ (BWHBC 1976, p. 11). The group continued to meet from the common perspective of seeking ‘to do something about those doctors who were condescending, paternalistic, judgmental and non-informative’ (BWHBC 1976, p. 11). From this beginning BWHBC sought to produce health information for women that put women as the central concern and with women as the target audience.

A rhetorical feature is the adoption of the use of ‘we’ throughout the text. As noted earlier, this has a tendency to homogenize all women, as the ‘we’ is used in a collective way, speaking of authors and the subjects of writing collectively. There is reflexivity about differences between women: age, sexual orientation, race, class and ethnicity. That seems to reveal what standpoint theorists would call an alignment to socialist feminism¹⁵, yet such a stance is not always overt in

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¹⁵ Alison Jaggar (1988) defines the socialist feminist position as follows: ‘(s)ocial feminists believe that a primary condition for the adequacy of a feminist theory, indeed the adequacy of any theory, is that it should represent the world from the standpoint of women….They believe that, in any historical period, the prevailing world view will
the text; where the book does give women information and description of activism and change initiatives (Chapters 19 and 20), the authors do not expound the political or philosophical underpinnings, other than to state that ‘knowledge is power’ BWHBC (2006, p. 295). Another feature of the textual structure of the text involves its organization, with a main text and subtexts presented as vignettes, inserts that contextualize and politicize topics, and boxes titled Myth or Reality? to dispel populist notions with hard facts and individuals sharing personal experience. Use of insert boxes and subtexts could be read in different ways, either as highlighting issues validating both activism and resistance to patriarchal biomedical-science and information, or diminishing the import of the information as it lies ‘outside’ the main text.

A separate textual feature is the quotations embedded and italicized in the main text. The italicized quotations are taken from a survey of women’s views and presented throughout the book, and it appears the women’s voices are used to set the context of chapters. In this way varying viewpoints are foregrounded in an egalitarian style with heterogeneous representations in women’s own words, thus cementing the point that individual views count for their difference from one another in a text where expressing inclusiveness is a goal. The use of diverse textual features permits variable ‘readings’ of the text: the personal and political provocations are included, but as asides from the main text.

The book provides a social context to health care, acknowledging the continuing fight against ageism and sexism (OBOM 2006, p. x). The authors promote self-help in quite radical ways, and alternative knowledges are presented on an equal/impartial footing with medical, preventative and epidemiological health information. The section titled ‘Making healthcare decisions’ informs women of their rights, but also alerts readers to the continuing need for vigilance and the importance of researching for themselves the evaluation of their symptoms as well as the efficacy of treatments. Language use is also critiqued, for example, commenting that the medicalization of menopause occurs when body function alteration is named a ‘symptom’ rather than a ‘sign’ (OBOM 2006, p. 21). A further critique is that the use of the phrase ‘side effect’ implies an effect is a side issue, when it is actually a direct effect of a medication and can be devastating (2006, p. 21). This section also contains a critique of the status of ‘evidence,’ as referred to by

reflect the interests and values of the dominant class. Consequently they recognize the establishment of a less mystified and more reliable world view will require not only scientific struggle and intellectual argument, but also the overthrow of the prevailing system of social relations’ (p. 370).
the term ‘evidence-based medicine’ (2006, pp. 24-25). So in these senses the book is revealed as critical, feminist and even radical in intent. However, there is an aspect of parochialism in the book. As an American publication, its discussion of the health system, access and funding regimes, and medical insurance apply to the United States only.

Two significant discourses emerge from the OBOM text: a feminist health discourse and a public health discourse in which individual responsibility and preventative approaches feature comprehensively. The public health discourse echoes the discursive constructs presented in the previous chapter of this thesis, where prevention, risk reduction, health promotion and population epidemiology are cornerstones of the discourse. OBOM relies heavily upon the US National Institute of Aging and the Office of Medical Applications of Research of the National Institutes of Health statement on The Management of Menopause Related Symptoms published in 2005 (NIH State-of-the-Science Conference Statement on Management of Menopause-Related Symptoms 2005).

Feminist health discourses emerge as counter and resisting discourses to traditional medical discourses (Foucault 1976/1990), and are not only concerned with health matters but extend to such issues as ageism, sexism, relationship matters, inner worth, and financial security, thus addressing the context of women’s lives. Given that women are knowing subjects, the discourse usurps the medical discourse which created a divide between doctor/patient, where the doctor was the knowing active subject and the patient (particularly a woman patient) the passive recipient of assessment and treatment. During thirty years of proliferation this discourse has infiltrated and altered medical discourses, as some medical professionals participate and question past assumptions, accepting patients as knowing individuals with whom health care decisions can be made in collaborative rather than dictatorial ways (Krieger et al. 2005). Some concepts are common to both discourses. Self-responsibility, for instance, is an element expounded in both discourses, albeit in a more narrow application within the public health rather than within the feminist discourse.

Through reading the women’s testimonies alongside and against the OBOM text the following object fields were identified:

- information is knowledge
- menopause exacerbated by other life events and health issues
- women as self-managers of well-being
- the right to choose
- women as judicious recipients of health care
- positioning the patient as consumer
- reframing aging and self-appreciation

The major discourse arising from the texts, as will be shown, is the feminist women’s health discourse. In presenting the analysis I move between the sets of data to elucidate the feminist women’s health discourse and its constituent parts, although always keeping in mind that discourses and their elements are not static rather have shifting boundaries, are fluid and changeable.

6.2 Information is knowledge

A new genre in the patient/doctor encounter was promulgated from a feminist health advocacy stance to shift the style of encounter between ‘doctor/patient’ to a consultative interaction, more conversational between equals (of sorts) in any interactions. The players are equal but different as the knowledge bought to the encounter is different, yet both knowledge sets ought to be valued. Texts such as the BWHBC’s are part of women’s health politics, broadly communicating that women are entitled to accurate health information.

Some of my study participants reveal that they are aware of the scientific developments on MHT, with a few having knowledge of physiology which ranged from sparse to considerable. Some of the women expressed confidence about their knowledge, and viewed learning as a continuing endeavour in looking after themselves. The women reported their search as an on-going quest for knowledge.

Ruby: I was perhaps a little bit more fortunate than other women [holds a qualification in medically related sciences], you weigh things up, read the medical journals.

Tansy: I do read anything about it [MHT]. Time magazine does quite a few, from time to time, there was one about 2 months ago, talking about HRT and the risk of cardiovascular disease I think it was…every now and again they would have a public release or a notice on TV about it, another research study would come out and they would…and it always seemed to be pointing towards this suggestion that it [MHT] maybe caused breast cancer. So because of that and because of my having that long history of breast problems I just thought I am just not a good person to have it. (57yrs old, natural menopause. Took Remifemin (OTC) for 6months).
The women reported their search as an on-going quest for knowledge.

Aster: I know, you can talk to a number of people and you can get a different version or opinion from them and then you end up with about three lots of opinions and you think well which one is right. You just have to keep reading and then try and weigh that up and work out for yourself what’s more important because you know the quality of life…I mean I am looking at 5 years on HRT… but you do have to look at the quality of your life and it affects your mood, what problems you have and weigh it all up I think. (53yrs old. On bio-identical hormones for 3yrs, and at interview).

Valerie: It was a specialist consultation and I had to pay for it [HRT] because our health insurance only covered surgery so it was my decision. So she weighed me and ran tests etc etc…um…basically her advice was that I should take HRT. It was at that time there was an awful lot of controversy about whether HRT was good or was it bad. My doctor had put me on it briefly and I had taken it for about a month and then all this other stuff was…. Information in the paper made me think….No I don’t think I am prepared to [be on it]. (54yrs old, never taken HRT, took Remifemin briefly).

Another participant had had been a victim of the Dalkon shield\textsuperscript{16} debacle in New Zealand, which made her determined not to be deficient in knowledge about things medical or her body again.

Sylvia: I took a claim against the manufacturer and got some funds (in compensation). I had all my notes; the specialists, the GPs I had seen. It was probably the first time I had seen all my notes and was bold enough to see what was written, how they described you etc., and how they get it wrong sometimes. Much nicer nowadays to be able to freely talk to your GP…you have to keep communicating….I kept up reading, enjoyed Sandra Coney’s [Coney 1991] book. I was wary…. I must say I felt pleased that I had been right, for me to be cautious about it [MHT], when they did come out with the findings that it perhaps it wasn’t a good idea long term. (65yrs old, postmenopausal, never took MHT).

On questioning, some participants were clear about aspects of the Ministry of Health guidelines on monitoring and the parameters of the recommended period to be on MHT.

Iris: In the last two or three years I have tried to wean myself off it, the doctor said he was trying to limit it [MHT]. (57yrs old, on MHT for 12yrs, taking MHT at time of interview).

Several women mentioned they were weaning themselves off MHT. Two women were using the guidelines timeframe as their own parameter.

\textsuperscript{16} Phillida Bunkle’s book outlines the Dalkon shield debacle for New Zealand women where a successful class action was taken by women against manufacturers (Bunkle 1988).
Briar: I would never take it long term. Five years I am happy to take it but after that no way. (50yrs old, On MHT for 1.5yrs and at interview. Has had heart attack and is on warfarin to prevent blood clots).

Aster: You just have to keep reading and then try and weigh that up and work out for yourself what’s more important because you know the quality of life…. Of course I had lots of blood tests and all that sort of information... I mean I am looking at five years on HRT. (53yrs old. On bio-identical hormones for 3yrs, and at interview).

Others found the need for regular monitoring tedious, seemingly unaware of the balancing of risks versus benefit that monitoring tracks.

Several women’s scripts (Ruby, Tansy, Rose, Briar, Daphne, Holly, Scarlett, and Aster) revealed they took learning about health, diet and exercise seriously and had read widely.

Briar: I am very fit, I had been to the gym for an hour that morning, I was extremely fit and I used to run up to [name] mountain and back…um… I have always watched my diet.

Sylvia: I am very interested in health matters, what we eat and supplements we take.

Daphne: So I don’t think it is just one thing, I think it is a combination of things. Keeping your hormones balanced, keeping your exercise up and keeping a balanced diet really. I think those three things…is a lifestyle to maintain the um…the ability to snowboard, to play squash and all those things. (55yrs old, took HRT for 4 years, changed to bio-identical hormones for last 3.5yrs).

Scarlett: Yes a balanced diet, fresh produce…because my feeling is that if we ate seasonally we would get all the nutrients that we needed at the best value. (On MHT for 7yrs.)

The excerpts above point to a lifestyle discourse that links with a healthiest discourse promoted to us in myriad forms. One participant regrets not following advice that she knew was in her best interests as she did not appreciate the import of monitoring.

Rose: …anyway she said to me after a month I was to go and get my blood pressure taken, and I was a bit naughty and I didn’t. (55yrs old, on MHT for 3 years, stopped one month prior to interview due to having a stroke, had been treated for 13 years for hypertension).

Cherry struggled with differing advice from various doctors.

Cherry: But it is amazing, you know when I had my hysterectomy I was just given this medication and I didn’t sort of ask questions at the time. I just took it because I thought that was what everybody did after a hysterectomy. And so I just kept on taking it. And then I thought well I had better find some information about this….But I think 20 years is probably a long time to be on it…So I have my battles ahead with these new young doctors that I am old enough to be
their grandmother. But I just think we are very lucky that we have a choice….I would like to get
a year’s supply and be done with it before I have to face up to it [going off MHT]. I almost feel
guilty really taking it. But then I think why should I? It is my choice, it is my body isn’t it? (62
yrs old, had hysterectomy 20 yrs ago, retains ovaries, on HRT for 20 years).

The intent of the slogan ‘My Body My Choice’ is taken up by this participant, although with a
militancy that is a little at odds with the rest of the quotation where she reveals diffidence about
the best course of action for her.

The political slogan ‘My Body My Choice’ asserted the rights of women to choose. It is
representative of the wider movement for societal and cultural change that characterized feminist
activism. It resists medical control and ‘ownership’ of people’s bodies, and laws that restrict
access to contraception and abortion (BWHBC 1971). Originally the phrase was a reaction to
traditional health systems and conventions within medicine and society that limited or foreclosed
choice (for example, many doctors limited access to oral contraceptives to married women only
in the 1960s), whereas now, where a plethora of choice exists, the phrase is co-opted to assert a
personal desire rather than resistance to a systemic barrier. The phrase has become enmeshed in
the lifestyle and healthiest discourses often both promoting and in turn drawn upon to justify
choices and as motivators to activity toward bettering one’s life circumstances.

6.3 Menopause exacerbated by other life events and health issues
In the excerpts below women relate how menopause was compounded by other somatic concerns.

Iris: I was just up and down. I was not getting the sleep. And I was in a ...um...stressful
relationship....And I sort of thought right I have got to do something about this....and then my
doctor said straight away....I sort of knew what he was going to say.... He said ‘You need some
help.’ But I was still menstruating then so the Trisequens [combined E & P derived from plant
extract] keeps you menstruating. And then...um... so I started on that 12 years ago. (Iris had
abdominal pain with numerous investigative procedures during peri-menopause.) (57yrs old, on
MHT for 12yrs, taking MHT at time of interview).

Valerie: I didn’t have problems with hot flushes, I didn’t have major problems except that
probably the thing that I was really looking to find help with was my low energy levels, the fact
that I just didn’t seem to get as much done as anybody else, in my estimation and my doctor also,
depression to be quite honest. (54yrs old, never taken HRT, took Remifemin briefly).

Hardy and Kuh (2002) studied 1572 British women who were 52 years old in 1998 and reported
poor psychological health to be due to other life events rather than menopause.
Several women recounted seeking medical advice beyond their usual GP and some changed doctors.

Tansy: I actually went along and made an appointment with [gynaecologist] and had a really good sit down and discussion with her about what somebody like me should do to try and deal with menopausal symptoms ….I do have…increasing anxiety at times and I don’t cope so well with that and I think that couples up with the insomnia. So I went along to see [gynaecologist] and she more or less concurred with me that because of my breast history that HRT possibly wasn’t the best way for me to go. (57yrs old, on Remifemin for 7yrs and at interview).

Daphne, Flax, Scarlett, Cherry and Aster all actively sought out sympathetic practitioners for menopause advice whilst continuing with their usual GP for other concerns.

Women deploy strategies to explain their choices. Below, co-option of a scientific discourse justifies actions:

Daphne: And I feel better because the molecular structure of this is identical to what’s in your body. So the lock and key system works you know, it goes in and it doesn’t block it up. So it is just a natural lock and key for me. (55yrs old, took HRT for 4 years, changed to bio-identical hormones for last 3.5yrs).

The well-known explanatory metaphor of the lock and key used in teaching the action of hormones in the biological sciences is deployed by this participant. There is also a reference to the ‘naturalness’ of the product (an idea critiqued later in the section). This participant repeatedly referred to bio-identical hormones as useful to attain what she termed physiological levels. The word ‘physiologic’ has been seized upon by those promoting bio-identical hormones, and on analysis appears to infer revision of the criteria for ‘normal’ in the medical sense (Canguilhem 1978), using the term at odds with the normal decline of hormone levels with aging. Citing a ‘physiological level’ without reference to age is misleading, as a normal physiologic pattern is for levels of fertility hormones to decline with the onset of the climacteric.

Furthermore, the expression buys into a deficiency model about menopause where a change in level, if deemed necessary to restore, is by default a deficiency and by extension, disease. Such a position harks back to a take on menopause that much of science has left behind. Over the decades commentators have moved from naming hormone therapy for menopause as ET to HRT (where ‘replacement’ signaled a supposed lack) then to MHT, removing the word replacement and its implications. The defending of bio-identical hormone therapy by recourse to a deficiency

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17 The lock and key model of biochemical reactions explains the target cell concept where systemic hormones are released and are compatible with the receptor cell causing reaction (Thibodeau & Patton 1999, p. 485).
model is the old argument about hormone level changes due to age being categorized as deficiency under another guise, the outcome of which was to recommend replacement therapy for life (Burrell 2009; Wilson 1966). Not all participants taking MHT affirmed its effectiveness.

Willow: I don’t know what the miracle cure would be for the hot flushes. The patches [MHT] didn’t stop them and that is why I thought, what is the point of staying on them?’ (54yrs old, on MHT for 3yrs, stopped 6 months prior to interview).

Eight participants tried varying ‘natural’ products, and some found these effective.

Tansy: I told her [doctor] that I was taking that Remifemin with the Evening Primrose and she thought that was good. They don’t really tell you what’s in it. It has got the black cohosh or something. It says that it has been used for over 40 years by women in Europe and [endocrine specialist] didn’t seem to have any reservations about it. And I have always taken the Evening Primrose Oil because a doctor told me many years ago that it was good for breast lumps. (57yrs old, on Remifemin over 7yrs).

Rose: So anyway that was alright so I tried various things like the things you get at the Health Food shop …and including that Remifemin, which actually the doctors do recommend. But I tried that for six months but it didn’t actually do anything for me at all. I gave it a good go, twice actually, but it didn’t…I would say the second time I gave it about 5½ - 6 months so it still didn’t really do anything. And of course we all know what brings the hot flushes on of course…coffee, tea, alcohol. (55yrs old, on MHT for 3 years, stopped one month prior to interview due to having had a stroke).

Some women found over the counter (OTC) products ineffective.

Willow: I did go back to the Remifemin (about 6 months ago) from the Health shop but I didn’t buy a second packet because that didn’t make any difference either really. So I have been taking nothing at all. (54yrs old, on MHT for 3yrs, stopped 6 months prior to interview).

Briar: I can’t go on the natural…um…cos I went on the natural Remifemin…. And I went to…um… a nurse said to get off it, you can’t have that when you are on the Warfarin, so I got scared and went off that. So Warfarin, there are a lot of things you can’t take with it...there is something in that…. I mean I would prefer to be on that, something natural, than this stuff….I hate it…it scares me….I mean I love it….I have a love hate relationship with this…what I am saying is I love it because I don’t get the sweats but I don’t think that is the right one because I mean I am not sleeping, I feel my moods are fluctuating. (50yrs old. Consultation in 2005, on MHT for 1.5yrs, on MHT at interview).

Tutu and Valerie discussed taking OTC products with their doctors.

Tutu: I started taking Evening Primrose, because that is what everyone said to take. That went on for quite a while and my doctor was aware of it. Then I started getting hot flushes…. I tried all
sorts of things, went to a naturopath, [given] Chinese herbal things – they tasted disgusting! Nothing really worked and the doctor just let me try these things [laughs]. And then we decided that enough was enough and I would go on HRT, the lowest dose. And things have settled down nicely. Then there was this big hoo-ha in the media about HRT and how dangerous it was. (57yrs old. On MHT for 6yrs and at interview.)

Valerie: I decided, no, I was really not comfortable about this HRT and what the newspapers were saying about it. So I tried Remifemin, which is a naturopathic that I brought at a health food shop. I tried that for a couple of months and quite frankly it didn’t make much difference. And then I think I… I am trying to think what else I tried. I think there was something else…wild yam or something else was recommended. I actually talked to…name [an endocrinology specialist]…about that and [the specialist] was very sceptical about its use or benefits. So I must have taken the wild yam before I went. [The specialist] did not think much of it so I stopped it after that. Basically I just continued with …um…Rescue Remedy when I was feeling anxious or stressed, that seemed to be most helpful. (54yrs old, never taken HRT, took Remifemin briefly).

As we saw in the earlier chapter an appeal based on the ‘naturalness’ of a product arises from valuing products that have not been manipulated or refined, and signals something pure, untainted and therefore benign. The potential for harm is that unless a product has had sufficient research to verify its safety, it should not be deemed safe.

The women’s texts revealed they sought advice and searched out knowledge in various ways, requiring rationale for their actions. It is clear from the women’s narratives that doctors, other health professionals, texts and sources of health information mediated the women patients’ understanding. Confusion and dissatisfaction persisted if advice was unclear. Information is knowledge only if one has the background to approach a plethora of diverse information. The women’s health movement was a voice of resistance due to a patriarchal male-dominated medical profession in the decades up to and including the 1970s. Women could not depend on the advice of doctors who took a superior attitude, failed to explain processes in the body or treatment options fully, and excluded them from decision making. Having knowledge about their bodies gave women power over their own bodies, and the proclaimed intent of OBOM was to inform and thus empower women. Reciprocity between women and doctors is evident in some of the narratives, although not all. Specialist information is not the exclusive province of professionals any longer. Rather, a militant women’s health discourse is one among various intersecting discourses that have made the past exclusivity redundant (other discourses are a public health discourse, patient advocacy discourse, health ethics discourse and post modernism). Over recent decades information that was guarded and held by the professions is readily available, and in the
women’s health arena the collective was instrumental in accomplishing ready access for the public.

Within the title of the last section of OBOM, the Collective advanced another term, ‘Knowledge is Power,’ that is an extension of its precursor ‘information is knowledge,’ and this can be interpreted to mean the knowing subject is therefore a powerful subject (BWHBC 2006, p. 295). Traditional boundaries around knowledge and professions have been breached and Foucault’s analysis on power informs the changes in the utility of knowledge, a point that will addressed in the discussion chapter.

The authors of OBOM state the book is a ‘valuable discussion of the most up-to-date information about menopause’ and ‘each chapter will help readers analyse information and apply it to themselves’ (p.vii). The introduction claims it contains the ‘best available evidence’ and ‘trustworthy information,’ and that the Collective categorically ‘reject(s) the medicalization of women’s natural life transitions’ (p.ix). The book is authored by a large collection of experts (women and men) in relevant branches of women’s medicine, nursing, epidemiology, sexual health, aging, endocrinology, psychology, women’s health advocates and health research. As already indicated, the authors are overt about the fact that the book relies heavily on the 2005 NIH State-of-the-Science consensus statement. Best practice information is claimed to be based in systematic review of literature and expert assessments of current knowledge: information is pooled to gain what is collectively ‘known’ about a subject. Important to note here is that the concept of ‘best practice’ is itself a construct and open to post-structural challenges. The OBOM publication claims to provide the ‘best available information’ at the time of writing, and readers are advised to take into account new information in making health decisions. As a text OBOM has changed the landscape of writing on the menopause; it is considerably more comprehensive than other publications and attempts to speak to women in the wholeness of their lives as mid-life women. It makes the current debates on facets of the menopause overt for readers, and it informs women about political activism aimed at advocacy for better information and resources to enhance participation in the maintenance of their health. In this way it is avowedly feminist, with intent to change the patient/doctor interface, communication, and balance of power relations.

18 ‘Best practice’ guidance involves consensus decision making (that particular element of treatment and prescribing guideline formation is critiqued later in Chapter 7).
To Foucault knowledge is generated out of a ‘relation of struggle, domination, servitude and settlement’ (Foucault 2002, p. 9). As it is for the pupil to instruct the teacher, so it is for the patient to instruct the doctor: it is an upset of a so-called ‘natural’ order. Foucault advanced the power/knowledge nexus to explain how a regime of practices (such as the practice of medicine) comes to be in the first instance prescriptive and then subject to questioning and precarious (Foucault 2002). As women come to the patient/doctor encounter with more knowledge, the balance of power is altered even though powerful players line up on one side of it.

6.4 Women as self-managers
The women’s interviews relate their participation in self-help activities, how they strove to enjoy the best possible health (avoid overweight, eating for health), how they were well versed in the messages to keep fit, and were motivated to seek out solutions, thus assuming self-responsibility for their personal health concerns.

Sylvia and Ruby are very clear about their approach to health decisions.

_Interviewer: so you seem to have a reasonable knowledge of your own physiology._

Sylvia: Yes I have always been interested - I did some [human science] training some time ago. It is a passion of mine - being informed. We are at the time now, my GP and I talk and things and we choose, I make an informed decision for myself - like I choose not to have mammograms and that is my decision. It is not that I am against all things medical I just like being informed. I have all my Pap smears and things like that. (65yrs old, postmenopausal, never took MHT).

Ruby: I think it’s all part of that attitude to take responsibility for your own health and if there is something that you can do which will benefit your health then OK. If it has negative side effects you look at those and weigh them up but if you perceive the benefits to be greater than risks…then take HRT. (63yrs old, on MHT for 7 years).

Here Ruby expressed a pro HRT stance in balancing what she viewed as risk vs benefits.

Tansy gleaned knowledge across the years.

_Interviewer: So where did you learn that…find out that there was a connection to breast cancer?_

Tansy: I think I slowly just gleaned it over the years. I don’t ever remember a specific time when I found that out. I think I would just read the odd thing in the paper. even years before I was coming into menopause myself. (57yrs old, natural menopause. Took Remifemin (OTC) for 6 months).

_ Interviewer: So it was sort of incidental?_
Tansy: It was really, every now and again, they would have a public release or a notice of TV about it, another research study would come out and they would…and it always seemed to be pointing towards this suggestion that it maybe caused breast cancer. So because of that and because of having that long history of breast problems I just thought I am just not a good person to have it unfortunately.

Tansy explained that she had sought specialist advice about her breast problems of her own volition. She put herself on Remifemin 7 years ago and takes it on and off. Iris reflects how decisions making can be multifaceted.

Iris: So I just had myself to look after because…I think I started to get…my life has become a lot more stable [after a change in her relationship]…and I am not working at all now…so I am just so…I have never been so relaxed before [laughs]…I have some days but I think they are soul searching, not for the HRT, but for other reasons. Where I am going? And those sorts of things. So it is really hard to link those things up to your absolute health. Because I believe those things like menopause are exacerbated by your personal situation. (57yrs old, on MHT for 12yrs, taking MHT at time of interview).

Below quotations from three women show their efforts to seek answers and solutions had not been helped by the lack of, or confusing (even conflicting) advice they received on occasions.

Briar: I have been told about nothing, my doctor was that keen. I mean I went to see her/him and she/he was in the drawer pulling out the HRT, telling me to take it and I said I won’t take it because of my Warfarin and my blood clots. So she/he never gave me…we never really discussed it. I went back when the symptoms got worse, and she/he gave them to me …a low dose…and I took them basically. I do know there are some doctors that won’t give you HRT. (50yrs old, on MHT for previous 15mths).

Willow: I was really worried so I went to the library. My father had a heart attack at 49 and I was really worried because things kept coming in the papers about how bad they were, how bad hormone replacement was. That was the one thing he (GP) did tell me that it would be quite good for me in that sense because it could prevent a heart attack as such. (54yrs old, on and off HRT over 6 yrs, stopped 6mths prior to interview. Consultation in 2004 after a hysterectomy).

Interviewer: When was that – that he told you that?

Willow: That was when I first went on HRT, about six years ago. I did go to him [my GP] and tell him I was really worried because things kept coming in the papers about how bad they were, how bad hormone replacement was. That was the one thing he (GP) did tell me that it would be quite good for me in that sense because it could prevent a heart attack as such. (54yrs old, on and off HRT over 6 yrs, stopped 6mths prior to interview. Consultation in 2004 after a hysterectomy).
bloody hell, it isn’t menopause.” That was why I went to the library. And when it came to menopause I still didn’t know. What is estrogen and things, I still don’t really know. I mean I have read about them at the library and that. That is where I am picking things up.

Interviewer: So you looked at some biology or physiology books on the body’s structure and function?

Willow: Hundreds, I would come out (of the library) with armloads trying to figure out what was going on.

Interviewer: What did you find at the library? Do you remember when you went there?

Willow: I went to the library first about 6 years ago when I started on HRT. The main thing I found was that it was comforting to see a list of my symptoms in a book that someone else had written. That they were common to other people and I wasn’t going through it alone. You get so scared, you feel like you have cancer or something like that, because you are so unsettled inside you.

Briar felt caught between differing recommendations by the hematology specialist and her GP and feels let down in her quest by conflicting information.

Briar: And then I went to my doctor and [doctor] said about HRT and I said “No” because I am on Warfarin, and my haemotologist (not that I see him now) said to me, “One thing you can’t touch is the hormone replacement.”

I said to my doctor about it and she said, “Well you are on Warfarin, you are hardly likely to get a blood clot if you are on Warfarin.” So I just thought well at that time the quality of life…. I mean I can’t lead my life if I don’t get something for this menopause. Then I get scared. And I do know that there is a chance on it that you can get breast cancer, I have been told that. But you sort have got to weigh up [information] what you do...a day doesn’t go by when I don’t think about, should I come off it and just go with the flow?

Self-help is interdependent on knowledge and understanding (as well as psychological status), and OBOM is very clear that the book provides information for women to use. In a feminist health discourse women are accepted as knowing subjects.

The discourse of self-help is expressed in many ways, whether by highlighting the benefits of reading and learning for oneself, accessing publicly available information, libraries, internet books, having a network of peers or ‘doctor shopping’ to obtain the type of health care service one ought to be entitled to expect. Moreover, self-responsibility is rudimentary to the public health discourse, therefore at times the two cannot be separated but feed one another in a circular complementariness (Foucault 1980). The women’s health discourse of self-responsibility is no longer illegitimate, and sits alongside, yet juxtaposed to professional (thus legitimated, even if eroded) discourses. So a power shift has occurred; power is not contained in one place and the
practices have changed, the rules of engagement have been transformed. The jurisdiction of medical power has altered (Foucault 2002). The discourse of self-help permits a new way of engaging, yet it cannot achieve entirely what it purports as individuals are reliant on medicine where interventions are in the domain of medicine via legislation (for example, prescription drugs, surgery and radiotherapy). What self-help does provide is a position of engagement where passivity is rejected, and the self-helpee is active in the relationship.

In OBOM a feminist frame infiltrates the discourses of Public Health; the idea of taking self-responsibility may on the one hand conform to the public health discourse, while on the other hand, it is congruent with the feminist standpoint position. It is a resistant strategy (to a traditional discourse with the doctor as expert and the patient as passive recipient) (Foucault 1972/1980). The feminist position affirms a woman on her individual life goals, and recognises that women are not homogenous but that there are differences between women, and that difference is acceptable and even valued. Standpoint theory by its very name posits that there is a distinct women’s ‘standpoint.’ The women’s health movement has reconstructed the reality of the experience of menopause, ensuring women’s interests are foregrounded and not subordinated to the ideas of men of medicine, who over previous decades conceptualised a system of health care that infantilised women and used a deficit model.

A necessary criterion in standpoint theory is that the representation of women’s bodies and health draws from the variety and multiplicity of all women’s experience. OBOM is a working model of standpoint theory as it attempts to represent women in their diversity, including depictions, personal anecdotes and cameos contributed by many women, women of colour, lesbian or heterosexual, ability and disability, white/Anglo, single and partnered, well and those with medical conditions, and the spectrum of economic classes.

With such tolerance of differences, along with the validation of difference, comes a recognition of multiple truths, a very post-modern idea. Although never overtly expressed by OBOM, this epistemological possibility is permitted. In OBOM the possibilities within the descriptor ‘woman’ as it is used are being deconstructed and reconstructed, and the discursive entity of the confident questioning and self-managing woman conceptualised and recognisable within the feminist women’s health discourse (BWHBC 2006; Shildrick 1997).
In the feminist health discourse women are impelled to optimise their own life; the idea is conveyed that one cannot rely on necessarily being looked after by the doctor, as they may not in every instance. Being self-responsible may entail going against professional advice at times (for example, in instances where vested interests are perceived).

At times perhaps, the OBOM book presents a unitary enduring subject, promulgating a humanist view of the self. And yet interwoven within the text there is valuing of diversity and positioning leaning to the post-structural. The book does not attempt to explore ontology and therefore ontological questions are left open to interpretation. The commitment which endures throughout the text around foregrounding women and political activism on multiple levels does underscore feminist standpoint theory, as discussed earlier.

There is a shift in relations around authority (Fairclough 1993) in the way the text is written. OBOM has wrested authority on menopause from being largely in the medical professional domain, transferring it to women’s health advocates and also to women themselves. In so saying, this ‘transfer’ is more of a spread of authority, as it cannot be said that the medical domain has lost such authority. In addition the authors are professionals or well educated; it seems their intention is to write as a health professional or research scientist, and in addition, to speak from the place of shared female experience.

### 6.5 Right to choose (My Body, My Choice)

Doctor shopping and refusal to accept one medical opinion as definitive are activities that are indicative of women taking up the right to choose. Several women reported changing doctors and consulting new doctors as they were dissatisfied.

Aster: Well I spoke to a doctor…and took an estrogen patch and that helped for a while…I heard about a clinic [in another city] and went there for a while. (53yrs old. On bio-identical hormones for 3yrs, and at interview).

Tansy: I recognised the prescription immediately and I thought this is HRT. So I went back to work and asked one of the doctors there, “Is this HRT?” And he said, “Yes.” And I said “Oh.” So I was really quite amazed…so I didn’t take it because I thought I don’t want to go on HRT. (History of bleeding. 57yrs old, natural menopause. Took Remifemin (OTC) for 6months).
Holly: I can remember in the early 1970s going to a seminar, you know a community organisation...there was discussion about medical doctors as gatekeepers...I wasn’t happy with my old family GP, so I tried to change doctors, eventually I was successful but several doctors had receptionists well primed to prevent you moving to a new GP unless you were new to the city! It was staggering wasn’t it? Basically they were refusing to accept transfer of your notes and protecting one another’s patch. I only go to a woman GP now. (55yrs, natural menopause).

Sylvia was an ardent advocate of patients’ rights, which was galvanised by her personal experience as a claimant about the Dalkon shield.

Sylvia: I think I felt jerked about by the largely male dominated medical profession at that time. Was very much “Just lie there dear...[gestures patting on the head]... just leave it to me.” I had a very good GP in [city], I think he was largely good because of his wife who was a feminist. (65yrs old, postmenopausal, never took MHT).

Below are examples where participants assert a personal appeal by recourse to a patient rights discourse.

Flax: I refuse to come off it [MHT]. I have always had a high sex drive and it [MHT] dampens it down...she [doctor] just [regularly] talks to me about knocking it off. (61yrs old, hysterectomy 22 years ago, on HRT for 9 years and on interview).

Here the doctor and the patient have entered into a kind of negotiation around the competing priorities (the woman’s sexuality concerns and the doctor’s concern regarding exposure to risks). It a circular conversation that is repeated; the doctor regularly presents cues for the woman to commence a dialogue about ‘what is best’ for her. As the participant conveys, a conciliatory way of relating is apparent between the woman and the doctor, and they have entered into a way of relating where reciprocity is present. In this example expressions used within the text allow negotiation to take place (discourse practice): the woman asserted her rationale for her choice, and along with how the doctor receives her decision reveals the configuration of social practice (Fairclough 1992) as it unfolds.

To a large extent over recent decades the rights of patients have entered the formal discourses, embedded in legislation and codes of practice, changing social relations. As we saw earlier in Chapter 5, the Llewellyn-Jones Fundamentals illustrated change in discourse practices with its tendency to vacillate between foregrounding the agency of the woman patient and directing information to the professional audience about women. The Llewellyn-Jones Fundamentals
reveals that although there is change in social relations and social practice, the old and the new style of authority relations sit together and are interchangeable: the old, while eroded, is also recuperated in the shifting discourses on menopause and aging women.

Some women use the saying ‘it’s my body’ to defend a priority they hold ahead of potentially the best health decisions. It is a paradox that through the feminist inspired women’s health movement, the phrase ‘My Body, My Choice’ entered our lexicon as both a political slogan and an expression of resistance to established health practices (which often among other things negated individual choices around contraception, the right to natural childbirth, and the right to change doctors), yet the phrase may be taken up to justify any choice where competing best interests may exist. The excerpt below gives an example of one woman weighing her priorities:

Interviewer: So those 3 occasions when you went off it (HRT). Were they in the last couple of years?

Cherry: No, the first time probably say 10 years ago, 5 years after that and then just last year. Only through pressure though. (62yrs old, on HRT for 20yrs after hysterectomy, retains ovaries).

Interviewer: Pressure from doctors? Your GP?

Cherry: Not my own doctor...the neurologist, and me thinking well the media says you should only be on it for five years, so perhaps I had better be a good girl. But now I am determined. But I don’t tell a lot of people I am on it because they fly up in the air.

Interviewer: Since 2002 when those two large studies were stopped there has been a lot more information about it hasn’t there. People have become more cautious.

Cherry: I go onto the internet quite frequently and have a look at the updates and it is all bad.

Interviewer: Yes but you are weighing it all up.

Cherry: My skin has been better than it ever was...um...I have felt great for 20 years. But the only drawback, of course, is the migraines. So if I haven’t been through menopause....

Interviewer: Would you call them persistent?

Cherry: Yes, I get them every month. Sometimes are worse than others. Last month I had four days in bed, and I have to have morphine and all that jazz. I still feel that it is only every month and say two bad migraines a year, is worth it to feel great. I would like to get a year’s supply and be done with it before I have to face up to [coming off] it [HRT]. I almost feel guilty really taking it. But then I think why should I? It is my choice, it is my body isn’t it?
Originally the slogan ‘My Body, My Choice’ signalled resistance to the state of systemic control of women’s sexuality and reproductive health. It opened a discursive space for legislative change. The slogan has liberal roots, and humanistic influences on rights and justice. In Foucauldian terms, ‘My Body, My Choice’ originally would have counted as a subjugated discourse (Foucault 2002) that has become legitimated in discourse on women’s rights and co-opted into patients’ rights movements more generally, for example, in advocacy in the disability and mental health sectors. As a subjugated discourse, women’s health advocacy has been legitimated through struggle, born out of collective organising. The slogan signalled the refusal of women to continue to allow themselves to be governed as a group by others, and asserted freedoms. Yet, the slogan is also turned against women as a catch cry, firstly, where it is used in the guise of offering ‘choice’ when choices are manipulated toward particular products for commercial gain rather than health benefits, and secondly, when used by women themselves to justify desires, couched as choices, that are against reasoned advice and contrary to their best interests (for example, to continue to smoke). Foucault (2002) posits that ‘actions structure the field of other possible actions;’ furthermore, he goes on to write that ‘power relations are deeply rooted in the social nexus,’ facilitating ‘some to act on the action of others’ (p. 343): possibilities thus create new possibilities. Thus where the medical profession by its status and ‘governing’ no longer holds power over women as it did traditionally, some practitioners take up a discursive tack intended to structure choices.

6.6 Women as judicious recipients of health care

In this section two areas are considered. Firstly, the engagement with women readers by authors of OBOM as ‘recipients’ of health care is analyzed. Secondly, attention is given to how women address commercialisation and the ‘consumer’ in health matters.

OBOM is written on the premise that readers can be as well informed, knowledgeable and as confident about their health decisions as the women cited in the book. Reading the OBOM text and assessing its construction permits the identification of a discourse I nominate as ‘women as judicious recipients of health care.’

The OBOM text plays a role in coaching readers to be well informed in health care decisions. It attempts to both engage readers in building their own knowledge and provides tools to enhance
capability in information gathering and interpretation. OBOM contains several vignettes which inform readers of the commercialization of research (pp. 23, 24), and of health care products (pp. 228, 236, 241, 252), as well as informing readers that companies reinforce for commercial purposes negative stereotypes of older females in the promotion of anti-aging products (pp. 129, 131). The authors critique the term ‘evidence-based medicine’ and trace the increasing amount of research that is undertaken by for-profit research organizations, particularly since the 1990s (p.24) citing a United Kingdom government document titled *The Influence of the Pharmaceutical Industry* (House of Commons Health Committee 2005). The Health Committee document discusses the dangers ghost writing poses regarding the integrity of some research findings. OBOM discusses how drug companies can shape research outcomes, favor their products and therefore affect medical knowledge. Readers are also informed about the erosion of the independence of research and research journals, and health providers’ reliance on corporate sponsors in the distribution of new knowledge. In 2005 the European Medical Writers’ Association issued guidelines for medical ‘ghost-writers,’ attempting to address these very issues (Jacobs 2005).

The OBOM text not only educates women in techniques to become critical consumers of health care, providing lists of questions as prompts to use if offered a treatment or assessing a drug (pp. 27, 28), but also encourages readers to be politically active in calling for stricter controls over activities that are compromised by commercialization. For example, one vignette critiques ‘word choice,’ deconstructing the use of the phrase ‘side effects’ (p. 21). The authors suggest the term is misleading when the importance of an actual effect is minimized in a figure of speech that is in common use within both formal and informal contexts.

Consumerism is viewed with suspicion in feminist health discourses, and women are exhorted to be aware of the system within which health interventions and health products are promoted. In the last three decades there has been an upsurge in seminars for the public on menopause.

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19 Negative stereotypes may be the inference that women at menopause will experience incontinence, sagging breasts, dry and wrinkled skin, have brittle bones, develop a dowager’s hump etc.

20 Drug companies that sponsor trials are in a position to have influence over sample selection leading to inclusion of groups of people less likely to be eventual users. Sample composition, age and co-morbidity status can be manipulated, and the depth and scope of the results that are published; partial results only may be published, showing the favorable outcomes rather than the unfavorable, leading to ‘incomplete and biased research’ (OBOM 2006, pp. 24-25).
Several participants (Ruby, Daphne, Holly, Scarlett, Cherry) recounted attending women’s health seminars, many of which were drug-company sponsored where particular products were promoted.

The transcript excerpts below reveal some participants were wary of companies’ marketing, and some changed doctors and or medication regimes due to their perception of excessive costs or because product promotion led them to doubt the integrity and therefore reliability of the information.

Aster: I did find one [a doctor who prescribed natural hormones] that I went to and he was very helpful initially and I had lots of blood tests and then it started to become a very expensive, I thought over the top sort of stuff. And I thought I don’t need all of this. It started to become…I thought it was more a money making business for this particular [natural and bio-identical hormone] clinic. So I stopped going there. (53yrs old. On bio-identical hormones for 3yrs, and at interview).

Ruby: The pharmaceutical companies pushing their products has not been to the benefit of their market. It is driven by the dollar, it is certainly not driven by the welfare of the end user. Only wealthy people can take HRT, it’s too expensive for everyone. (63yrs old, on MHT for 7years).

Some women had attended various conferences and/or seminars on menopause and hormones.

Cherry: I have been to hear a woman doctor speak [specialising in menopause], I was on it [HRT] but I went with an open mind. She ended her talk by saying she was never going to stop taking it, ever. (62yrs old, Hysterecory 21yrs ago. On MHT for 20yrs and at interview).

**Interviewer:** You would see yourself taking the combination (bio-identical hormones) for how long?

Daphne: Lifelong.

**Interviewer:** You would? And is there any claim about improving bone density or maintaining bone density?

Daphne: I would [stay on it lifelong]. Umm there is a lot of study. Estrodial is the one you need to be taking but that is combined also with diet and exercise so it is not just um…your hormones is it. I think it is diet and exercise [too], a combination of things I believe.

**Interviewer:** So that was the doctor’s advice or did you read that.

Daphne: Yep his advice and I have read that too. I have been to a lot of conferences um…I have done a lot of study on it [bio-identical hormones]. They use it a lot overseas and in the States. (55yrs old, took HRT for 4 years, changed to bio-identical hormones for last 3.5yrs).
OBOM explodes the myth of medical practitioners’ independence from product marketing. Chapter 16 is on ‘Bone Health’ which outlines how the pharmaceutical industry use scare tactics to cause fear about people’s health, then promote their products to treat a problem their rhetoric helped create. Osteoporosis and the rhetoric surrounding it are one case in point. Despite the enduring idea that HRT prevents osteoporosis, authors state that estrogen-progestin treatment is ‘no longer a first-line approach for treatment’ (p. 242). More effective first line options exist such as bisphosphonates (National Health Service 2005) (a point developed further in Chapter 7). Yet companies promoting specific treatment and prevention therapies rely on the fear factor generated by visual images of older women with spinal curvature, and rhetoric about decreasing bone density in post menopause. Oats and Abraham’s (2005) advice differs from present guidelines on prevention and treating osteoporosis as they recommend HRT to post-menopausal women with ‘risk factors’ (p. 336). The authors fail to state that MHT is not recommended as a first line treatment and is not as effective as other therapies such as bio phosphates. The US Agency for Healthcare Research and Quality notes that ‘bio phosphates are not consistently associated with any serious adverse event; raloxifene and estrogen increase thromboembolic events; estrogen increases stroke; and estrogen with progestin increases coronary heart disease and breast cancer’ (Oregon Evidence-based Practice Centre 2010, p. iii).

Merck aggressively marketed Fosamax (alendronate, a bisphosphonate), targeting doctors and women in making various exaggerated claims about the numbers of women in risk categories for osteoporosis to enhance uptake of their product. They pursued a multi-pronged marketing strategy including direct to consumer ‘education’ about bone health and aging. Direct to consumer strategies (rather than those mediated by the practitioner) seek to alter perceptions and create a consumer market for products. Not unrelated to menopause, OBOM questions the promotion of cholesterol lowering drugs (p. 252) when the evidence is insufficient to warrant the public health campaigns to promote statins.

Foucault’s genealogical method is brought to bear on a contemporary shift where we commonly categorize ‘patients’ as ‘consumers.’ The concepts ‘patient’ and ‘consumer’ are investigated here, providing a route into deconstructing what ‘patient’ and ‘consumer’ represent in contemporary health care. They are the ‘other’ of the dyads ‘doctor/patient’ and ‘producer/consumer.’ This discussion traverses the areas where these descriptive terms signal the interplay between groups of people (patient and consumer exist in relation to others).
Representation is placed in relation to those who can and do define, and those who are defined; one’s own positioning depends upon the rhetorical site of these two central nouns. ‘Consumer’ is a misnomer when it comes to identifying the ill person. It is my claim that neither ‘patient’ nor ‘consumer’ accurately represents the status of persons receiving care and treatment in contemporary health care.

6.7 Positioning the patient as consumer?

Historically the patient has been viewed as a passive recipient of care, and passivity and acquiescence to treatment was expected. Foucault’s (1963/1989) book titled The Birth of the Clinic expounds the influences that cemented such positioning of the patient to medicine. Utilizing Foucault necessitates recognition of power in disciplinary knowledge, and the working out of power in society and its structures. On the other hand, ‘consumer’ as a term encapsulates the power of choice, the option of discretion in which ‘product’ might attract or satisfy, therefore the power to choose is integral to being a consumer and thus presupposes/implies the existence of choices and freedom to choose.

In contrasting two key relationships, the medical doctor/patient encounter and the commercial banker/customer encounter, both share the seeking of a service on the part of the patient and customer. If we look at disclosure in relation to these two processes, the health assessment and, for example, a mortgage application, several elements of the encounters are common. Disclosure is a precursor to treatment and to financial dealings. At the personal level of the customer, full disclosure is expected by the banker, that is, earnings, debts and financial history. Just as in the health encounter, medical history and current status/symptoms are to be disclosed. Disclosure is always accompanied by concepts of ethical behavior and conditions such as privacy and protection of information. The conditions for disclosure must involve trust and privacy.

Although the disclosure aspect is common to the situations, it is not grounds to view the patient as a consumer in the sense of being part of a marketplace. It is my conclusion that the difference between ‘patient’ and ‘consumer’ rests not in the ability to exercise choice, but the life-affecting and health-affecting nature of medical treatment and the vulnerability that induces. Traditionally choice was rarely available to the ‘patient;’ in commercial speak it is always available to the ‘consumer.’ Hence the terms cannot be interchangeable. This leads us to ethics of the practice of
medicine as doctors are entirely different from bankers; they are awarded by society the role of proxy for patients at particular times (if unconscious, or when illness so disables that one cannot speak for oneself), a privileged role that entails an expectation that patients’ interests come first and foremost, certainly not commercial gain.

Two disparate paradigms, medical science and commercialism, are involved. These discourses occupy different spatial arenas, they are not static and the subject is conceptualized differently. The subjectivity of the person accessing health care pivots on a vastly different axis, as encapsulated in the noun ‘patient’ when compared with the noun ‘consumer.’ The first, regarding the ‘patient,’ is largely tied to the sites where medicine and the individual enter an encounter around the ‘patient’s’ health, whereas economics and commercialism spawn the ‘consumer,’ whose decision making and power to decide takes place in a market and makes the ‘consumer’ a ‘market force.’ In the case of MHT the intermingling of commerce and health are overt and it is apparent commerce has a direct influence.

The delivery of health care is accepted as a right available to all and one that ought to be available independent of purchasing power. Yet a market operates in consumption and discretionary activities among parties in the health market.

6.8 Reframing aging and self-appreciation

A theme throughout the text of OBOM is valuing of the older woman and promoting self-appreciation. A discourse valuing oneself in aging debunks the beauty myth (discourse), it provides an alternative and resisting discourse to the denigration of the older woman, and re-conceptualizes femininity and sexuality for the aging woman. The women expressed their views on the concepts of aging.

Interviewer: So from a femininity point of view, how did you view getting older, as a female?

Willow: Never bothered me. I never thought about getting older until you go through menopause and some days you do feel really old. I have a good, happy life. I have been married for 37 years. So growing old gracefully with my husband is just, you know…[the same]. I’m contented. (54yrs old, on and off HRT over 6 yrs, stopped 6mths prior to interview. Consultation in 2004 after a hysterectomy).
Sylvia: I know that I grieved at 40 for my lost fertility but 10 years later I found that I wasn’t saddened to be turning 50. (65yrs old, postmenopausal, never took MHT).

Daphne: But I also think if you keep your hormones up that that is part of the anti-aging process, that it does help with your energy levels. (55yrs old, took HRT for 4 years, changed to bio-identical hormones for last 3.5yrs).

Daphne appears to normalize anti-aging here, while Holly reports she has never felt so well as after menopause.

Holly: I’m now much warmer, my body temperature is more comfortable, I always felt the cold as a younger woman and needed layers and layers of clothes in the winter. I sometimes think the doctors got it wrong and being fertile is a disease not menopause. You know…women suffer so many difficulties due to fertility, sore breast when puberty hits, period pain, premenstrual symptoms, heavy bleeding…I bled a lot in my late 40s had progesterone for that…mmm…I feel good, now…I exercise regularly, swim in the summer, I have lots of positive older women I admire in life….capable, independent people. (55yrs, natural menopause).

Interviewer: You know those sort of claims have been made across the years: around the concept of HRT enhancing feeling feminine or remaining like a nubile young sexual kind of woman. Where do you sit on those ideas?

Scarlett: I have never even considered those things actually and I think I was going to say that before…a lot of patients want it because it is the elixir of youth and this is where my doctor is adamant that you should really take it for the time you need it and [then] come off it. (59yrs old, on MHT 7yrs and at interview).

Rose: I mean a lot of people actually take it [MHT] because it is supposed to keep you young. I can’t actually say you know being in a relationship that it made any difference at all. I mean I know with my partner when I was going to go on HRT saying, “That will be good, you will be wanting to…[have sex]”… you know….And of course, as I say it didn’t make any difference to me whatsoever. No effect at all [on libido]. Well you do hear some women…but you don’t really talk about [intercourse]…that’s getting right to the nitty gritty. But it used to be that women get dry…that is a bit of a fact isn’t it? that women can dry….but people don’t really talk about it.

Interviewer: So did you see yourself using any different aids or...

Rose: No, no, no, no I just did my usual pattern as you say. I mean you are either that way inclined or you are not of course and no I don’t think it made any difference to me like that at all. (55yrs old, on MHT for 3 years, stopped one month prior to interview, due to having had a stroke).

Positive images and views on aging as women stand in stark contrast to the negative stereotypes prevalent 30 years ago and even today. OBOM challenges discourses stating what counts as
beauty and femininity. OBOM dedicates Chapter 8 to ‘Body Image;’ on page 129 one subtext box addresses breast implants and another is on advertising and cosmetics (p. 131). At the beginning of Chapter 9 (p. 126) Margaret Gullette (aged in her sixties) provides a vignette and writes about resisting falling into the self-hatred that is learned by older women in a ‘patriarchal, capitalist America’ that is youth focused. She exhorts other women to avoid the trap of ‘reinforcing women’s supposed ugliness in the guise of friendship,’ and buying into ‘masochistic empathy,’ as avoiding complicity in the negation of the aging woman would prevent women being party to ‘personalized commercials for the commerce in aging.’ Margaret’s vignette ‘speaks’ to social relations between women, inserting the possibility of assuming different relations. The vignette recounts her experience of taking a new look at her ‘curvaceous and startlingly elegant’ body to appreciate it as it is rather than through a filter of youth obsession and denigration of all that is outside the narrow definition of female beauty promoted in popular culture and media. Rhetorically the vignette is reasonably strident and argumentative in style. It is in contrast to the main text that is written in a factual discursive tenor. Analysis of this vignette reveals insertion into OBOM of a discourse of positive aging and reassertion of the feminist standpoint discourse, both of which contest the beauty myth and anti-aging discourses.

These discourses are both counter discursive constructs that debunked the myths, perpetuated by Wilson and colleagues, that mid-life and beyond means to become decrepit and is a time of decline (Wilson 1966). Despite this, discourses of anti-aging are perpetuated and taking new forms with increasing interventions available, such as cosmetic surgery, Botox, hair transplants, and diets to counter weight gain. Promulgation of ‘solutions’ to deal with menopause and aging, when promoted to all women in a blanket fashion, and despite knowledge about risks of many interventions, are attempts to normalise anti-aging discourses and justify interventions to resist the aging process.

The OBOM text does not shy from description of the physiological changes that aging entails or the impacts of losses in life. What it does do, as shown above, is offer ideas drawn from the discourse of positive aging. Positive aging rehabilitates those previously neglected and maligned (aged, women, those with disability). Processes of colonization and re-colonization of discourses (Fairclough 2005) are evident from the intertextual interplay between discursive constructs. The women’s health discourse is both amenable and yet also resistant to medical and public health discourses, where intertextual elements have altered them too. Likewise medical and public
health discourses are amenable to alteration by the feminist health discourse, as collaboration around health decisions was experienced by some participants.

Daphne’s interview revealed she has bought into the idea of menopause as a deficiency. She is an advocate of bio-identical hormones. Although she has researched and read about those products, she has not accessed the literature which counters proponents’ claims and is critical (with good reason) of those who promote them as safe (as was explored in a previous chapter).

Daphne: I also think if you keep your hormones up that is part of the anti-aging process, that it does help with your energy levels. Because if you look at scales when you are 20, you have levels up here, and of course as you get older well they decline. And why do you get old? Well when you think about it, what keeps you young then? All your hormones, and your diet and exercise and things like that. But when they start falling off all your body starts falling off too. [Laughs].

Interviewer: But we can’t stop it altogether.

Daphne: Oh no no no.

Interviewer: Do you think there is a natural state of aging well?

Daphne: Yes I do. I don’t think bio-identical hormones and DHEA stop you from aging completely. I think, though, what it does do is give you the energy and the ability to live a healthier lifestyle in your later years. I think it lowers your risks of things like osteoporosis, rheumatoid arthritis, cancers specifically. I am not saying that you are not going to get them, but I think in general and overall from the reading and the studies I have down that it reduces those risks…. And it hasn’t got the side effects and it just keeps at the physiological levels so you can monitor it. (55yrs old, took HRT for 4 years, changed to bio-identical hormones for last 3.5yrs).

After the conclusion of the formal interview this participant revealed indirectly (by handing me a pamphlet) that she worked in a practice that sold bio-identical hormones. DHEA has not been studied in large RCTs (NIH 2005, p. 17). As I argued earlier (page 57) it does not follow that in the absence of data a product is safe (Cirigliano 2007). This participant is certainly assertive, although assertiveness alone is not adequate to avoid risks when coupled with limited research.

This chapter has investigated the items participants identified as spurring their choices and courses of action when deciding about MHT. Despite wide variation in their preferences at times, some commonalities existed: the hunger for information that has integrity; holding the expectation that they are partners with experts in managing their health and well-being; acting to
enhance their quality of life; safe-guarding their right to choose; displaying willingness to take self-responsibility for their own health; and rejection of ageist conceptions of women.
CHAPTER SEVEN: FASHIONING THE GENEALOGY OF MHT

7.1 Introduction
The prior chapters have analyzed the impact of cultural norms about mid-life femininity and health, identifying how assumptions and rhetoric about normality, scientific truth, health and disease, and female subjectivity have influenced discourses constitutive of MHT. To achieve this I utilized a Foucauldian genealogical approach to analyze assumptions informing the subjectivity of mid-life women via an investigation of the constructions of bio-medical science, public health discourses about the female subject of healthcare and health systems, and discourses of women’s health advocacy.

The analysis of normality and the abnormal (deficiency) highlighted the political nature of competing stories about bodies and therapies. In analyzing medical discourse in Chapter Four I explored the premises that medicine works from. There was the story of aging women as somehow deficient, and therefore abnormal, that permeated medical discourse, providing a reason to medicate women even when the efficacy of MHT was contested and the risk of cancers known. This discourse appeared to have permeated popular culture as a story told repeatedly over decades, and by many (including Wilson (1966), that women are deficient, that menopause is disease, a time ripe for intervention as female mid-life bodies are somehow failing, and therefore unattractive and displeasing. The women’s narratives referenced this ‘story’ in ways that revealed a few were entrenched within it, and others were resistant to it.

Resisters of popular discourses countered and contested women being defined by the parameters for such rigid and, supposedly, universal dichotomous ideals which are culturally endemic. The knowledge arising from science purports to deliver certainty, and control is expected to ensue. The subject positioning of the mid-life female was effected through scientific descriptions that couched aging negatively, and thus women as a group with deficiencies that science could remedy or mediate through hormonal therapy, controlling the rapacious female. Chapter Four revealed the tactical responses the women deployed to resist negative conceptions; they pursued information independently and sought out other advice in diverse places and from diverse people: medical consultations, practitioners, public seminars, friends and family. Chapter Five documents a shift in assertion about women’s subjectivity, reflected in acceptance of self-
responsibility as a feature of contemporary participation in healthcare, and when package inserts for patients in hormonal preparations were mandated by the FDA. Women’s access to knowledge was no longer mediated wholesale by the medical profession. Furthermore, in Chapter Six, analysis revealed resisting discourses about women in discursive constructs of the women’s health advocacy movement, and as study participants’ tactical responses involved self-managing their health and reframing aging positively.

Knowledge was discovered to be pivotal to the foundations of claims to expertise. Medical and scientific expertise was seen to be enveloped in a network of power that affected an assortment of responses. Foucault’s power/knowledge nexus permitted analysis of claimed medical facts, scaremongering, promotion of bio-identical hormones (Chapter Four), opinion leaders at the highest levels involved in consensus decision making, and the commercialization of medical treatments. Analysis revealed contestation of truth and truth claims, identifying that the reverence shown experts is based in fragile claims to scientific truth, and that truth is unstable, and open to manipulation for commercial and professional advantage. Yet the constant claim of truth, and publication and distribution of material about women and their bodies, keeps medicine in a position that is rarely, and only ever partially, threatened within society, despite the influence of resistant discourses.

The next major discourse - public health - was shown in Chapter Five to construct the recipient of health care as a responsible citizen. As noted in public health policy, the state joins medical discourse to control populations. Promotion of MHT appeared to be an aid to the preventative medicine message. When apparent benefits such as preventing heart disease and osteoporosis were touted, a subtle form of coercion evinced complicity in the control and protection of women’s own bodies. A Foucauldian reading of risk discourse proposed that governmentality operated in the lives of women and was a mechanism of control as the force of state gives weight to public health messages. The idea of self-responsibility in health was iterated further within the women’s health advocacy discourse in Chapter Six. It took expression in the women’s narratives as they spoke of assuming responsibility for researching facts about MHT, consideration of other life events, and their uptake of the public health rhetoric to eat well, be fit and act preventatively. Risk aversion and seeking quality in life were complementary themes to responsible citizenship, where populations are exhorted to personal fulfillment through attaining a life of quality. Revealed in Chapters Five and Six were the moral imperatives that are culturally embedded. The
The cultural norm of consumerism, which depends on discourse of consumerism, was explicated in Chapters Five and Six, and positioned mid-life women as a ready market for MHT products. The discourses of commerce were a complement to public health imperatives to be healthy and vigilant about one’s wellbeing. A further seductive accompaniment to the discourses of commercial and public health drivers discussed in Chapters Five and Six was the directive to attain quality in one’s life. In Chapter Seven a picture of the adherence of drug companies to commercial mandates at the risk of the safety of products became clear, emphasizing Foucault’s insistence that truth is merely rhetoric.

Deconstruction of cultural norms about mid-life women proposed that female subjectivity, and thus femininity, are fragmented and even improvised. Post-structural analysis revealed the subject as unstable, able to take-up and/or resist (to varying degrees) recognizable subject and necessarily gendered positions. Butler (2004) poses that expression of gender ‘is an incessant activity performed….One is always “doing” with or for another, even if the other is only imaginary’ (Butler 2004, p. 1). In this thesis the others were professionals in the formal health system - doctors, pharmaceutical companies, compounding pharmacists, medical writers, health promoters - and those outside the formal health system, friends and family and women’s health advocates. Some participants’ narratives and formal texts (for example, Llewellyn-Jones Fundamentals) reiterated the common populist notion that women want to stay perpetually young and attractive, and view aging negatively. Although as discovered, laying information on menopause and therapies before people may (and did) affect many results for the women participants, and the key point about discourses of disruption, difference and resistance is that they allow multiple responses, whereas dominant discourses tend toward only one. Multiple responses are expressive of multiple subject positions. The unstable and malleable subject was evinced in the women’s narratives and in the formal discursive constructions of peri-menopausal women.

This thesis has argued that norms about mid-life women have rendered them first, as gendered and negatively stereotyped; second, as hormonally deficient, so that abnormality and pathology characterize this life-stage of women; and third, as a homogenous, undifferentiated group. The
above norms have permitted MHT to be discursively constructed as capable of intervening and
remedying hormonal deficiencies, to make women normal and attractive through recuperation of
losses and intervention to treat pathology. The norm, exhorting women to be self-responsible,
often complements the presentation of the norm to strive for quality of life. This synergy has
resulted in rhetoric about MHT being an instrument to assist in preventative disease practices,
and attain, by symptom control and preventative activities, fulfillment of quality of life goals.
And lastly, the norm within health broadly, that bio-medical knowledge (scientific truth) has
resulted in (and expects) deference to bio-medical opinion has generated discourses to promote
MHT. The promoters of MHT have utilized the high esteem of bio-medicine to market products,
co-opting scientific language and opinion leaders, and strategically positioning their products
before prescribers and patients. Furthermore, the assumption that mid-life women are consumer
orientated, and that consumerism is a norm, encourages manufacturers and doctors to foster the
uptake of MHT. This thesis identifies that women are not entirely in the throes of constraints or
discourses, but participate in self-work, care of the self and practices that illuminate the post-
structural subject.

The findings summarized above are explicated in this chapter, fashioning a genealogy in keeping
with the methodology of the thesis as a Foucauldian genealogical investigation. In this vein the
content of the findings and analytic chapters are discussed with consideration of earlier events, as
noted utilizing Foucault’s analysis of descent, to examine the structure of society’s regulatory
frameworks and sites where the generation of knowledge about women’s bodies and hormones
operate(d), which together form a history of the present. This chapter is structured to achieve a
genealogy to 2010, and in so doing, past events, practices, perceptions, elisions and gaps are
examined in the developments in the phenomenon of MHT revealed in the texts studied.
Foucault states genealogy ‘operates on a field of entangled and confused parchments, on
documents that have been scratched over and re-copied many times’ (1971/1984, p. 76), and
furthermore it is ‘effective’ history as an ‘event, consequently, is not a decision, a treaty, a reign
or a battle, but the reversal of a relationship of forces, the usurpation of power, the appropriation
of a vocabulary turned against those who had once used it’ (Foucault 1971/1984, p. 88). In
pursuing my genealogical investigation of MHT concerning cultural norms about peri-
menopausal women, I trace the ‘genes’ of contemporary concepts, practices and their reversals in
order to identify how they came to be seen in the way they were and are. Achieving the
genealogical investigation into MHT entails going behind and beyond the surface of concepts to
uncover the nuances, influences and interpretations over time that have shaped discourses and discursive constructs, in this instance investigating how normality has been constructed in medicine, how scientific truth has found prominence, and how subjectivity is construed. These are necessary, detailed and comprehensive notions to progress discussion of the findings in producing the genealogy. Utilizing Foucault’s notion of emergence, analysis focuses on the various forces contesting the grounds for ‘truth’ concerning estrogen medication and the bodies of middle-aged and ageing women. Foucault himself is indebted to Nietzsche as we saw in Chapter Three, and in addition to Canguilhem, whose theories along with Foucault’s own contribute to this chapter. The follow five paragraphs set out in detail the intentions and the structure of the chapter.

The first section of this chapter interrogates, under the heading ‘The Problem of the Normal,’ aspects of the evolution of medicine as a potent and normative force in the emergence of the subject/patient. To understand the genesis of the idea that menopause was seen as a state of ‘deficiency’ and therefore categorized as disease, it is necessary to trace the trajectory of medical science that permits such claims to arise. Here, in explicating the thesis, I interrogate the concept of normality and its sequelae, abnormality, and the role this opposition of terms has played in firstly, medical knowledge, and secondly, in medicine’s construction of women patients.

In the second section, analysis of the ‘Normalization of the Female Subject’ is examined through the lens of Cartesian dualism and its dichotomies. The imprint upon the human body of scientific knowledge and professional discourses about estrogen therapy is discussed, using Foucault’s genealogical approach. Thirdly, I analyze counterpoints to the notion that menopause is a deficiency or some kind of disease, attending particularly to the biomedical literature, contemporary scholars’ reflections and feminist critiques of constructions of the female body.

A further section deals with practices of regulation, assessing the methods of constraint and their mechanisms that operate on populations. The chapter proceeds under the heading ‘Myth or reality?’ to address the strategies deployed to ensure MHT remains a viable commercial product. The section titled ‘Drug safety and reduction of harm: Debating public health’ looks at the FDA as an agent of public health discourse. Foucault’s five traits of truth provide the analytic lens to evaluate regulation and the public face of pharmaceuticals. Lastly, the section, ‘Who is the menopausal woman? Female subjectivity’ discusses how in the light of the data analyzed, the
menopausal woman’s subjectivity, self-advocacy and ‘care of the self’ might be illuminated using Foucault’s conception of the subject. To inform these issues, interview data provides understandings of feminine and feminist subjectivity in the contemporary context of hormone administration and consumption.

7.2 The problem of the normal
The polarity of the ‘normal’ and the ‘abnormal’ (pathological) is the crux of medical deliberation, so that an avowed deviation from some norm in an individual becomes the reason for intervention. Through manifold relations of power and the ‘struggle of knowledges,’ medicine derives social authority influencing the establishment of social orthodoxies (Foucault 1972/1980). Appreciating the complexity of the science involved, and avoiding a simple approach, it is needful to try and make sense of how it is that elements (discursive constructs) combined for a particular conceptualization of health versus deficiency gained traction. Following Foucault, I attempt sense making by delving into ‘the entangled and confused parchments’ of medical writing, ‘documents that have been scratched over and copied many times’ to unpack the mesh of ideas that contributed to the concept of deficiency and abnormality being attributed to the menopausal woman (1971/1984, p. 76). To Foucault, orthodoxies work to normalize the subject, in this study the woman in the peri-menopause.

Foucault (1963/1989) investigated early medical writing and viewed eighteenth century medicine as one of the major discourses exercising governance over the body. The coerciveness of a discourse is that in creating the effects of truth, it is repressive in the sense that other views are rendered illegitimate and medical discourse is inculcated with power. Crucial to a Foucauldian concept of power relations is the production of knowledge(s), whereby any power hold is secured within an episteme. The power of medical science rests on the discoveries, claims and productions of proof it sponsors. Foucault sees the ubiquitous authority of biomedical-science anchored by its claims to sets of particular scientific knowledge. He notes that a circular interdependency operates where ‘truth’ is claimed, and then establishes the foundation from which power might be exercised, and in turn, reasserts that same truth (1980). Such knowledge then is productive; the ‘truth’ claim is the axis upon which some things are legitimated by inclusion and others are excluded, thereby becoming illegitimate and/or ‘unthinkable’ and thus evidencing the operability of power.
Returning to Foucault’s claim quoted on page 14 that bodies are ‘imprinted by history,’ the menopausal body has been subject to professional discourses which have been infused with long held stereotypes about the aging female. Menopause became widely thought of as a time of danger with heightened propensity for disease, and even as a state of disease. Foucault relates that the phenomenon of hysteria was detailed by Galen, the second century Greek physician (Galen’s theories relied on Hippocrates’ idea of the ‘wandering uterus’), who thought retention of bad humors caused hysteria (Foucault 1984/1990, pp.115-118). Across the centuries variations on these ideas repeatedly arose and took a new guise in early psychiatry through Freud’s case studies of ‘hysterical’ nervous women, and Helene Deutsch’s reassertion of the word in psychiatric discourse (Deutsch 1945). To Foucault, psychiatry and psychoanalysis had normalizing functions (Foucault 1984/1990, pp. 5, 110-120) where, for example, female distress at menopause was pathologized. Seeming divergence from how normal sexuality and femininity were conceptualized became labeled as deviant (Irigaray 1985). The proliferation of medication prescribed to treat menopause from the 1950s to 1970s testifies to the endurance of these views linking psychological distress to the event of the menopause (Kennedy 1985). Although not all physicians took such a view, it was nevertheless a perspective that was widely published by some crucial factions in the profession, including gynecologists (Greenbalt 1942; Greer 1991; Kennedy 1985; Krieger et al. 2005; Llewellyn-Jones 1999; Wilson 1966).

No one disputes that adult female sex hormone levels do measurably decline, signaling the onset of menopause; this is an objective fact. But this alteration is not an irregularity as it regularly takes place in all healthy women who reach the peri-menopause. Vaso-motor alteration (sweats, reddened coloration) can be objectively observed, and onset of ‘symptoms’ can be connected with alteration of blood level measures and a decline of periods and bleeding (Bungay 1980; Ettinger 1998; Greenblatt 1979; Guthrie 1996; Hammond and Maxson 1986; Kopera and Utian 1990; McKinlay 1992; Seaman and Seaman 1978; Utian 1977; van Keep 1990; Wilson 1966). There is then, a scientific discourse of ‘facts’ upon which we can draw to understand the phenomenon of menopause, although the quality (good or bad) attributed to any fact or measure is very much in the domain of discourse and evaluations where power/knowledge holds sway.

Foucault (1963/1989, p. 40) posits that as the medical profession became ‘expert’ on the ‘science of man,’ a profession that delineated the terms for what constituted health, as well as disease,
medicine presented us with the *model man* (the blueprint), thus defining the normal from the pathological in an absolute form. On the development of such precise and rational science, medicine gained a unique place of authority, with society awarding it dominion over both the natural and the social man. Foucault assessed the relationship of medicine to the state, particularly at the time of the French revolution with the radical reorganization of society involving principles of liberty and democratic ideals.

It has been common over the twentieth century for health to be equated with normality, yet Foucault argued against conflating these terms. Foucault (1963/1989) wrote about the emergence of medicine as a profession in the late eighteenth and early nineteenth centuries in his book titled *The Birth of the Clinic* (translated into English in 1973). In the early part of the eighteenth century, health was equated ‘to qualities of vigor, suppleness and fluidity, which were lost in illness and which it was the task of medicine to restore’ (Foucault 1963/1989, p. 41). Here, Foucault notes that medicine at the end of the eighteenth century was linked explicitly and primarily to ‘health,’ with the shift to ‘normality’ as a central feature in medicine arising later. Proliferation of physiological knowledge and the formalization of experimental methods cultivated a shift, where normality and its collateral, the abnormal, became the dominant organizing concepts for medical intervention. Canguilhem (French philosopher of medicine and Foucault’s mentor), notes standard measures (for example, normal parameters for pulse and respiratory rates) evolved from the experimental biological sciences, thus delineating the parameters of standards for healthy functioning and organic/natural structure from the unhealthy (Canguilhem 1978).

Claude Bernard (1813-1878) was the French experimental physiologist who was a major contributor in developing scientific methodology involving observation and application of the laws of chemistry and physics to living things. The idea of norms for bodies and identifying the constancy of their internal environs was linked to universal mechanization about the materiality of bodies. Bernard believed the physician undertaking experimental medicine should assess every patient in the light of ‘vital laws that shall include the relation of the pathological state to the normal or physiological condition’ (1957, p.198). Canguilhem, however, dismissed Bernard’s expectation that science and experimental methods would produce a pure science of

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21 Canguilhem edited Foucault’s 1963 book *The Birth of the Clinic*. Michel Foucault was a student of Canguilhem, who published his own doctoral thesis in 1943 on the nature of the discipline (medicine) and elaborated that the object of medicine is constituted by the distinction between the normal and the pathological (Tiles 1993, p.729).
Canguilhem, writing on the normal and the pathological, states:

Modern physiology is presented as a canonical collection of functional constants related to the hormonal and nervous functions of regulation. These constants are termed normal insofar as they designate average characteristics….Physiological constants are thus normal in the statistical sense, which is a descriptive sense, and in the therapeutic sense, which is a normative sense (Canguilhem 1978, p. 68).

Canguilhem addressed the more recent history of medical science from the nineteenth century to the early twentieth century. Canguilhem (1978) posed rather a radical challenge to the profession of medicine. In critiquing Bernard-style deterministic positions on medical science, he proffers:

(T)he ambition to make pathology, and consequently therapeutics, completely scientific by making them derive from a previously established physiology would make sense only if, first, the normal could be defined in a purely objective way, as a fact, and second, all the differences between the normal state and the pathological state could be expressed in quantitative terms, for only quantity can take into account both homogeneity and variation (p. 23).

Thus, in dismissing the possibility of such a pure science he (along with Foucault) undermines the idea that the object (patient) of medicine is wholly subject to measurable (factual), quantifiable, objective determination.

Foucault and Canguilhem sought to reveal the embeddedness of values within the medical sciences which steer medical judgments and evaluations, infused as they are into the very conceptual frameworks of the profession. Foucault, in writing the Introduction to Canguilhem’s English language edition (1978) of On the Normal and the Pathological, attributes Canguilhem with recognizing that the strategically decisive moment for the ‘history of the biological sciences is that of the constitution of the object and the formation of the concept’ (Introduction tenth paragraph). In other words, it is in the descriptive writing of a biological process that we
know/understand it; it is filtered through the author’s linguistic constraints, that is, in the choice of phrasing, language and analogy used. Thus, we could well understand concepts in some other configuration had they been relayed in another form.

Canguilhem (1978) reflects on the relationship between a purely objective science of the physical being and the transference of values to being in the social world:

If it is true that the human body is in one sense a product of social activity, it is not absurd to assume that the constancy of certain traits, revealed by an average, depends on the conscious or unconscious fidelity to certain norms of life. Consequently, in the human species, statistics frequency expresses not only vital, but also social normativity. A human trait would not be normal because frequent, but frequent because normal, that is, normative in one given kind of life, taking these words ‘kind of life’ in the sense given to them by human geographers (p. 92).

Foucault (1963/1989) and Canguilhem assert that values enter at the point of the declaration of a norm, and in such activity emerges the model man and model woman which are then symbolic and metaphorical constructions of the embodied subject. This process is summarized by Canguilhem (1978):

The co-relativity of social norms-technological, economic, and judicial – tends to make their virtual unity an organization. It is not easy to say what the concept of organization is in relation to that organism, whether we are dealing with a more general structure than the organism, both more formal and richer; or whether we are dealing with a model which, relative to the organism held as a basic type of structure, has been singularized by so many restrictive conditions that it could have no more consistency than a metaphor (p. 154).

Medical and psychiatry claimed to have defined the normal and the deviant. These professions have been key references for social and political decisions where separation of the deviant from normal society was deemed necessary. Women were valued for childbearing, a function that was normalized, while the post-menopausal woman was therefore cast as less than normal in that she had declined from full functioning woman-ness. As noted, scientific progress saw the
development of sciences of sex and sex hormones in early endocrinology (Ettinger 1998; Gusberg 1947; Krieger et al. 2005; Utian 1987). Freudian psychology viewed menopausal women as suffering from neuroses linked to the endocrine system (Deutsch 1945). Medical opinion became authoritative, creating orthodoxies and being consulted in relation to them for many aspects of everyday life. As noted (on page 59) the Llewellyn-Jones Fundamentals text positioned doctors as needing to be willing to offer advice about self-stimulatory sexual pleasure to older women patients without a partner (Llewellyn-Jones 1999, p. 321; Oats and Abraham 2005, p. 333; Oats and Abraham 2010, p. 324). In doing so, the authors assert doctors as experts on sexuality, yet also reveal the assumption that women would (and ought to) view medicine as a repository of such knowledge and expertise. To illustrate the idea that medical authority extended beyond the technicalities of pure science to influence the social and moral fabric of societal structures, the following two examples are presented. They highlight the ways in which a dyad of power and knowledge operates to produce medical orthodoxies in social aspects of life.

First, in the early twentieth century various scientific disciplines, politicians and academics were seeking to mitigate negative social aspects of human behavior, particularly so-called wanton expressions of sexuality as cities expanded rapidly with the spread of industrialization, and sexual promiscuity became rife in the First World War. For example, in the 1920s, social, political and scientific leaders, and members of the New York City Bureau of Social Hygiene, came together to form the Committee for Research on Problems of Sex. This committee functioned under the auspices of the National Research Council of the Academy of Sciences and was linked into the major universities and scientific societies of America. This committee considered social practices from within a physiological model of organic capacity, human variation, and health and disease. The influential medical physician and researcher, Yerkes, was invited to be chair of this committee. Yerkes studied the evolution of both animals (primates in particular) and humans. He viewed mammals as complex physiological organizations and he sought explanations for instincts, behavior and capacity. This had led to the development of intelligence tests for conscripts in the First World War, and Yerkes ‘conceived the work as part of the medical management of society’ (Haraway 1991, p. 49). The powerful place of medicine in the structure of such an organization symbolizes what Foucault refers to as a ‘political economy’ of truth (see reference page 78) where control is exerted over the population by professional disciplines such as orthodox medicine because of their specialized branches of knowledge (Foucault in Rabinow 1984, p. 73). The widespread advocacy of hormone replacement by those such as Wilson (1966),
who saw an opportunity to medicate women from puberty (via the oral contraceptive) to the grave (with MHT), had echoes of social engineering too (Ussher 2006). Gillett (2004) refers to orthodox medicine as a discursive regime due to the pervasiveness of medical discourse in social structures. In Chapter Five analysis of public health discourses, with the exhortations for citizens to assume self-responsibility for their health, exemplifies the persistence of the power hold of medicine on everyday life.

The second illustrative example of the extension of medical sciences into the social and moral aspects of life involves the advent of the contraceptive pill. In analyzing the political, legal and moral maneuvering to control its use in relation to different groups of women (married, unmarried, or elderly) it can be seen that social and moral discourses dominated legislative processes and regulated access to the contraceptive pill. Fertile women were seen primarily as ‘producers,’ and societies categorized women as ‘fit’ or ‘unfit’ in relation to these roles of reproducer and parent. The contraceptive was a controlled medicine in the 1960s and thus the convention was to prescribe the pill to married women only, with most countries introducing legal limits to prescription to prevent teenage access. These legal and conventional strategies removed the possibility of fertility control for those excluded from the sanctioned groupings, unmarried and young women (Cook 2004).

The case of depo-provera sheds further light on the social implications of fertility control. This form of contraception was initially banned in the United States as it was deemed unsafe, yet it was marketed and sold to largely third world countries, as well as New Zealand (Bunkle 1993). Morality around female sexuality is ‘produced’ through medico-scientific discourses of contraception and its distribution. Thus subject positions emerge from the packaging of messages to women about what counts as proper behavior, permitted behavior and what is relegated to the immoral. Additionally, analyses of race and class are significant in ethical consideration of the residue of what can only be assumed to have been neo-eugenics policies surrounding the distribution of contraceptives. Both of these historical examples center around sexuality and its regulation.

Disclosure of sexual practices to medicine is, in Foucault’s view, confessional (Foucault 1976). Behaviors are assessed, classified and objectified against sexual codes and norms, thus rendering the patient adherent or deviant concerning societal codes. Such confession renders one complicit
in one’s own control. Foucault (1984), in part two of his three part *History of Sexuality*, contends that it is the imposition of controls that delineates how sexuality might be expressed. Thus medicine, in having a part in the regulation of sex, as the two examples show, participates in the production of the moral discourses of sexuality and sexual behavior, at once asserting authority and creating the knowledge platform of normative biology and psychiatry as the basis for such authority. A discipline claiming authorship of particular truths creates a sense of shared cohesion whereby its science advances authoritatively. Its truths become widely sanctioned as society repeatedly seeks professional opinion to inform social and political decision-making, thus cementing medical authority on wider social concerns. Such authority becomes self-fulfilling, recalling Gillett’s (2004, p. 157) note that medicine ‘is incited to further efforts to expand and use its truth from within and without’ the profession.

The majority of participants in this study had consulted doctors concerning menopause, seeking expertise and guidance. Briar, Cherry, Daphne and Aster all had female doctors who told their patients they took MHT themselves. Female doctors’ practice of bringing their own personal status into a consultation raises interesting queries. It appears the women patients’ decision making was compounded by their doctors giving expert advice in tandem with a personal commendation for the therapy. The social ‘authority’ linked to the position of doctor appeared to stymie and even silence the patients. Thus the women reproduced a passivity expected in the medical discourse of a ‘patient.’

Outlined above are illustrations of Foucault’s power/knowledge nexus in operation as medicine established its position in society. Foucault (1972/1980) refers to a triangle of forces: power, right and truth. He elaborates that ‘there can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association’ (p. 93). It is through the truth ‘that power is exercised.’ Where medical science produces a ‘truth’ of the nature of humanness, whether in a diagnosis of a genetic disorder or discovery of a sexual deviation, authority accrues through ‘manifold relations of power,’ fixing the parameters of the rightness (correctness) within power relations (Foucault 1972/1980, p. 93).

In the above section historical examples of the effects of ‘truth making’ when medicine was ‘on the rise’ to being a profession have been discussed. The examples are symbolic of the modern episteme (Foucault’s term for the period commencing at the turn of the nineteenth century) which
Foucault asserts is characterized by the emergence of ‘the subject as a domain of possible knowledge’ (Florence 1984, p. 2). Firstly, the delineation of the abnormal led to medicine articulating and being a dominant reference point for social and legal evaluations of physiological and social normality, and secondly, the effects of ‘learned talk’ influenced and structured the social fabric of society. These together illuminate Foucault’s contention that genealogy makes ‘visible the constant articulation ….. there is of power on knowledge and of knowledge on power’ (1972, p. 51) in the production of truths that both claim and are awarded legitimacy in social life. Medical science’s facility to produce truth via knowledge generation, its tightly guarded educational structures, inclination toward research, economic resourcing and the buttressing of medicine by social and legal esteem, expand and cement the domain of medicine.

Contemporarily in this study, the trajectory of interventions at menopause in common use was not in line with women’s experiences of concerns about menopause. Several participants (Cherry, Daphne, Aster, Holly) reported attending company sponsored seminars on menopause at which doctors were the key speakers. The social power that accompanies the title Doctor has aided success in marketing products, as there was a steady rise in prescriptions over the years before estrogen was linked to ovarian cancers in the mid 1970s (Krieger et al. 2005; Stefanick 2005). Then progestin was given in combination with estrogen and prescriptions rose steadily again (Stefanick 2005). Disease mongering has been defined by Moynihan and Henry (2006) as ‘the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments’ (p. 192). To sell an item a marketeer is required, and some doctors become ‘marketeers’ for female hormonal products. As noted the menopausal change has been a target for disease mongering over several decades where, as a life stage, it was categorized as deviant from the norm, and thus by some seen as a deficiency disease (Sturdee et al. 1978; Wilson 1966).

Women were primed to view menopause as a period of health risk that MHT would alleviate (Mintzes 2006). The post WHI era is not exempt from this problem despite the plethora of research and review documentation on risks and guidelines on MHT (National Cancer Institute 2007; National Health Service 2005; Nelson et al. 2005; WGWHII 2002). Two participants in this study (Daphne and Aster) reported being prescribed bio-identical hormones, and below I present two examples (the promotion of bio-identical hormones and the publication of the Journalist’s Menopause Handbook, 2006) that show the contestation of the normal/abnormal.
Doctors promoting bio-identical hormone therapy (BHT) have persistently overstated the safety and benefits of their products, enacting a form of disease mongering. The pamphlet of the Optimal Health Clinic, Christchurch NZ, states that with age: ‘[l]evels of life-sustaining hormones drop precipitously’ and that ‘this marked decline is linked with conditions as varied as fatigue, hot flushes, anxiety, depression, insomnia, diminished libido and decreased bone mass.’ In this quotation the claim is only partially true of hot flashes and bone mass, not the other items listed (ADEC 2004; FDA 2002b; Nelson 2005; NZGG 2001, 2004; WGWHII 2002).

The back panel of the Optimal pamphlet contains the following: ‘Are Bio-identical hormones safe? Research has shown that at physiological levels people who use supplementation actually decrease their risk of chronic diseases, for example, heart disease, diabetes, cancer and osteoarthritis.’ This statement is extremely worrying, as if bio-identical hormones are indeed identical to some commercial pharmaceutical preparations, as already noted (on page 77), it can be expected that the same risks regarding chronic illness exist with them as with conventional therapies (Cirigliano 2007; Fugh-Berman and Bythrow 2007). None of the above claims are backed up by rigorous scientific research, and aspects are refuted by published research and review articles (ADEC 2004; Boothby 2004; Cirigliano 2007; FDA 2002; Nelson et al. 2005; NZGG 2001, 2004; WGWHII 2002). The authors play on the existence of poor quality study findings and literature that appears to support their position. Often it is what is not said that provides a vacuum where popular discourses on menopause are left to interpretation and so fill the void.

An Australian company (Menopause Institute of Australia) admitted deceiving patients in a case brought against them by the Australian Competition and Consumer Commission (ACCC) in December 2006 about Natural Hormone Replacement Therapy (NHRT). The company made misleading and deceptive representations on the safety and effectiveness of its hormonal program in comparison to conventional HRT, claiming ‘that NHRT: reduces the risk of cancer, heart disease, Alzheimer’s disease and senility; is without dangerous, unwanted, reported or any side effects; treats osteoporosis, premenstrual syndrome and loss of libido’ (ACCC 2006, p. 1). The company was required to ‘take all steps necessary to adequately warn patients about the health risks. Without such corrective measures, these patients may have remained unaware of the serious medical risks posed by the Menopause Institute’s Natural Hormone Replacement Therapy’ (ACCC 2006, p. 3). Significantly, since the findings have been made public, the
company has changed its name, thus re-representing itself to the public in a strategy to distance itself from past misdemeanors (Burrell 2009). It must then be assumed that they still perceive a viable market for their products.

Wyeth (the manufacturer of Premarin and Prempro as noted), in 2006, funded the publication the *Journalist’s Menopause Handbook* with the Society of Obstetricians and Gynecologists of Canada (SOGC) (Mintzes 2006). Page five of this publication (SOGC 2006) lists symptoms of menopause including sexual changes, wrinkles, and issues with mood, memory and bladder control. However, by the year 2000, the evidence based literature was inconclusive or showed no association of the items on this list with the menopausal transition (Nelson et al. 2005). The findings provided by Nelson et al. (2005) are affirmed in various international publications by experts including OBOM, all of whom have had their own teams of experts assess research outcomes, particularly the WHI and HERS trials (ADEC 2004; FDA 2002; National Health Service 2005; Nelson et al. 2005; NZGG 2001, 2004).

It is misleading to provide a resource for journalists when it is expected they will utilize the information in general release publications and promote misinformation.

Persistent exaggeration of the risks of menopause and over inflated claims about what HRT can achieve in relief of symptoms, or prevention of diseases, in the face of research findings that refute such claims can only be regarded as *disease mongering*, that is reproduction of the myth of menopause as a time of increased health risk for women and the onset of deficiency disease, for which apparently intervention is necessary for all women. Such rhetoric is a political means of promulgating the power and influence of systems such as medicine as part of a ‘regime of truth’ that to Rail, Holmes and Murray (2010) ‘ostracizes those with contradictory and hence “deviant” forms of knowledge’ (p. 261).

These examples have shown how ideas are produced, then reproduced in the Foucauldian senses where experts use professional weight to carry the claims even when they are out of step with other knowledge. Seemingly, constant reiteration of the deficiency model (in the face of refutation) reinforces the popular discourses of menopause as deficiency and degeneration, thus cementing the view that being older, and being well, are not phenomena permitted to exist together. ‘Deficiency,’ then, is a *sign* of the discourses that place menopause in a negative light

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22 NB The references cited were all published prior to the Canadian publication and therefore publicly available.
as an apparent cause of ill health (Foucault 1973). In addition, deficiency is signaled in efforts to gain wide uptake of bone density screen of middle-aged women, screening that will allow uptake of medication (OBOM 2006).

In deconstructing three consecutive editions of Llewellyn-Jones’ Fundamentals (1999, 2005, 2010), I have sought to identify whether or not the authors were responsive to first, incorporating the latest best practice recommendations across the eleven years; second, the release of the WHI findings and the termination of the English WISDOM trial (Vickers 2002; Vickers 2007), which were the catalysts for publication of the risks and overturned the belief that HRT was cardio-protective; third, the discourses of deficiency in relation to menopause; and fourth, the revised guidelines for practitioners:

1. All three editions of Llewellyn-Jones’ Fundamentals assessed identify that there are ‘two true symptoms of menopause as hot flushes and vaginal symptoms (“burning,” dryness and dyspareunia)’ (1999, p. 319; 2005, p. 332; 2010, p. 323). This statement does reflect cognizance of the robust knowledge based on the results of well-designed population studies (Dennerstein et al. 2000; Nelson et al. 2005; McKinlay 1992) although no references are cited in the two later editions.

2. Regarding risk the authors have altered their text in several sections. In the 1999 edition a section headed ‘management of the menopausal woman includes’ suggests ‘discussing the benefits of hormone (estrogen) replacement therapy.’ In the later versions, discussion of ‘benefits and risks’ is suggested.

3. The series of texts all contain the heading ‘Long term effects of estrogen deficiency.’ The authors persist in this label despite challenges and revisions to the term from within their own profession (Dennerstein et al. 2000; Krieger et al. 2005). In using the word ‘deficiency’ within the heading and in the text they continue to signify disease and insert a denial of a natural life course.

4. In the later texts breast cancer risk information aligns with the new guidelines, and the authors recommend MHT use for five years only, although they neglect to state that MHT be given only at the lowest effective therapeutic dose. Therefore the major recommendation on international guidelines23 is not presented in its entirety in the 2005

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23The following excerpt appears in the Center for Drug Evaluation and Research’s guide, ‘Noncontraceptive Estrogen Drug Products for the Treatment of Vasomotor Symptoms and Vulvar and Vaginal Atrophy Symptoms- Recommended Prescribing Information for Health Care Providers and Patient Labeling (I): ‘Use of estrogen, alone or in combination with a progestin, should be with the lowest effective dose and for the shortest duration consistent with treatment goals and risks for the
and 2010 texts. What counts as normal, I have shown, is contested in the saga of menopause and its treatments. The imprint of history on the menopausal body is at the very least confusing and at its worst dangerous. The portrayal of menopause as negative misrepresents this event in life for many women.

7.3 Normalization of the female subject

In this section I begin by exploring the normalization of the female subject, and secondly, consider the middle aged woman, specifically analyzing normative aging and the menopausal state as normalizing constraints are informed and directed by cultural norms.

Western philosophy persistently appears to relegate the category ‘woman’ to a subnormal position derived from differential assessments of capacity (intellectual, moral, and physical) attributed to the sexes. Traditional biosciences fashion understanding of the humanist subject (arising from Descartes’ mind/body split) so as to produce a reductionist and mechanistic schema of the body (Fox Keller 1992; Martin 1991; Shildrick 1997). Descartes’ dualism has endured throughout Western medical discourse for over 300 years, with earlier roots in Greek philosophy (Shildrick 1997). To Descartes, the mind is elevated by rationality and selfhood whilst the body is rendered mechanistic, mundane, even profane (Descartes 1912). The binary is not benign; rather a hierarchy is instituted in the very act of posing a dichotomous relationship in the dyad. The axis of difference is a violent hierarchy according to the philosopher Derrida (1981), a poststructuralist and contemporary of Foucault’s. Thus when applied in the context of gender the co-existing concepts are already laden, and delineate the female/feminine and male/masculine at the level of the materiality of bodies and their socio-cultural meanings (Butler 1990, 1993). Social norms affect the relegation of women to a plane less valued due to assumptions of passivity and lack compared to males (where women are referred to it is frequently as a modified reflection of maleness).

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The critiques of medical science’s tendency to represent women and their bodies negatively in relation to men and male attributes are many and varied, but the work of Emily Martin is especially pertinent here. Martin (1991), drawing on excerpts from classical medical texts, clearly illustrates that in many instances female biological processes are not reported in the value neutral language of objective science as purported, but are reported with negative bias as in Alberts (1983), Delaney (1986), Erikson (1964), Mountcastle (1980) and Vanders, Sherman and Luciano (1980). In assessing the language and analogies used in scientific and academic texts Martin is analyzing what Foucault calls ‘learned-talk.’ As we saw earlier, ‘learned-talk’ has the weight of disciplinary power in constructing normative understandings. Martin quotes Mountcastle’s (1980, p. 1624) classical text and identifies the language as value laden in his comparison of female and male reproductive processes (1991, p. 486). A large portion of her article deals with specific references in formal texts that attribute differential language to women and men, noting that positive representation is denied in the case of the female body as in Alberts (1983) and Mountcastle (1980). Passivity is attributed to eggs (oocytes) and its opposite, activity, to sperm. The verb shed is attributed to explain that gametes are released monthly, then the text compares this process with the male equivalent, stating ‘seminiferous tubules produce hundreds of millions of sperm each day’ (Mountcastle 1980, p. 1624 in Martin 1991, p. 486). She queries how it is that the verb shed is used to depict the release of the egg instead of saying ripen, which is equally representative of the process yet lacks the negative connotation. Martin (1991, pp.487-489) identifies instances where oocytes are viewed as ‘merely sitting on a shelf…like an over stacked inventory,’ and oogenesis is termed ‘wasteful’ throughout the fertile years, whereas Alberts (1983), Ganong (1975) and Vanders et al. (1980) describe sperm as penetrating and possessing velocity. Martin concludes her article by highlighting the dangers inherent when science uncritically imposes these cultural and gendered metaphors at the level of cells, imbuing cells with agency and personhood and thus attributing unequal value to equivalent biological process.

Jo Diorio and Jenny Munro (2000) analyzed schools’ sex education materials in the 1990s, concurring with Martin in her assertion that the use of such language (bodily processes understood in gendered forms) has far reaching consequences. From the analysis of four free publications used in New Zealand schools they reported that sexual feelings are acknowledged and therefore validated for boys experiencing bodily change in puberty, whereas ‘there is no analogous material relating to girls, thereby failing to open the possibility that they may
experience sexual thoughts and feelings, or how their bodies might respond if they do, for example, increased vaginal secretions’ (Diorio and Munro 2000, p. 355). The authors state that ‘while girls are told to be excited about growing up so they can have babies in the future, boys have their developing adulthood linked to power and pleasure now’ (emphasis in the original) (p. 354). The educational materials analyzed in this study perpetuate gendered messages, conveying them to repeated generations of young people. In particular they promote the innocence (and ignorance) of girls, innocence which is often to their detriment when they are deprived of knowledge which could lead to anticipation of danger in some situations. Foucault’s concept of constraint of subjects promulgated through a discursive formation about sexual difference is clearly in evidence in these examples.

Identifying the differential treatment in language between the sexes reveals the cultural imprint of stereotypical association permeating medical discourse and thus normalizing discursive constructs. Additionally, in relation to biology and biological sciences the stereotypical trajectory of thought opens the possibility of pathologizing a normal event as the norm for women who are already culturally relegated to the ‘abnormal.’

### 7.4 Menopause as deficiency disease

The ever-present tendency towards negative regard for women’s biology in formal contexts created the conditions of possibility for menopause to be conceptualized as both deficiency and disease. A distinction between what counts as normal and abnormal is central to discussion of health and illness in relation to menopause. Deficient elements are elements which ought to be present. The discourse of deficiency has a resonance with established truths; it takes the language of norms and the weight of a norm, that is, its enduring, constant form (Canguilhem 1978) (see Canguilhem’s definition provided earlier on page 127). Foucault informs us that it is in the ‘medical bipolarity of the normal and the pathological’ that we organize our world, groups of persons, by race and by societies (Foucault 1963/1989, p. 41). Both Foucault and Canguilhem...
interrogate and undermine the idea that the object of medicine can be known through the scientific experimentation, factual, exacting, objective determinations as Bernard states (Tiles 1993).

As outlined in the historical background chapter, nineteenth century physicians described the ‘change of life’ as a time of sin and decay (Ratcliff 2002), moral insanity, loss, and as a time when women ‘ceased to exist for the species’ (de l’Isere1845 in Utian 1997, p. 74). Tilt (1857), who wrote one of the first books dedicated to menopause, said ‘women at the change of life are frequently affected with cancer, gout and rheumatism;’ he also claimed that ‘well-localized nervous affection sometimes occurs at this critical epoch,’ and women in post-menopause may display ‘dyspepsia, diarrhea, rheumatic pains, paralysis, apoplexy, hemorrhage, tuberculosis and diabetes’ (Tilt in Utian 1997, p. 75). He recorded both the physical and psychological aspects associated with menopause. Despite much negativity, on the positive side Tilt also reported that the change of life can ‘impart a firmness of purpose’ where women display effective household management, revealing themselves to be politically and socially astute (Tilt in Utian 1997, p. 75).

In discussing menopause from a historical perspective, Utian (1997) incorporates more of a balanced view of the menopause, reporting research that documents midlife changes for both women and men. By the 1920s the term ‘menopause’ was in use (Council of the Medical Women's Federation 1933).

Articulation of scientific measures of sex hormones and their norms of variance at different stages of the reproductive cycle produced, in Foucauldian terms, a discourse of the ‘model woman.’ Conceptualizing menopause as a deficiency state gained traction in the twentieth century as several discourses intersected to allow the conceptual leap from natural benign decline to disease to occur.

Early twentieth century psychiatrists devised a diagnosis of ‘involutional melancholia,’ a step that led to the hospitalizing of women over a normal life course phase. Psychologically, women could present with irritability, depression, hysteria, melancholia or even insanity (Dickson 1990). Psychologist Helene Deutsch (1945) held the view that a woman’s key developmental task in postmenopausal years was to ‘accept the progressive biological withering’ that marked the stage (Fausto-Sterling 2002). By definition theories of developmental tasks are articulated within theories generalized to all humankind. They are based in the universal assumptions that some
enduring truth about human development (based on an a priori grand plan) can be discovered (Morss 2000). To post-modern academic John Morss (2000), such views delimit the ability to create and envisage new ways in the helping practices, as well as limiting the tools psychology works with. For now, the question that demands an explanation is, ‘how did a norm of a natural decline of female fertility hormones in advancing years (menopause) become a deviation from a norm for a healthy woman and then in turn become pathologized?’ In addressing such a question, it is necessary to deliberate on this conceptual extension of ideas, which can be depicted as below:

Physiological norms > aging > physiological decline of sex hormone levels > pathologizing of norms in menopause > pathologizing of aging.

The writings of Robert Wilson insinuate a social ideology of women as sex objects and reproductive organs. Wilson (1966) author of Feminine Forever, promotes a view of the older woman as redundant to society and herself, reflecting the sentiments in earlier publications by authors such as de l’Isere and Deutsch. He defines a ‘woman’ predominantly by the bodily processes of aging and not by any other attribute or quality. Further, we might ask, how did the post-menopausal woman (infertile woman) suddenly become a diseased woman? It could be claimed that this occurred because of the norm of fertility and the fact that older women could no longer able to carry the male seed. The non-fertile state is relegated to deviancy, a state which is too easily translated into one of disease. Such a transition reveals a simplistic reduction of women to body parts and a diminishment of the person imbued with subjectivity: a person of potential, a position that depends upon an essentializing argument. Identifying a deficiency disease leads to a new form of social control (McCrea 1983).

Philosophers of medicine have deliberated on the question of what constitutes a disease, when a complex set of physiological change(s) in a patient might be categorized as a recognized disease. Over the last century, signs (those alterations in a patient’s presentation noted by the physician) have become increasingly observable (magnification, micro-instruments, imaging, bio-sample testing and technological aids) and quantifiable in scientific measures, making specific diseases identifiable. The accompanying signals of disease, symptoms (those alterations reported by the patient, such as pain, decreased function), have become less important as a factor in isolating specific diseases (Aronowitz 2004). Symptoms on their own do not lead to the identification of
specific diseases; diseases are entity complexes recognized by established patterns and specific features (Aronowitz 2004; Szasz 2004; Tiles 1993). Aronowitz (2004) points out that functional disorder was understood in the nineteenth century as ‘physiologic, diffuse and hidden,’ whilst contemporarily it means an absence (or alteration) of body mechanism (p. 67). The development of technological tools enabled the isolation of diseases as deviations from norms were observed/quantified.

In this case the diagnosis of disease depends upon the presentation of symptoms conveyed almost exclusively by the patient (as rarely would a doctor observe the symptom cluster typical of menopause). Alteration of measures such as decreasing secretion of levels of hormones in the bloodstream is a normal decline observed in every aging woman, so not technically a ’sign’ of disease. Wilson (1966), and those of a similar mindset, in naming menopause as a deficiency state, rely on an approach to diagnosis which Aronowitz (2004) suggests is flawed, as it appears to be have been based in symptomatology (purely clinical criteria). It is usual for diagnosis of a presentation to use consensus criteria (tables which mix and match combinations of symptoms, signs and data (laboratory and body fluid, biopsy, radiologic test results) to gauge the fit between the patient’s profile and a named disease. While in menopause the reason for the symptoms is a decline of hormone levels; this is a habitual, normal, physiological alteration for the age group and sex, not an abnormal departure from a lifelong stable norm. If decreasing blood levels of aging females’ sex hormones are categorized correctly as normal (given that it is normal for hormone levels to decline in all menopausal women, knowledge provided to us by a normative physiology), it can then be deduced that the diagnostic frame for menopause as deficiency can only depend upon symptomatology, not the matrix of contributing factors Aronowitz outlines as characteristic of diagnostic good practice. It could be interpreted that those purporting menopause to be a pathological state appear to view middle age and beyond as a diseased state; in other words, the aging woman is perpetually unwell. Aronowitz (2004, p. 68) maintains that social factors have a significant role to play in the phenomenon of symptom clusters getting to achieve status as diseases. He notes that the limits of contemporary medical knowledge constrain our ability to isolate factors and also condition our view of what is regarded as healthy function. Many authors state that the rigor of science was neglected over several decades in the claims of the existence of a hormone deficiency disease called menopause (Bell 1990; Coney 1991; Greer 1991; Krieger et al. 2005; Lewis 1993; Leysen 1996; McCrea 1983, 1984; Seaman and Seaman 1978, 2003; Utian 1997; White and Schilling 2000).
Diethylstilbestrol\textsuperscript{26} (DES) provides an example of such neglect. It was with remarkable acceleration that diethylstilbestrol was manufactured and marketed, after publication of its initial production in 1938. DES was prescribed for various purposes, including hormone replacement in menopause (Seaman and Seaman 1978). Sir Charles Dodds, who was responsible for its synthesis, remarked in 1965 that:

\begin{quote}
Within a few months of the first publication of the synthesis of stilbestrol, the substance was being marketed throughout the world. No long term toxicity tests on animals such as dogs were ever done with stilbestrol …. It is really surprising that we escaped major pharmacological disasters until a few years ago.
\end{quote}

(Dodds 1965 in Seaman and Seaman 1978, p. 5).

The ‘disasters’ referred to involved the discovery that when given to pregnant women to reduce the risk of miscarriage, diethylstilbestrol had no therapeutic value (as had been widely claimed) and research with animals had shown it to be carcinogenic. A worse disaster was to unfold when the daughters of pregnant women who had been treated with diethylstilbestrol developed vaginal and other cancers, revelations first published in 1971 (Herbst 1971).

Krieger et al. (2005) query why several decades passed before RCTs were undertaken in the late 1990s on the effects of HRT, when much research, including epidemiological research, pointed to increased risks of cancers, and there was controversy over the cardiac effect of these drugs. As noted in Chapter One, it was as early as the 1930s and 1940s that publications warned that estrogen increased the risk of endometrial cancers (Gusberg 1947).

Two possible explanations (not mutually exclusive) can be ventured. One possibility is that the absence of the large population based science research being applied to the HRT issue raises a query about discriminatory mindsets toward women in general by some factions within medical science (note here the discussion in Chapter Six on the subjugation of women’s voices). Secondly, Foucault’s concept of truth suggests that when professionals espouse a truth, the repeating of it in the manner of ‘learned talk’ produces and reproduces the discursive construct leading to widespread uptake of the idea, and thus in this case led to the proliferation of

\textsuperscript{26} Diethylstilbestrol is commonly shortened to stilbestrol; these terms are used interchangeably in this thesis.
prescribing of ERT and HRT. The fact that HRT was largely prescribed to selected populations of middle class white women alerts us to the commercial interests invested in the uptake of this cluster of medications. Interestingly, several decades after the publication of Wilson’s book *Feminine Forever*, his son revealed it was underwritten by the giant pharmaceutical company Ayerst (Krieger et al. 2005). This kind of knowledge leads one to conclude that perhaps Wilson’s penchant for promulgating the view of middle age women as diseased had a self-interested rather than a scientific or therapeutic motive.

Discourses that couched menopause as a deficiency disease gained traction due to certain discursive forces. These were forces such as the resonance of scientific truth: the language of science (deficiency refers to concrete mathematical measures recalling identified parameters of the normal, that is *signs*) proclaimed by a benevolent and authoritative profession playing on a presumed desire (that it is somehow natural for all women to wish to reverse the ‘truth’ of beauty lost as age advances), along with the very powerful idea that science can remedy deficient states by replacement of elements (chemicals). The idea of menopause as a deficiency disease was promoted largely to middle class women, the economically established, thus raising issues about the impetus for promotion being linked to commercial interests (Krieger et al. 2005; Stefanick 2005).

The elevated place of medicine in the social hierarchy, the power of learned talk (linked to medical scholarly and academic activity) and a professed desire ‘to do well by women’ filtered through a discourse of ageism and sexism based in the feminine beauty ideal, resulted in an unprecedented prescribing of ERT. The appearance of neutrality/naturalness is embedded where a discursive construct is hegemonic, in that its very concepts are premised on an accepted knowledge/wisdom and consequently yield a particular potency as persuasive ideas/ideals and normative constructions of women.

Menopause, as noted, has been viewed as the root cause of many and varied health complaints (Anon 1975; Deutsch 1945; Greenblatt 1979; Kopera and Utian 1990; Krieger et al. 2005; Stefanick 2005; Wilson 1966). Latterly those who seek/appear to promulgate diseases are coming under critique by scholars who, as noted, have coined the phrase ‘disease mongering,’ which in the one stroke both highlights the issue while denigrating the actions of proponents of unfounded diseases (Tiefer 2006). Recent commentators note that family/social, psychological or pathological events that are concurrent or parallel with menopause are often wrongly conflated
with the peri-menopause. This is a point echoed in the texts of participants in this study, who remarked that other issues compounded their experience of the peri-menopause. This finding is also reported in the literature. For example, a prospective population study by Dennerstein et al. (2000) followed 438 Australian women for seven years, assessing symptoms prevalence, severity, change and relationship to menopausal status, blood levels of follicle stimulating hormone and estradiol and other factors. The researchers concluded that only three symptoms, vasomotor, vaginal dryness and breast tenderness (which decreases), out of 33 were related to hormonal changes. Other so-called symptoms were not directly related. Some other concerns, such as mood disturbances and insomnia, are related to bothersome symptoms like vasomotor (hot flashes) issues but not to estrogen levels as such.

Brown, Mishra and Dobson (2002) in a large (n=8,623) Australian wide cohort survey found that prevalence of physical symptoms was not significantly reduced in women taking HRT during menopause compared to those who were not on HRT (Brown et al. 2002). Hardy and Kuh (2002) in a survey of 1572 English women reported that psychological issues are not affected by menopausal status; instead such symptoms are related to life stresses and family difficulties (Hardy and Kuh 2002). Three studies, Dennerstein et al. (2000), Brown, Mishra and Dobson (2002), and Hardy and Kuh (2002) were cited as high quality studies in the Agency for Healthcare Research and Quality’s evidence report number 120 (Nelson et al. 2005).

Oats and Abraham (2005) refute a rather commonly held idea that menopause is related to an increase in depression in mid-life women. The National Institutes of Health Consensus Statement on menopause reports that there is ‘strong evidence’ that the menopausal transition causes vasomotor symptoms and vaginal dryness, and only ‘moderate evidence’ that menopause is linked to sleep disturbances (National Institute of Health 2005b). The consensus found there was not sufficient proof of a link between menopause to somatic symptoms: cognitive disturbances, urinary incontinence, uterine bleeding problems or sexual dysfunction, so any relationship claimed is unproven (Nelson et al. 2005). Breast tenderness decreases with advancing menopause. Interpersonal stress, smoking, or poor overall health are compounding factors in menopausal discomforts.

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Rhetoric about the menopausal female is fluid and shifting, with various discursive constructs occupying the rhetorical space about midlife, health and normality. The idea of women being ‘deficient physiologically’ is still perpetuated in the public space of health discourses, yet it sits uncomfortably with the discourse that states the majority of women will not be incapacitated by menopause. Many experts espouse the potential and actuality of aging well through menopause. In these discourses (whether partial or thoroughly enunciated) we see the ‘imprint of history’ on the woman’s body, ideas mooted four decades ago (Wilson 1966; Kennedy 1985) and proliferated through popular media as well as academic sources, ideas that some ‘take up,’ stereotyping the mid-life woman (Foucault 1971/1984, p. 83). Equally, women and health professionals ‘take up’ the discourses that challenge and oppose a negative view (BWHBC 2006; Coney 1991; Krieger et al. 2005; Seaman and Seaman 1978).

The Llewellyn-Jones Fundamentals contain partial discourses and mixed messages (where over the three editions some revisions and additions of information have been made according to research findings). There are instances where the script has not been changed, but rather presents negative and even out-dated discourses and assumptions about women. For example, the texts contain the inference that lowered estrogen causes osteoporosis, yet that causal link is not that simply established, and other causes such as diet, dieting and poor activity levels account for morbidity (Massion and Fugh-Berman 2000; National Women’s Health Network 2002; Oats and Abraham 2010). It is what is missing that fortifies the inferences in the case of osteoporosis. By omission and silence a negative discourse is affirmed. Concerning osteoporosis, failure to mention dieting, weight loss over life span, consumption of medications that deplete minerals, insufficient calcium intake and insufficient exercise as causes of the disease, affirm to the reader that, by omission, declining estrogen levels must be the cause. Llewellyn-Jones Fundamentals 2005 (p. 336) and 2010 (p. 327) editions state that women with risk factors should consider taking HRT. Bio-phosphates are introduced into the text in such a way as to imply they are an alternative to HRT, when internationally consensus and governmental guidelines state bio-phosphates ought to be first line treatment, and estrogen medications are not recommended as such (ACOG 2008; Institute for Quality and Efficiency in Health Care Germany 2006; National Cancer Institute 2007; National Health Service, 2005; New Zealand Guidelines, 2004; NHMRC 2005; RCOG 2004; SOGC 2006).

Under the section headed ‘Long-term Effects of Oestrogen Deficiency,’ the introductory section of each Llewellyn-Jones Fundamental texts considered in this study state that ‘long-term effects reduce life expectancy and quality of life. These are an increased risk of ischaemic heart disease and osteoporosis’ (1999, p. 320; 2005, p. 324; 2010, p.333).
Under a Foucauldian analysis, the authors of the Llewellyn-Jones Fundamentals are participating in reproduction of the deficiency discourse. Moreover, an absence or failure to mention a point does not by omission make what is left said the truth; rather, it is rhetoric only. For example, the dichotomy of sexes (male and female) is not a truth, as the third sex (or inter-sexed persons) exist, yet have been denied by the rhetoric that has divided humankind into two sexes (Butler 2004). As the Llewellyn-Jones Fundamentals are medical texts for the instruction of medical students, the idea of menopause as a deficiency disease is perpetuated to new generations of doctors where patients will become subject to such categorising. The possibility exists that future doctors will present MHT to women with risk factors despite the evidence. Interestingly the 2010 edition contains other instances where the consensus guidelines are reiterated. Two examples are noted below. First, the authors, in line with the guidelines, write ‘(H)RT has not been shown to either prevent dementia including Alzheimer’s or reduce the degree of dementia in established suffers’ (p. 325). Second, under the heading of ‘Contraindications to the use of HRT,’ the 1999 edition contained the following statement: ‘current evidence is that the benefits of HRT, even in asymptomatic women, are greater than its disadvantages, and a campaign to persuade women to take HRT would improve women’s health, but must be handled carefully’ (p. 321). The quotation is omitted in the later editions, in line with consensus guidelines (discussed further in the following paragraph). Therefore it can be concluded that there is an acknowledgement of divergent discourses (Foucault 1972/1980) in the Llewellyn texts. Discourses are partially expressed, incomplete and as we saw earlier (in Chapter Five) the text is directed at differing audiences at various times.

7.5 Drug regulation: A game of truth?
Conflicting claims in the public sphere about the efficacy and safety of MHT indicate an ongoing contestation of the truth premises in the promotion of therapeutic interventions. In considering drug regulation in a contemporary democratic society that values individual freedoms, to effect regulation there has to be buy-in from the community, buy-in that is accompanied by the expectation that force is only ever used as a last resort. It is pertinent here to consider the role of consensus gatherings (usually attended by practitioners, scientists, researchers, and allied health professionals). These are processes by governments, regulators and disciplinary societies to gather the best evidence and review data, both research findings and expert clinical opinion, to
reach a consensus about whether interventions are safe and efficacious for defined populations. Interestingly, accompanying the FDA’s Center for Drug Evaluation and Research’s (2005) Guidance for Industry ‘Non-contraceptive Estrogen Drug Products for the Treatment of Vasomotor Symptoms and Vulvar and Vaginal Atrophy Symptoms — Recommended Prescribing Information for Health Care Providers and Patient Labeling (I)’ is a rider that states FDA guidance does ‘not establish legally enforceable responsibilities’ (p. 2); rather, the document ‘describes current thinking on a topic’ and should be ‘regarded as recommendations.’ Consensus meetings produce guidelines that could be expected to be the definitive ‘word’ on various treatments, yet it appears some practitioners continue to ignore or only partially follow the parameters of the guidelines regarding relief for the symptoms of menopause. Therefore some doctors depart from the spirit of collective wisdom (as in guidelines) and under the cloak of their profession ensure the reproduction of alternative discourses that promote interventions not widely considered ideal.

Returning to the Llewellyn-Jones Fundamentals’ use of the words ‘true symptoms’ of menopause, the texts, by virtue of placement in the chapter, position other issues as part of menopause. For example, osteoporosis is not a gynecological condition (the authors do state that osteoporosis affects men as well as women). The authors, however, place this material in the chapter on menopause, and by association it is linked to the menopause, yet in their own words is not a ‘true symptom’ of menopause. Inconsistency in discourse on menopause leaves women confused, as some participants in this study revealed that mixed messages open the door for promoting interventions regardless of guideline recommendations. Doctoring has structured the possibilities of subjectivity for women by deploying discursive strategies that describe menopause and ‘solutions’ to menopausal concerns. Reliance on a discourse of deficiency is a discursive strategy that proscribes the menopausal experience in advance, so that anticipation of menopause is already couched in the negative.

Throughout I have considered the content of official guidelines on the efficacy and risks of MHT, and yet there was (and still is) a wave of backlash as proponents of MHT have sought to mitigate the fall off in consumption that followed the change in guidance. Those who recommend caution, and limiting prolonged use of MHT, were (and still are) accused of scaremongering. The scaremongers about disease were barely silenced by the publication of the WHI and HERS findings, as further campaigns were commenced condemning those who advise caution (Shapiro
This appears as a case of detractors participating in scaremongering themselves. As promoters of MHT they relied on women’s fears of potential diseases and scaremongered by advising uptake of a medication on the grounds that it could prevent certain diseases, yet once the prevention claim was challenged they themselves returned with counter-attack style scare tactics.

Within the texts of the participants in this study arguments about lifestyle choices were deployed and inserted alternative discourses. The idea of enhancing ‘lifestyle’ has powerful synergies with a ‘right to choose’ argument (interview excerpt Rose p. 120). There is evidence that MHT can be viewed as a ‘lifestyle drug,’ given its promotion often included references to enhancing appearance, youthfulness, sexual performance, preventing a dowager’s hump and dementia. In the right-to-choose discourse a plethora of alternatives and configurations exist to which people can align themselves. Where originally the idea of a ‘right to choose’ in health signified the overthrow of constrictions of a proscribed life that restricted and subjugated women’s freedoms to a paternalistic medical fraternity, it is now sometimes a catch-cry used to justify any choice.

Although media and advertisements have promulgated a discourse that hormones are responsible for every difference between men and women and every unpleasantness for women, findings from scientific studies refute such a view. As already mentioned, Merck, who manufacture the alendronate Fosamax, targeted aging women in a multi-pronged campaign to increase the uptake of their product. Their campaign clearly had a gendered slant despite the fact that osteoporosis also affects males, albeit to a lesser degree (Ebeling 2008). Taking such a tack underscores the sexist and deficiency models that persist about aging women. As Rose (2006) notes, drug company advertising strategies seek not just to market lifestyle medications but to reshape the potential patient’s understanding and presentation of their problems to their doctor. In the US, direct to consumer (DTC) marketing was deployed with vigor by pharmaceutical companies after laws were relaxed in 1985 (Hollon 1999). This came about after agitation from the companies, and was an added strategy to the underwriting of articles and books targeting populations of interest. As noted, Wilson’s research and 1966 book were underwritten by the giant pharmaceutical company Ayerst (Krieger et al. 2005). Other strategies to promote the uptake of estrogen therapies were ghostwriting and the cultivation of opinion leaders (Fugh-Berman 2010).

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29Ebeling (2008) notes that with osteoporosis, ‘Vertebral fractures are common in men; rates for men over age 65 years are only half those among women (p. 1474).
David Healy (2006) details three strategies (consensus conferences, pharmaco-economic modelling and ghost-writing) used by pharmaceutical companies to market their products despite weak evidence or dubiousness of the efficacy and safety of products (Healy 2006). Techniques discovered in the case of MHT reveal the mischievous and even serious political and economic intents behind prolonged promotion of MHT across the decades.

Firstly ghostwriting: in the case of Premarin and Prempro, the manufacturer, Wyeth Pharmaceuticals, had a longstanding (1996 to 2004) association with the media education and communication company DesignWrite (Fugh-Berman 2010). During litigation brought against Wyeth by 14,000 plaintiffs (who had taken Prempro and developed breast cancer), documents related to the company’s marketing and promotion of HRT/MHT became publicly available. Fugh-Berman (2010) maintains these documents revealed a myriad of strategies and maneuvers that were unknown up until this point. It seems recourse to litigation is unequalled as a vehicle for eliciting disclosure of drug-company practices that are otherwise concealed as commercially sensitive practices (Kesselheim and Avorn 2007). The marketing strategies included publications in academic journals, strategic positioning in journals, mini-reviews, case reports, editorials, journal supplements, letters and comments, and convening seminars/meetings (including sponsorship of continuing medical education (CME) materials). All of these activities rely on the cultivation by companies of opinion leaders (who may be health professionals or bio-scientists). These strategies promoted off-label uses, provided information that minimized harms, and promoted unproven benefits. From the early 1990s condemnation of ghost writing for the promotion of pharmaceuticals had surfaced in medical journals (Anon 1993; Horton 1996; Rennie 1991).

In the face of evidence that MHT causes cancers (in the 1970s endometrial cancer (Smith, Thompson and Herrmann 1975; Ziel and Finkle 1975), in the 1990s breast cancers (WGWHII 2002), companies merely produced a new iteration of their drug. After ET came ET + P, and latterly production has shifted to a low dose MHT regimen. Among DesignWrite company documents available to the court on Premarin and Prempro was a handwritten notation that stated their strategy to ‘dismiss/distract’ any opposition (Singer and Wilson 2009). These two words appear to capture the tactics deployed in countering challenges about their products.

Another strategy Wyeth used from 2002 to 2006 was to sponsor continuing University of Wisconsin medical education programs and contribute teaching materials. The programs
attended by thousands of doctors contained the contention that the Women’s Health Initiative study ‘misses the mark on quality of life’ (Singer and Wilson 2009, p. 1). Where no data exists or is weak, by filling gaps and areas of doubt with information advantageous to their strategic direction (usually increasing sales), drug companies set out in a systematic and multipronged program to target professionals and consumers. The reiteration of ideas linking their product to discourses on ‘quality of life’ and ‘the right to choose’ can be (and have been) utilized to advantage by any faction in the chain of delivering drugs to the market.

There was a deliberate strategy to insert rhetoric to influence thinking and imply merits of MHT where they did not exist (Fugh-Berman 2010; Singer 2009; Wilson 2009). MHT was ideal for drug companies to pick up and exploit doubts on risks, despite having a hand in creating and expanding the depth of uncertainty about risks. Fugh-Berman (2010) and the New York Times (2009) detail the ghostwritten publications that arose from Wyeth’s strategic plans as set out by DesignWrite. Twenty-six articles published in prestigious journals appeared between 1998 and 2005. They maximized the benefits and minimized the risks of MHT in protection against dementia, heart disease and aging skin, and promoted novel uses of MHT. Other articles mitigated the perceived risks regarding breast cancer, promoted SERMs and after 2002 positioned low dose MHT regimes as safer. Wyeth’s part in the publications was not disclosed to the journals (Singer 2009). The company’s habit of creating discursive spaces by reiterating the inconsistencies and gaps in knowledge about MHT, and then proposing concepts that allowed them to continue to push sales, was done under the cover of privacy due to commercial sensitivity. Spielmans and Parry (2010) comprehensively detail pharmaceutical manufacturers’ strategies used to influence biomedicine by critiquing internal industry documents. These are strategic activities that operationalize Foucault’s concept of ‘political economy’ of truth expressing a particular sort of power, in that under the cover of legal and commercial conventions the relentless marketing took (and is taking) place (Foucault in Rabinow 1984, p. 73).

Consensus negotiation is open to manipulation and participants may have ulterior vested interests, such as ongoing research projects that would be undermined if consensus decisions and resulting guidelines alter the status quo. The 2005 NIH document that has widely influenced perceptions on MHT and been the basis (along with other data) for numerous guidelines and advice was the publication that arose from a consensus process (National Institute of Health 2005). It is nominated as a ‘State-of-the-Science’ statement following a consensus conference
convened under the NIH Consensus Development Program, an initiative that ‘generates evidence-based consensus statements addressing controversial issues important to healthcare providers, policy makers, patients, researchers, and the general public’ (National Institute of Health 2011, p. 1). ‘State-of-the-Science’ conferences are convened ‘when the available evidence [on a topic] is weak or contradictory, or when a common practice is not supported by high-quality evidence’ (National Institute of Health 2011, p.1). MHT fitted this category as evidence was contradictory (like its role in breast cancers), and common practices (widespread prescribing for off-label uses for prevention of dementia and heart disease, and treating depression) were not supported by strong evidence. Healy (2006) has pointed out that consensus conferences are open to commercial influence as decisions are made by agreement and not evidence alone or experimentation. It is the very ground of perceptions of uncertainty, weak evidence and self-interest that opens the door to outside influences.

In addition, at play in the case of menopause are the denigration of the aging woman and the rhetoric of ageless beauty (a point which will be consider later in the discussion). Manufacturers have taken up from the consensus recommendation that the lowest dose possible (that is, therapeutic) be given for the shortest time to treat the major symptoms of menopause, and have heavily marketed a low dose pill. This strategy circumvents the damaging research findings based on the dosages of MHT in the WHI and HERS trials. Low dose Premia® (Prempro) is not Ministry of Health subsidized by Pharmac in New Zealand, and therefore there is a low likelihood participants were prescribed low dose products. That low dose products are safer is an assumption that a low dose must entail less risk, yet the low dose regimes have not been trialled in large population RCTs. Therefore evidence to support a shift to low dose regimes is lacking.

As already mentioned, there has been rigorous recruiting of ‘messengers’ to continue to promote products and interventions concerning MHT. Messengers enlisted to promote products, often indirectly by voicing the areas of controversy, are opinion leaders, medical experts whose views carry influence as conference speakers, clinicians, authors and researchers. The terms ‘opinion-leader’ and ‘thought leader’ have entered our lexicon. Coining phrases is a tactic devised by companies as revealed in the court proceedings of the plaintiffs’ action against Wyeth (and

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30Pharmac is a governmental organization that devises the Pharmaceutical Schedule of medications to be publicly funded in New Zealand. Premia (Prempro) (.625 mg conjugated estrogen/2.5mg progestin) is the sole combination MHT funded by Pharmac.
latterly Pfizer as they bought Wyeth in 2009) relating to the development of breast cancer while taking Prempro (DesignWrite n.d.). 
The section above has documented events and activities that when viewed through Foucault’s genealogical lens reveal power platforms that have affected the health of many women. The bodies of participants were subject to the imprint of history as they sought advice and treatment for menopausal concerns. The academic, scientific and lay rhetoric on MHT moulded the ways women could perceive hormone therapy. Gross manipulation of what ought to count as truth has occurred, perpetrated by drug companies and associates. As already acknowledged, the multiplicity of ideological possibilities created room for doubt and illusion to abound regarding the efficacy of MHT. The emergence of specific manipulation by Wyeth, since the 2009 court action, provides some explanation for the apparent conflicting understandings in information on benefits and risks that participants (and their doctors) in this study had access to (Fugh-Berman 2010; Singer 2009). Retrospectively we can assess the positioning of MHT in the literature. Recalling the quotation from Foucault in Chapter Two that ‘behind things (there) is not a timeless and essential secret, but the secret that (things) have no essence or that their essence was fabricated in a piecemeal fashion’ (1971/1984, p. 78), it is my claim that the interchange of discourses and events has treated women as pawns in a commercial endeavor, played out to maintain the market share for pharmaceuticals. Equally, health professionals have been strategic movers as company operatives, and some have acted as pawns themselves in the fabrication of beliefs about MHT. Significantly, these events have compounded the other intersecting discourses already discussed about women and normality.

Where truth about the science of hormones and bodies ought to have existed in academic and research journals, we have seen that truth (that is, knowledge) is a fabrication. Knowledge is about evidence, whilst thought or opinion are about belief systems or instincts, and the tension between evidence and opinion is the ground on which the building of consensus resides, making consensus processes a social practice (Fairclough 1993). I do not wish to imply that knowledge is certain or fixed, as new knowledge is always a challenge to existing knowledge, and open to uncertainty. Achieving consensus is a battle within the discursive realm. Fugh-Berman states that although definitive data exists to the contrary, many gynecologists still believe that the benefits of HT outweigh risks in asymptomatic
women. This non-evidenced-based perception may be the result of decades of carefully orchestrated corporate influence on medical literature (2010, p. 1).

By identifying opinion leaders and courting their participation in commercial endeavours, pharmaceutical companies are tapping into the disciplinary prestige of the medical profession, whilst setting doctor against doctor in consensus meetings where knowledge is contested and directions for the profession set. Foucault tells us, ‘there cannot be particular types of subjects of knowledge, orders of truth, or domains of knowledge except on the basis of political conditions that are the very ground on which the subject, the domains of knowledge, and the relations with truth are formed’ (Foucault 2002, p. 15). Consensus gatherings to set the directions for a profession, and guidelines on treatments, are examples of Foucault’s power/knowledge nexus in operation. Foucault impresses on us that ‘relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation, and functioning of a discourse’ (1972, p. 93).

Catch phrases such as ‘quality of life’, ‘right to choose,’ ageism toward older women, rhetoric on unproven benefits and uses of MHT and evidence on efficacy of menopausal treatments were all circulating discourses. At times they are partially expounded and even can be seen to have arisen from the Wyeth/DesignWrite’s secret strategy to ‘dismiss/distract.’ There is now evidence available of the company’s aim to promote MHT as a panacea, and this idea is overt in the discursive spaces on MHT. These discursive elements can then be deployed in myriad ways by any involved in consensus activities, thus a consensus of experts is not between individuals meeting together in a room for several days, it is the outcome of power at work via discursive productions and iterations of familiar and novel discourses. An interesting point with the outcomes of the WHI trials was that the federal government ‘owned’ the data as the studies were federal sponsored, unlike much data that is company owned and not available for independent assessment or analysis.

7.6 Drug safety and reduction of harm: Debating public health

In analyzing the role of the FDA in public health discourse, I am returning to the concept of the discipline of public health as a scientific and cultural artifact outlined by Lupton (1995), who
stated that public health is subject to ‘political, economic and other social imperatives’ (p. 4). The FDA stands between the public and free trade exponents as an arbiter of safety as the agent of the US government, as outlined in Chapter Two on the regulation of drugs (Temin 1980). Several incidents illuminate the FDA’s effectiveness in these endeavors.

Firstly, the circumstances surrounding a Bill to reform the FDA in 1997 reveal the FDA itself as shaped by political, social and economic imperatives. Leading up to the reforms in 1997, political agitation involved opposing sides (those who sought relaxation of restrictive controls of the FDA and those against). Regulatory mechanisms were perceived as cumbersome and protracted to the point that American companies lost commercial opportunities in new developments (Temin 1980). Detractors of the FDA drafted a bill that would have considerably relaxed the FDA’s control (and emphasis on public safety). With the FDA under threat, the Clinton administration garnered support to defeat the bill, and legislation passed in 1997 with the reform being far less radical, and cementing in law some of the FDA’s long standing practices. Two such practices involved the evaluation of new drugs, involving panels of scientific experts in assessments and establishing the rule that drug approvals were based on one rigorous clinical study and confirmatory evidence (Review.org 2008).

One incident after the passing of the 1997 Act reveals the FDA as subject to powerful and competing discursive influences. The FDA had ‘restrictive policies on dissemination of information regarding off-label uses of drugs;’ after a legal challenge they were forced to liberalize regulations, enabling manufacturers to disseminate information more widely, that is, from peer review studies in medical and scientific journals (Review.org 2008). This was further relaxation for prescribers and manufacturers, although still limiting advertising as mentioned in Chapter Four (FDA Fed Register 2008,74:9342). The change did, however, open the door to widespread publication of off-label uses.

Peer review literature supposedly offers public protections as review is independent of manufacturers, although even peer review publications are reliant on disclosure by companies as trials are conducted by manufacturers. Failure to give full disclosure by selectively releasing studies, provided partial findings and controlled what is published by omission of important outcomes, thus contributing to weak regulatory control (Joshi, Patel and Holdford 2011). This set of circumstances appears to have provided a climate suitable to foster ghost writing and promote
opinion leaders (Fugh-Berman 2010; Singer 2009). Where companies are restricted from shaping cultural understandings by advertising, it appears they have sought to shape the regulatory environment and then taken advantage of the contextual landscape. The NDA 04-782/S-128 (FDA 2010) approves Premarin® for vasomotor symptoms, vulvar and vaginal atrophy, hypoestrogenism due to hypogonadism, for palliative treatment of some breast cancers, advanced androgen-dependent carcinoma of the prostate and prevention of postmenopausal osteoporosis. Other uses are off-label. The continuing iteration of supposed menopausal ailments (that MHT is not approved by the FDA to treat) as needing MHT intervention again reproduces the menopausal woman as deficient.

Taking the influence of ghost writing, use of opinion leaders and promotion of off-label use together we can see that concerted and well-funded strategies are deployed to encourage the uptake of MHT. Spielmans and Parry (2010) have coined the term ‘marketing-based medicine’ (MBM) and claim that it is usurping evidenced based medicine; they even claim it actually captures the real situation, as they deduce it, from the examination of internal industry documents. They concur with Kesselheim and Avorn (2007) that without the intervention of the courts the public would never know about the depths of drug company manipulation. They reiterate the point made by Joshi et al. (2011) that not all findings of clinical trials are released by drug companies (Spielmans and Parry 2010). Spielmans and Parry detail several strategies they have uncovered that drug companies utilize to manipulate public and professional opinion about their products. Although Spielmans and Parry base their analysis on their specialty in mental health, I will take their categories to look at strategies that we now know companies selling MHT have used. Spielmans and Parry have listed the following factors as influencing the knowledge and practice of medicine (pp.13-14): suppression and spinning of negative data, ghostwriting, disease mongering, market segmentation of physicians, and failure of regulatory authorities and peer review journals to police the system. I have already discussed ghost writing and disease mongering. Suppression and spinning of negative data has influenced MHT’s place in the market. The symptoms listed as due to menopause in literature repeatedly attribute symptoms that do not have a proven association (Oats and Abraham 2005; Oats and Abraham 2010). Spielmans and Parry term this ‘science as marketing.’ Earlier I discussed DesignWrite’s phrase to ‘dismiss/distract’ in relation to MHT, a phrase that Spielmans and Parry could well correlate with their term about the ‘spinning’ of negative data (p. 13).
Foucault (2002) presents five traits regarding ‘truth;’ the first is ‘centered on the form of scientific discourse and the institutions that produce it’ (p. 131). Pharmaceutical companies have had increasing control in producing the ‘truth’ as they conduct the time consuming trials to create new drugs, and then control the flow of information that becomes available, that is, the ‘story’ about any drug. The story-line is built, as I discussed above, by co-opting the services of medical professionals, and promoting them as opinion leaders and ghost writers to tell the ‘story’ of MHT. Bioethicists Spielmans and Parry (2010, p. 13) relate that manipulation of evidence through ‘suppression and spinning’ of results from studies that are adverse and the omission of deleterious side effects are strategies used by drug companies, affirming that what the scientific community thought they knew about a product is itself a production of a story.

The second trait Foucault (2002) lists is that ‘truth’ is ‘subject to constant political and economic incitement [that is,] the demand for truth, as much for economic production as for political power’ (p. 131). Litigation exposed the concealment by Wyeth of untoward effects with MHT, concealment under the guise of commercial sensitivity (Kesselheim and Avorn 2007). Fugh-Berman’s (2010) exposé of the manipulation of the politico-legal apparatus by Wyeth and DesignWrite provided insight into the activities of ‘economic incitement’ (Healy 2006). In addition, Kesselheim and Avorn’s (2007) and Fugh-Berman’s (2010) work points to the enduring nature over time of the companies’ efforts to maintain secrecy about poor performance and risks of MHT compared to the company’s claims about the Premarin® family of drugs. Suppression of raw and negative data from studies, and secrecy about company practices to infiltrate the medical profession, are examples of ‘economic incitement’ to maintain and grow their market for MHT preparations. Through lobbying, influencing and petitioning the government and the FDA, drug companies have been thoroughly political. Drug companies lobbied political allies to draft the US 1997 Bill to reform the FDA (as noted above), and relaxing constricting regulation would certainly have assisted commercial interests. Instead, less contentious legislation was eventually passed, retaining a strong role for the FDA (Review.org 2008). Truth was contested in the event debating the Bill: Foucault states the importance of ‘detaching the power of truth from the forms of hegemony, social, economic, and cultural, within which it operates’ (2002, p. 133). Since 1997 we have observed entrenched activities, both political and economic, to grow the drug industry. Spielmans and Parry (2010) go so far as to claim that ‘science has been taken captive’ by pharmaceutical companies in order to hike profits (p. 13).
Foucault’s (2002) third trait regards ‘truth’ being the ‘object, under diverse forms, of immense diffusion and consumption (circulating through apparatuses of education and information whose extent is relatively broad in the social body, notwithstanding certain strict limitations)’ (p. 131). In analysis of the Llewellyn-Jones Fundamentals text I identified persistent use of the deficiency ideation; while medical texts circulate this view and persistently link unproven symptomology to the menopause, pharmaceutical companies reiterate such strands of ‘knowledge’ to foster their products: they are rhetorical ‘truths’ from which to launch marketing campaigns. In the case of MHT the institutions of medical education (discussed further on p.175) have been targeted by drug companies to foster off-label uses of products (Kesselheim and Avorn 2007), and educational materials they provide about products over-inflate their effectiveness (Singer and Wilson 2009); the spreading of their ‘truth’ is shown, as Foucault signaled, to be diverse, diffused and reliant on the formal systems of education, educational apparatus and people as educators.

The fourth trait to Foucault (2000) is that truth ‘is produced and transmitted under the control, dominant if not exclusive, of a few great political and economic apparatuses (university, army, writing, media (p. 131). Regarding MHT I have argued that medicine as an academic, research and professional endeavor has ‘produced and transmitted’ truth about menopause and therapies. Likewise, as an arm of the state, the FDA and public health organizations have disseminated particular ‘truths’ about preventative practices and risks, and promoted self-responsibility by the public. ‘Writing’ and the ‘media’ (for example public relations firm DesignWrite) take their part as apparatuses constraining what we know, and thus the public image of menopause, potential and actual therapies, and safety and effectiveness. Menopause and the efficacy and safety of therapies has been written, rewritten, and as I have shown, been invented at times by exaggeration, and at other times, by minimization of claims to ‘knowledge.’ The last trait ‘is the issue of a whole political debate and social confrontation (“ideological” struggles)’ (Foucault 2002, p. 131). In Healy’s (2006) article on manufacturing consensus he suggests a course of action to remedy the flaws in the consensus approach, that is, resorting back to what he calls the ‘norms of science,’ and effecting separation from the marketplace (p. 151).

The battles over regulatory power exemplify instances of the operation of governmentality through a ‘political economy of truth’ as maneuvers and struggles of power are exerted at the level of government (Foucault in Rabinow 1984, p. 73). The FDA produces policy and regulations based on scientific assessment with the weight of government behind it (Temin
1980); likewise, the sphere of commerce has its own imperatives, and the one does not always serve the other.

Taking Foucault’s position on truth, one possibility is that we are witnessing struggles of a nature that are a form of resistance by manufacturers to the norm of medical practice and pure research practice. In Chapter Five (5.8, p. 85), I discussed an example of the working (operation) of power in the crisis in epidemiology, and how those promoting MHT seize upon the grey/indecisive areas of science to talk up MHT. Given the arguments outlined above on the ‘political economy of truth,’ a finding of this thesis is that the saga of MHT and menopause reveals that outworking of truth, through power, exemplifies Foucault’s ‘regime of truth,’ in his sense that truth is ‘to be understood as a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements,’ and ‘the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true’ (Foucault 2002, p. 132).

7.7 Who is the menopausal woman? Female subjectivity

The category of the ‘menopausal woman’ incites individuals to fulfill subjectivity signaled by the term. This will vary for different persons. The assumptions of female subjectivity portrayed in the texts analyzed, Llewellyn, FDA and OBOM, reveal that female subjectivity is contested. Many representations and competing discourses of femininity and womanhood and ‘how one ought to be’ are exemplified in the material assessed in this study, the women’s texts and the formal texts that refer to women. The middle-aging woman is a consumer, suffering deficiency, decrepit, old and ugly, feminine, autonomous, self-responsible (entitled to quality of life, my body, my choice), knowing subject, self-manager. How do all these representations, and those of color, ethnicity, wealth or poverty and educational status, come together simultaneously in the subject?

Recalling Foucault’s example of the panopticon (see pages 49-50) and the constraining effects of being observed and under the gaze, Foucault informs us that certain schemes organize our perceptions of the self (Foucault 1994/2000). The schemes are often dissonant, and each woman is a medium of transformation within, without and between the configurations of schemes that
signal womanhood. Subjectivity is formed in relation to others and by the government of self (p. 88).

Foucault admits a difference between material truths and facts as opposed to the discursive. In using Foucault’s theory of knowledge, categories (such as woman) are fabrications. The term ‘woman’ does not have universality, and the category is not uniform but fragmented. A post-structural approach admits difference, and accounts for differences in subjectivity by unseating the idea that ‘shared female experience’ is somehow unitary in character, essence or interpretation.

Concerning MHT, this thesis has uncovered/revealed four major constructions of female subjectivity: the woman patient (presents self for investigation, passive, compliant), the public health citizen (self-responsible, risk averse, participates in preventative activities), the aging woman (carries imprint of sexism and beauty myths, denigration of aging), and the emergent feminist self-advocate (researches information to take own decisions, health activism). Although these are permeable and fluid, they are nevertheless important, in unraveling how large numbers of women were induced to take up a therapy, encouraged by their doctors, in a climate of doubt and controversy about its efficacy. Foucault (1972/1980, p. 57) posits that we undergo ‘control by stimulation’ rather than control by repression. In other words, we are exhorted to become certain types of people in discourse: ‘be slim - lose weight, be wrinkle free, have a moist vagina.’

As discussed earlier, power and knowledge work together (the process of normalization), and the ‘who’ becomes a type of currency of personhood. Constructions of ‘who’ (man, woman, teen, wife, aging woman, including stereotypes) circulate and are recognizable in social discourse between speakers; repetition and multiple objectifications permit recognition of a type of ‘who.’ The ‘who-type’ signals all the trappings ‘wife’ or ‘older woman’ conveys as does the ‘patient’ and ‘the feminist.’

The post-modern subject is fluid, may hold degrees of coherency through a recognizable discourse(s), yet is unstable, never entirely formed (Foucault 1971/1984). Crucial for menopausal women is how they have learned to recognize themselves as ‘middle-aged and aging women’ through and in association with such terms and what they signify. Indeed, in contemporary medicine the self-responsible patient is the product of the effect of ‘pastoral power’
as it operates in medicine and public health. The exhortations to present oneself for monitoring (blood tests, breast screening, bone scans, colonoscopy and being weighed); to participate in preventative tasks (have courses of inoculations regulated in repeat patterns, take cholesterol lowering drugs); and maintain strength and fitness through exercise, all emerge from the techniques of pastoral power (Foucault 2002). Foucault (2002) contrasts pastoral power to power that results in arbitrary groupings where legal apparatus\(^\text{31}\) underpins the exertion of power, separating the ‘mad and the sane, the sick and the healthy, the criminals and the “good boys”’ (p. 327).

The concept of ‘pastoral power,’ once the strength of the Christian church and proliferating from it into wider society, appears to capture contemporary and more subtle expressions of power at work in the state apparatus (by which medicine and public health are conferred authority). It has several characteristics: individualizing, co-extensive and continuous with life, it is linked with a production of truth - the truth of the individual himself (Foucault 2002, p. 333). The modern exhortations to be responsible, risk adverse, healthy citizens share these characteristics. Both the individual and populations are targets of state health messages (and health promotion), conveyed through the institutions of ‘family, medicine, psychiatry, education and employers’ (Foucault 2002, p. 335).

Foucault refers to the active subject who fashions the self through ‘models’ that are ‘proposed, suggested and imposed upon him(her) by his(her) culture, his(her) society, and his(her) social group’ (2002, p. 291). To Foucault three ‘forces’ (goal directed activities, relationships of communication and power relations) co-exist, and their interplay is the mode of operation with the pastoral form of power (2002, p. 338). The practices of the institution of general practice (community medical practices) with common elements such as spatial configuration, defined areas for patients, symbols in color and graphics to denote dangers and infective materials, procedures to catalogue bodies, measurement of body fluids, infection and disease rates, technical interfaces with national screening databases, attempting coverage of a practice’s population for immunization, routine monitoring for diseases that have strategic importance (such as reducing the incidence of diabetes and heart disease), conveying prescriptive ‘rules’ around the

\(^{31}\)Legal apparatus refers to the powers to, for example, forcibly separate those infected with virulent communicable diseases from the non-infected, commit the insane to psychiatric care, or imprison the criminal.
consumption of medication to ensure compliance, assessment of individuals on qualifying criteria for various funding streams, myriad systems and strategies (health checks, skin checks, recalls, screening drives, UV/safety warnings, education and accident prevention strategies/programs), all together these elements coach and coax the correct behaviors in patients that will lead to, restore, and maintain health. Goal directed activities about treating illness (reducing mortality and preventing illness), relationships of communication (instructing, teaching advising), the power relations (who presents to whom, who interprets, who treats whom, who acquiesces to whom) are the mechanisms producing effects of power. Thus the system of signs is created that exemplifies the outworking of the three forces denoting the site of pastoral power in the case of medical practice (Foucault 2002).

Analyzing the operation of power within the events of the changing patterns of uptake of MHT, it is my claim that ‘pastoral power’ operates. Firstly, competing goal directed activities were at play, target chasing by drug companies, treating a ‘deficiency’ by health professionals, with direct and indirect exhortation of a population to be healthy and youthful. Secondly, relations of communication were active, with publication of research findings, drug company information placed in multiple outlets to target multiple audiences, together with opinion pieces, consensus gatherings, life stories, and the positioning of menopause in the life course literature. Thirdly, the complexity of power relations is illustrated via doctors working with drug companies, companies reward schemes in medical markets, the state’s relations to big business, and the doctor/patient relationship with its inherent power differential (expert/lay).

The operation of these three elements is not linear, uniform or consistent, and power relations are diverse in their interconnections and apparent interdependencies. Foucault explains:

> [P]ower relations are exercised, to an exceedingly important extent, through the production and exchange of signs: and they are scarcely separable from goal-directed activities that permit the exercise of a power (such as training techniques, processes of domination, the means by which obedience is obtained), or that, to enable them to operate, call on relations of power (the division of labor and the hierarchy of tasks) (2002, p. 338).
The production of signs about the menopausal woman produces discourses of the hormonal measures and somatic changes in the body. On consultation with the doctor an indicative profile is obtained that signals the type of the climacteric and the discovery of parameters that indicate typical symptoms (decreasing menses). The woman presenting has knowledge of the ‘who-type’ of menopause, and the consultation takes place in the presence of past and immediate communication, information and iteration of signs, resulting in relations of power that give rise to decisions about benefits, risks and/or interventions.

Nikolas Rose (1999, p. 247) outlines that discourses of risk perform a role as a further mechanism of regulation and self-regulation. As communities and individuals we are urged to ‘take upon ourselves’ the responsibility for our well-being, safety and health. We are urged to give attention to and analyze our diets and levels of exercise, avoiding harmful activities that would threaten wellbeing. Risk is calculable, and measures and potential consequences are relayed by the media, often in uncoordinated and sporadic forms.

In these multiple configurations and reformulations the subject is produced and reproduced, and possibilities may be inserted to amend the subject. A coherent truth (the knowledge of science, humanness, or sexuality) is a construction of knowledge that transforms the subject. The subject engages with these multiple expressions of so-called truths ‘and turns her/himself into a subject, and learns to recognize themselves as subjects of sexuality’ (Foucault 2002, p. 327) or additionally a menopausal woman, an aging woman, a grandmother. The subject is at the same time an object of knowledge.

In contrast to the Llewellyn-Jones Fundamental texts and the public health texts, OBOM promotes self-advocacy by women in health and lifestyle matters. This is an emerging conception of subjectivity not evident in the other texts. It is dependent on a knowledgeable subject, and as such, there is an engagement with the reader not present in the other texts. Such engagement assumes an active reader/subject. The text of OBOM is written on the supposition of the knowing female subject.

The dichotomous relationship of the patient to the doctor, and modes of classification implicit in that, are, as I have noted, apparent in disciplinary practices that position each subject. This has implications for the female subject in light of Foucault’s ideas about the processes of
subjectivation, where people themselves participate in the formation of their own subjectivity (Foucault 1985, 1996, 1994/2000). The women participants in this study revealed engagement in self-work, activities where they engaged with the models proposed to them in the discourses of medicine, public health and women’s health. They struggled with ‘doing the right thing’ by themselves: activities that would meet the goals of being responsible for one’s own health, reduce health risks and lead to a satisfying life of quality. The women’s interviews revealed much effort and self-work to achieve the right balance in life. When combined, these discourses propose the ‘who-type’ for the health conscious and self-responsible, menopausal woman. A recognizable scaffolding is presented, and in self-work people fashion themselves and negotiate the degree to which, or not at all, they conform. The ‘struggle’ for the self is the activity of fashioning oneself within multiple, disparate and even competing discourses. For example, Sylvia invested in a patient’s rights discourse when making her decisions about reproductive health and sexuality. Her conception of her own subjectivity had been affected by her experience of harm through medical intervention, and her subsequent involvement as a claimant against the manufacturer of the Dalkon shield. She refuses to be victimized again and took well considered steps to educate herself in health matters, and in doing so formulates herself subjectively as knowledgeable and assertive. Sylvia called herself ‘a child of the pill;’ this places her in a particular era of changing sexual mores, in a context where delineations between ‘good girls’ (no sex before marriage) and ‘bad girls’ (those seeking sexual freedoms) were clearly articulated, and medical intervention in the private sex lives of people was common. Being invested at this stage in her life in patients’ rights, refusing victimization and being assertive, are intelligible attributes of particular configurations of subjectivity articulated via discourses, both subjugated and professional. Foucault explains:

Of course all moral action involves a relationship with the reality in which it is carried out, and a relationship with the self. The latter is not simply self-awareness, but self-formation as an ‘ethical subject,’ a process in which the individual delimits that part of himself that will form the object of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve as his moral goal. And this requires him to act upon himself, to monitor, test, improve, and transform himself (1985, p. 28).
To Butler (2005), the act of self-questioning as one who queries ‘what can I be’ is a process that puts at risk who one feels one is, and who one imagines one is seen to be by others. Where discourses postulate particular subjects, in one’s self-work (choosing from diverse possibilities of subjectivity) one risks self-recognition and recognition by others.

Foucault’s concept of an ethics of the self (cara sui) assists in theorizing the women’s striving to ‘do the right thing.’ Self-reflection and striving to do better are vital components of constitution of the self (Foucault 1994/2000, p. 277). The women in this study were constrained by moral imperatives to follow preventative measures to avoid disease (as discussed in Chapter Five), and to be self-responsible, to fulfill both quality of life aims and also moral imperatives. In New Zealand, the health system has a distinct utilitarian aspect where individuals are expected to be responsible, take measures to avoid accidents or preventable diseases and thereby save health dollars (Bentham-like, for the greater good) (Beauchamp and Childress 1979).

To care for the self, techniques of the self must be deployed. To Foucault (1994/2000), people create a narrative of themselves, unlike material productions of tangible entities; narratives of the self are hidden, private even if written in the likes of diaries. Foucault (1994/2000) claims the ‘culture of the self’ never disappeared, although it went through many transformations (in Western European philosophies, through the Greek, Christian and Renaissance traditions) (pp. 253-280). Pursuit of effort in meditation (or reflection) for self- mastery are practices of the self in many cultures. In this study the women performed self-work through the acquisition of knowledge, via reading, talking with lay people and professionals, searching the internet, attending seminars, acting on knowledge and advice, exercising, careful planning of their diets, presenting themselves for examination, discussing and deciding about treatment options, following (and not following) prescribed regimes for medications, and participating in health monitoring and treatment reviews. Therefore the working and striving of the women to be self-responsible about their health is a practice of the self.

For the women in this study such ‘practices of the self’ appeared to have a synergy with ‘quality of life’ discourses. What culture constitutes as ‘quality of life’ concepts and items are cultural constructions and artifacts. For example, the imperative to exercise has several cultural nuances. Briar, Holly, Sylvia, Ruby, Daphne, Tansy, Scarlett, and Aster all spoke about their belief in the personal benefits of exercise. They constructed their talk about it in a variety of ways. In some
instances it was configured that exercise was good to avoid ill health, to be fit and active (and so not a burden on the health system), to be vital and youthful and thus independent, to stay slim and attractive and counter the effects of aging. All of these configurations are culturally bound, arising in medical discourse (Oats and Abraham 2005, p. 333), public health discourse (Institute for Quality and Efficiency in Health Care Germany 2006; Lupton 1995; National Health Service 2007; National Institutes of Health 2005, p.14) and women’s health advocacy discourses, where for example, OBOM’s (2006) Chapter Thirteen is titled ‘Staying Active.’

Foucault outlines that techniques of the self are often ‘linked to the techniques for the direction of others’ (1994/2000, p. 277). Culturally as partners, wives and mothers there are expectations that older women will look after themselves to model self-responsibility to family and others in society. As Cherry (page 96) recounted, she was ‘old enough to be a grandmother’ to the younger doctors, and her statement can be read as meaning she ought to be giving direction, not being the one told what to do. Techniques of the self go to the heart of subjectivity; it is a practice of the self ‘as an exercise of the self on the self by which one attempts to develop and transform oneself and attain a certain mode of being’ (Foucault 1994/2000, p. 282). So where coerciveness may no longer lie behind shaping the subject (in the context of a modern health system), to Foucault, then, it is a self-formation that is part of the construction of the subject (1994/2000, p. 282). To varying degrees the women in this study revealed their knowing [connaitre] of themselves. Foucault (1994/2000) states that ‘to take care of the self is to equip oneself with these truths: this is where ethics is linked to the game of truth’ (p. 285). To Foucault the self-forming subject is not preordained but ‘is constituted in relationship to itself as subject’ (1994/2000, p. 280).

7.8 Conclusion
Assessing the nature of truth and ‘truth-making’ was a key element of this thesis. Unpacking how ‘what we know ‘ and ‘how we know it’ about MHT has concerned investigating its science and utility within the practice of medicine, its manufacture and promotion as a therapy for menopausal women, its efficacy, and its safety as a medication and product to be sold.

Evaluation of the concept of ‘deficiency’ and the inevitableness with which it signals disease led to discussion of the medical profession’s hold on particular knowledge as ‘learned-talk.’ This
phrase was adopted to capture Foucault’s power/knowledge nexus in authoritative speak about biology, physiology, pathology and the dichotomy of the normal and abnormal concerning the menopause in women. Contemporarily, following publication of the WHI findings, even though we have more rigorous information and guidance provided by governmental warnings about the risks (and to whom) of consuming MHT, the ‘struggle of knowledges’ is in full sway for grounding such ‘truth.’ The tenuous coherency of medical orthodoxy of the 1990s concerning MHT and its efficacy was found to be erroneous, and yet a complex web of claims and counter claims now co-exists. Despite consensus in guidelines internationally since 2002, conflicts plague commentators on method and design of the major trials, and it is my conclusion that the truth is under constant contestation. The thesis discussed several instances summarized below.

Investigating the dichotomy of the normal and the abnormal, and its significance in the discipline of medical science, assisted in analysis of a stance that links menopause with deficiency and thus disease. This connection with its implication for risk to one’s health became the site of rabid disease mongering, notably with Robert Wilson in the 1960s, and due to the fervor with which hormone replacement was widely prescribed to address ‘deficiency’ over decades. Natural therapists joined in viewing women in the menopausal change as a growing market for alternative ‘replacements.’

Following criticisms of the use of the word ‘replacement’ in HRT, many desisted from using ‘R’ for ‘replacement’ in their titling of menopausal hormone preparations, although I noted that the Llewellyn-Jones texts continue to use the word ‘deficiency.’ Persistence of this link in formal medical texts is disturbing and underlines the recalcitrance of some in the profession who, it appears, refuse to abandon a flawed concept, and instead reproduce this negative idea, perpetuating it to future generations of medical practitioners. Reiteration of the concept of deficiency provides a reason to promote therapies to address a ‘deficiency’ by manufacturers, whether traditional or alternative, and as long as the concept has currency some will seek to capitalize. The drive to create and retain their market is notable in Wyeth’s marketing strategies, exposed recently in the US courts. Commitment to the covert mantra ‘dismiss/distract’ by Wyeth/DesignWrite, that generated strategies to present MHT as more benign than it was known to be, is a subtle (though destructive) form of disease mongering expressed in a hitherto unseen mode. Furthermore, the move to produce smaller dose preparations is yet another strategy to remain in this market. Large clinical trials have not been undertaken with smaller dose
preparations. Yet drug companies seize upon a gap in knowledge, emphasizing any doubt and thereby creating a channel for insertion of a new variation on their product, although no adequate studies give ‘proof’ of safety or efficacy. So, companies are devising a new tack to sell their products, even while the risks are announced around the world in concerted efforts to prevent preventable illness in women.

The term ‘quality of life’ has been co-opted by drug companies in the endeavor to contest official guidelines, and dismiss and distract from information that would threaten the market position of their products. The wider ‘quality of life’ discourse is highly influential in health promotion. It often lacks specificity, having untold application to different areas of our lives. It is seductive and enticing, and difficult to mount challenges against in some instances as ‘quality of life,’ as a term, has broad currency. Linked with the refrain on a person’s ‘right to choose,’ it is placed in a domain of individual rights. It is easy to conclude that women could be convinced (by concerted campaigns to convince them) that they can assert their individual rights to affect their ‘quality of life’ during the peri-menopause. Association of MHT with retaining youthful attributes, improving sleep disturbances, improving cognition and improving urinary problems, attributed to MHT, are used to cement it, I believe, as a ‘life style’ drug.

This thesis exposes the generative ability of language, where partial knowledges proliferate, leaving people confused on what constitutes, for example, ‘quality of life’ for them, in their age/stage/genetic make-up and particular predispositions. Any number of things could be signifiers of ‘quality’ to individuals. The person striving to live a ‘life of quality’ does so in response to a prevailing form, expressed as information that is repeatedly expounded in medical and public health discourses, in multiple sites (television and magazine articles and advertisements) for many and varied products.

My discussion of the debates within public health and preventative medicine on design of epidemiological studies revealed ongoing contestation of research orthodoxies. The knowledge that was claimed over decades turned out to be tenuous as methodologies were questioned, yet prescribing to middle and upper class women in the western world ballooned over decades. The MHT saga has called into question the very tools of scientific discovery (as in the hazard ratio and observational designs). The polemics continue, and the dilemmas bring Foucault’s theory of

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32 The evidence is inconclusive on the efficacy of MHT for the listed items (Nelson et al 2005, p. 14).
the creation of knowledge and *truths* as enmeshed in struggles into sharp relief. There were always those who warned of the potential for danger in wide-scale consumption of estrogens, yet market forces drove a proliferation of prescribing.

The axis of the power/knowledge relationship is crucial to the integrity of a profession. I have discussed some strategies drug companies use to keep a vital role for their products alive, where company rhetoric inserts itself into what we and medicine consider exclusive professional space; in medical publications, in consensus conferences, or in continuing medical education, we can ask the question: ‘Whose knowledge do we get to hear?’ The corpus of medical knowledge thus suffers from certain fictions. Persistent perpetuation of the myth of a need for drugs to treat women at menopause is in Foucauldian terms a ‘game of truth.’ The drug companies have infiltrated medical discourse by means of ghost-writing, fostering doctors as opinion leaders and messengers who participate in consensus conferences, medical education and writing commentaries for their own ends. Regarding those who appear to have left moral considerations out in their pursuit of commercial ends, further consideration is required on the question of conduct in the contemporary era (Butler 2005).

Genealogical enquiry has led to evaluating these roles concerning MHT and gives cause to pose the following questions: ‘What can we believe in medical journals and books?’ ‘Is medicine still medicine?’ or ‘Is medicine a fabrication?’ Foucault (1980) tells us, ‘one “fictions” history on the basis of a political reality that makes it true, one “fictions” a politics not yet in existence on the basis of a historical truth’ (p. 193). If *truth*, then, is a fabrication, it appears we have a pharmaceutical fabrication of a medical fabrication about menopause and MHT. Knowledge (*connaissance*) of menopause and MHT is what is held in a social consensus (as much as such a thing exists) as a truth, and the ‘hold’ Foucault would explain is the effect of power in operation and thus open to reformulation. This leads me to the conclusion that the word ‘therapy’ (as part of the term MHT) does not represent what it ought when the *therapy* is not therapeutic, and instead causes harm. Although to the poststructuralist this notion is problematic as it is the oft-time ‘tainted’ science discourse that quantifies *harm*. A discourse, that under investigation in this thesis, was found to be other than the objective, neutral endeavor claimed by its own, yet subject to the ‘modifications which may occur either outside it (in the forms of production, in social relations, in the political institutions), or within it (in the techniques of determining objects, in the
refinement and adjustment of concepts, in the accumulation of data, or alongside it, (in other discursive practices)’ Foucault (1994/2000, p. 12).

The women’s health discourse promotes a self-responsible self-advocate, in contrast to the passive patient of paternal medicine. Foucault states that the subject can only be known to themselves through a ‘regime of truth’ (Foucault 1997, p. 192). We saw that women index themselves against a known recognizable ‘type,’ and any ‘type’ is an expectation to be that arises outside from an external source. The making and the re-making of the subject happens as the modes of subjectivity are possible when the conditions of any ‘making’ alter and new conditions exist to which one can align, hence subjectivity is unstable and fluid (Foucault 1994/2000). The women’s health discourse re-inscribes the menopausal woman. A certain politic is involved in self-advocacy: it necessitates a link to best practice and patients’ rights discourse. It is an active stance, not passive. The women’s movement used knowledge about women’s bodies that had been exclusive to medicine and placed it in the public arena, in a form that demystified the medical and scientific language. As I have noted, the Boston Women’s Health Collective was the lynch pin of reform in this task. The movement envisioned confident well informed women who could self-advocate in matters of their own health. Analysis of assuming self-responsibility and self-advocacy led to unraveling the tenets of the modernist conception of subjectivity.

Concerning MHT and cultural norms in women’s lives, this thesis, in keeping with Andersen’s (2003) description of genealogy, has sought ‘by a gaze of disruption, to open up the discursive field through tracing practices, discourses and institutional lines of descent, including lines of connection to different historical conflicts and strategies of control’ (p. 30). Investigating the descent and emergence of ideas about MHT and discourses about mid-life women that influence cultural norms has led to insights into female subjectivity, and I, along with Foucault, conclude that female subjectivity is in formation, unstable and open to discursive constructs and symbols, and constituted in real practices as revealed in the participants’ narratives on menopause and their decision making about MHT.
Appendix 1

8 June 2006

Dear Professor Gillett,

I am again writing to you concerning your proposal entitled "Intervention and (Re)invention?: Exogenous Female Sex Hormones and Female Subjectivity," Ethics Committee reference number 06/012.

Thank you for your response to the Committee’s concerns. You have adequately answered the Committee’s queries and we will keep the email correspondence with the application for future reference.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Yours sincerely,

[Signature]

Mr G K (Garry) Witto
Manager, Academic Committees
Tel: 479-8256
Email: gary.witto@stonebow.otago.ac.nz
NGĀI TAHU RESEARCH CONSULTATION COMMITTEE
TE KOMITI RAKAHAU KI KAI TAHU

21 October 2005

Ms Beverley Burrell
Centre of Bioethics
University of Otago
DUNEDIN

Teina koe Ms Burrell,

Title: Intervention and (Re) Invention?: Exogenous Female Sex Hormones and Female Subjectivity

This research utilises a Focaultian post structural method to investigate the ways in which hormone preparation (contraception and HRT/IRRT) have been written about and thought about since the 1950s to interrogate the influences of scientific, ethical and cultural discourse upon promotion, administration and consumption of female sex hormones.

The Ngāi Tahu Research Consultation Committee supports this research study and the potential contribution to Māori health is important. The Committee would advise however, that consultation with Māori organizations such as the Māori Women’s Welfare League regarding this research project. Māori women participation in the study is important and how best this may be facilitated would need further exploring.

The Committee would recommend that a copy of your publish research findings be forwarded to relevant Māori health Service Providers, Māori health Research Centres and Māori Community.

The Committee would value receiving a copy of your published research findings.

Naku noa, na

Christine Rimene
Administrator
Ngāi Tahu Research Consultation Committee

The Ngāi Tahu Research Consultation Committee has membership from:

Te Rūnanga o Ōtākou Incorporated
Kāti Huirapa Runanga ki Paketariki
Te Rūnanga o Moeraki
Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you of any kind and we thank you for considering our request.

What is the Aim of the Project?
I am currently a student at the Bioethics Centre. This study is research towards my PhD. The research investigates the ways in which female hormone preparations have been written about and thought about since the 1930s. The study will look at the influences on women and society of scientific, ethical and cultural discourses of the promotion, administration and consumption of such preparations. 14-20 women will be interviewed and their scripts analysed in relation to the topic of hormone therapies and the effects upon health, lifestyle, sexuality, cultural, and identity factors.

What Type of Participants are being sought?
14-20 women between 20 and 65 years of age are sought for this study. These will be well, working age women who speak the English language and have taken or considered taking either hormonal contraception or hormone replacements in the last three years.

What will Participants be Asked to Do?
Should you agree to take part in this project, you will be asked to be available for an audiotape recorded interview lasting approximately 1 hour. The interview will take place at a private location agreed between yourself and myself, the interviewer. The interview will involve talking about your experiences, views and any influences on your decisions about taking hormone preparations. This project involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used. I will use another name for you or you may choose a pseudonym to protect your identity in any written reports. In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage.
without any disadvantage to yourself of any kind. Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

**Can Participants Change their Mind and Withdraw from the Project?**
You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

**What Data or Information will be Collected and What Use will be Made of it?**
The interview will be focused on:
- your views of health and lifestyle in relation to taking hormones,
- your views on sexuality, cultural, and identity factors,
- the information and advice available to you when you made decisions about taking or stopped taking hormones.

Some demographics will be collected (such as: age and the length of time participants may have taken hormones) although your privacy and anonymity will be protected at all times.

The data collected will be securely stored in such a way that only myself and my supervisors will be able to gain access to it. At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed.

The results of the project may be published in journals and conferences and the thesis will be available in the Canterbury Medical Library and Central Library, University of Otago, Dunedin. An executive summary of the project will be sent to you at the completion of the study. You will be offered a copy of your audiotape to keep.

**What if Participants have any Questions?** If you have any questions about our project, either now or in the future, please feel free to contact either:-

Beverley Burrell  
Centre for Postgraduate Nursing Studies  
Christchurch School of Medicine  
Phone 03 3643860 or 3643850  
7398

or  
Prof. Grant Gillett  
Bioethics Centre  
University of Otago, Dunedin  
Phone: 03 4747007 ext 7398

This project has been reviewed and approved by the University of Otago Human Ethics Committee.
CONSENT FORM FOR PARTICIPANTS
I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage. I know that:-
1. my participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. the data (audio-tapes and transcripts) will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed;
4. this project involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind;
5. I may request the audiotape be turned off at any stage and I may decline to answer any particular questions;
6. I may retain a copy of my taped interview;
7. The results of the project may be published and will be available in the library but every attempt will be made to preserve my anonymity.

I agree to take part in this project.
I request a copy of my audiotaped interview. YES □ tick.

......................................... ……………………… …  ………………………..
(Signature of participant) (phone number) (Date)

This project has been reviewed and approved by the University of Otago Human Ethics Committee
Transcriber's Confidentiality Form

The How, Why and Wherefores of Using Female Sex Hormones.

I agree to transcribe the audiotapes for the above research and to be bound by the ethical principle of confidentiality.

I agree to ensure all materials in my possession, related to this research, are securely stored until all such items have been handed over to the researcher, Beverley Burrell.

I will not discuss any content or aspects, or make references to these audiotapes and scripts now or in the future.

Any queries or concerns I have will be discussed with the researcher only.

Name: [Handwritten name]

Signed: [Handwritten signature]

Date: [Handwritten date]

If you require any information please contact:

Beverley Burrell
d/- Centre for Postgraduate Nursing Studies
Christchurch School of Medicine and Health Sciences
PO Box 4345
72 Oxford Tce
Christchurch

Ph: 03 3643860
## Appendix 6

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<th>Excerpts with author’s quotes taken from Chapter 8 page 126</th>
<th>Element of CDA displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The vignette ‘speaks’ to social relations between women, inserting the possibility of assuming different relations. Inclusion of this vignette in the book places before the reader alternative ways of relating to another as well as articulating the phrase ‘commerce of aging’ to indicate whole industries based on negative rhetoric of aging.</td>
<td>Margaret exhorts other women to avoid the trap of ‘reinforcing women’s supposed ugliness in the guise of friendship,’ and buying into ‘masochistic empathy,’ avoiding complicity in the negation of the aging woman would prevent women being party to ‘personalized commercials for the commerce in aging.’</td>
<td>Social practice</td>
</tr>
<tr>
<td>The vignette presents a refreshing text on the body and conceptualization and representation of the body. Description of the body as <em>curvaceous</em> and <em>startlingly elegant</em> defies the populist negative texts, while offering a revision of body imagery for the older person. The vignette contrasts the style or genre of the main text, enabling inclusion of provocative and challenging material yet as an aside from the main text.</td>
<td>The vignette recounts author’s experience of taking a new look at her curvaceous, startlingly elegant body to appreciate it as it is rather than through a filter of youth obsession and denigration of all that is outside the narrow definition of female beauty promoted in popular culture and media. Rhetorically the vignette is reasonably strident and argumentative in style. It is in contrast to the main text that is written in a factual discursive tenor.</td>
<td>Analysis of text</td>
</tr>
<tr>
<td>Specifies what other texts are drawn upon in the constitution of a text and ones that it resists.</td>
<td>Analysis of this vignette reveals insertion into OBOM of a discourse of positive aging and reassertion of the feminist standpoint discourse, both of which contest the beauty myth and anti-aging discourses.</td>
<td>Discourse practice</td>
</tr>
</tbody>
</table>
Appendix 7

Outside view Kitchener Ward, Queen Mary Reserve Trust, Hanmer Springs

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Appendix 8

Inside view Kitchener Ward, Queen Mary Reserve Trust, Hanmer Springs

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