

Menopause as a long-term risk to health: implications of general practitioner accounts of prevention for women's choice and decision-making

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Abstract Over the past two decades medical researchers and modernist feminist researchers have contested the meaning of menopause. In this article we examine various meanings of menopause in major medical and feminist literature and the construction of menopause in a semi-structured interview study of general practitioners in rural South Australia. Three discursive themes are identified in these interviews; (i) the hormonal menopause – symptoms, risk, prevention; (ii) the informed menopausal woman; and (iii) decision-making and hormone replacement therapy. By using the discourse of prevention, general practitioners construct menopause in relation to women's health care choices, empowerment and autonomy. We argue that the ways in which these concepts are deployed by general practitioners in this study produces and constrains the options available to women. The implications of these general practitioner accounts are discussed in relation to the proposition that medical and feminist descriptions of menopause posit alternative but equally-fixed truths about menopause and their relationship with the range of responses available to women at menopause. Social and cultural explanations of disease causality (*c.f.* Germov 1998, Hardey 1998) are absent from the new menopause despite their being an integral part of the framework of the women's health movement and health promotion drawn on by these general practitioners. Further, the shift of responsibility for health to the individual woman reinforces practice claims to empower women, but oversimplifies power relations and constructs menopause as a site of self-surveillance. The use of concepts from the women's health movement and health promotion have nevertheless created change in both the positioning of women as having 'choices' and the positioning of some general practitioners in terms of greater

information provision to women and an attention to the woman's autonomy. In conclusion, we propose that a new menopause has evolved from a discursive shift in medicine and that there exists within this new configuration, claiming the empowerment of women as an integral part of health care for menopause, the possibility for change in medical practice which will broaden, strengthen, and maintain this position.

Keywords: menopause, decision making, risk, choice, prevention, general practice

Introduction and brief historical overview of menopause

The explanation of menopause as 'deficiency', be it moral, psychological or physiological, is a long-standing description. Medical evidence from the 18th and 19th centuries illustrates how explanations of menopause positioned women as emotionally unstable and physiologically vulnerable (Smith-Rosenberg 1985, Formanek 1990). Feminist historians described medical accounts that depict menopause in terms of a complex and volatile reproductive system of ovaries and uterus that controlled women's physiology, emotions and mental state, and dictated her social role (Smith-Rosenberg 1985, Showalter 1987).

. . . Nineteenth-century physicians used menopause as an all purpose explanation for the heightened disease incidence of the older female; all of her ills were directly or indirectly diseases of the uterus and ovaries (Smith-Rosenberg 1985: 191).

For feminist scholars menopause is of interest not least because historically its medical management had horrific material effects for women (Showalter 1987), as well as reinforcing an inferior social position to men.

The developing theory of sex endocrinology in the early 20th century succeeded 19th century ideas about women's reproductive physiology, providing an explanation of menopause in terms of hormonal functioning that would dominate throughout the century. Hormones came to be regarded as the defining feature of both femininity and masculinity (Oudshoorn 1994). The science of sex endocrinology underpinned new explanations of women's bodies, and as Bell (1987) argued, firmly established menopause as the domain of the medical practitioner. Medical and feminist commentators alike identify Robert Wilson, working in the 1960s, as a key figure in the medical construction of menopause as a deficit of hormones that now resonates with contemporary practice (MacPherson 1981, McCrea 1983, Utian 1990, Bush 1992, Coney 1992, 1993, Hunt 1994):

The unpalatable truth must be faced that all postmenopausal women are castrates. There is a variation in degree but not in fact. Men do not live as long as the so-called weaker sex. However, they age, if free from serious disease, in a proportional manner. . . . From a practical point of view, a man remains a man until the very end. The situation with a woman is very different. Her ovaries become inadequate relatively early in life (Wilson and Wilson 1963 cited in Coney 1993: 61).

Robert Wilson is regarded in feminist and sociological literature as the person who popularised the use of hormone therapy for menopause (MacPherson 1981, McCrea 1983, Coney 1992, 1993). By engaging existing discourses of women's precarious physiological and psychological constitution, established in the late 19th century (*c.f.* Formanek 1990), Wilson, writing in 1963 with his wife, promised to protect women from what is described in papers and a popular genre book as the 'ravages' and 'vagaries' of the female body by providing '*Hormones from Puberty to the Grave*' (Wilson and Wilson 1963). Wilson promised women that hormone therapy would be the 'elixir of youth', which would keep them '*Feminine Forever*' (Wilson 1966). In this way, hormones defined femininity and what have come to be known as symptoms of menopause became synonymous with symptoms of a lost femininity.

Medical and feminist approaches to menopause in the 1980s and 1990s

In this article we refer to various medical and feminist approaches to menopause in an examination of the incorporation of prevention and risk into an example of general medical practice. The medical approaches include research drawn largely from epidemiology, and the feminist approaches cover a range of perspectives including modernist feminism, such as that of Greer (1991), the women's health movement and feminist ethics. By 'feminist' we refer to academic and popular writing that maintains a focus on the structuring effects of gender on social and power relations. There are, however, many feminisms. In recent years a blurring of traditional distinctions between liberal, Marxist and radical feminisms has occurred as these theoretical positions have developed and evolved. In this article we distinguish between modern and postmodern feminisms, regarding the ontological differences between these broad theoretical positions as more able to differentiate the arguments considered here. We thus refer to a realist modernist ontology and a relativist postmodern ontology. Nevertheless we recognise and acknowledge limitations inherent in this dichotomy; there are indeed many modernisms and many postmodernisms. We also acknowledge here the differences between modernist feminist criticism of medicine and the approach to health care taken by the women's health movement. It is not however our intention to examine these differences in detail. Rather, we are interested in the ways in which modernist feminist criticism intersects with medical practice and how concepts that are shared by modernist feminism

and the women's health movement are taken up in general practice. Based on examples of medical literature, modernist feminist literature and an analysis of semi-structured interview data about menopause from nine general practitioners (GPs), we put forward an argument about the positioning of women as responsible actors in relation to health care for menopause.

Medical approaches to menopause: the discourse of prevention

Following reports of the association of hormone replacement therapy with increased rates of endometrial cancer in the *New England Journal of Medicine* in 1975 (Smith 1975, Ziel and Finkle 1975) the popularity of hormone replacement therapy declined dramatically. From the early 1980s, however, menopause became identified in the medical literature as a crucial point in a woman's life because of the possible onset of preventable diseases. Studies began to indicate a protective effect of oestrogen on hip fractures and other bone breaks from osteoporosis (Weiss *et al.* 1980). In the mid 1980s further studies suggested there were protective effects of oestrogen on cardiovascular disease (Bush *et al.* 1987). Medical and feminist writers alike identify these findings, and a change in the treatment regime to counter the effects of hormone replacement therapy on endometrial cancer, as a major impetus for the renewed enthusiasm for hormone replacement therapy. There were several relevant publications in medical journals in the late 1980s and early 1990s, for example, *Medical Journal of Australia* (see MacLennan 1991), *American Journal of Obstetrics and Gynaecology* (see Utian 1987), and *Journal of Women's Health* (see Bilezikian 1994). These focused on the key idea that a reversal of the loss of hormones by long-term, possibly life-time, use of hormone replacement therapy would provide an opportunity to afford better health to women in their later years.

While the promotion of hormone therapy to restore femininity does not appear as blatantly as in Wilson's texts, evidence of a discourse of femininity is present, for example, in Bilezikian's description of the effects of menopause on 'skin quality, mood and mental function'. The medical menopause, in part constructed through the discourse of femininity, is reconfigured during the late 1980s through a shift towards a discourse of prevention, and later, a discourse of choice. Preventable diseases such as coronary heart disease and osteoporosis are thereby introduced as major public health concerns. The significance of preventing these diseases is highlighted using morbidity and mortality statistics, and their potential fiscal burden, that permeate the boundary of the medical menopause.

Feminist objections to the medical construction of menopause

From Wilson's (1963; 1966) attribution of a myriad of symptoms and the loss of femininity to menopause through to contemporary associations of menopause with future diseases, modernist feminists (*e.g.* Klein 1992, Coney 1993) have argued that the concept of menopause as an 'endocrine deficiency disease' has formed a key framework for medical practice and a rationale

for the development and application of hormone replacement therapy. In response to these medical constructions of menopause modernist feminist critics in the early and mid-1990s directly engaged arguments in relation to the use of hormone replacement therapy. Dissent regarding the use of hormone replacement therapy was voiced by Klein who considered unethical the use of a procedure that is not yet proven (Klein 1992). This objection is mirrored in concerns of epidemiologists such as Rosenberg (1993) and Vandembroucke (1995) who, on the basis of methodological problems, questioned the use of hormone replacement therapy in studies that purported to demonstrate the effectiveness of hormone replacement therapy. Coney (1993) argued that certain already present conditions supported the use of hormone replacement therapy including; women's existing relationship with the health system which allows the medicalisation of a normal life event; anxiety among women about the diminution of their social status as they age; definition of normal biological events of menopause as a preventable disease state; and the appropriation of non-gendered diseases, such as osteoporosis and coronary heart disease, in the 'new' menopause.

The relationship between mid-life women and the health system is distorted by negative stereotypes of ageing women which are exploited by vested interests for their own ends. The mid-life woman is oblivious to the deeply sexist ideology underlying the options she has laid before her. Naively she may think these are offered simply for her own benefit. She is not cognisant of the others whose benefit may also be served by her decisions. She is unaware too that the options themselves may be incompletely tested, that there may be considerable controversy about them in the medical literature and that doctors differ in their views. What she is told – how much and how – is mediated by her doctor (Coney 1993: 3).

Modernist feminists such as Coney (1993), in highlighting their critique of menopause, describe the menopausal woman who engages with medical practices as passive, naive and unknowing: a victim of medical dominance. For Coney power is held by doctors and wielded to control and subject women. Medicine is understood as having a sovereign power, a power that displaces the idea of the natural woman. Other modernist feminists, such as Daly 1978, Greer 1991 and Klein 1992, support this view. Greer (1991) proposed women reclaim their true selves; a 'witch-like status' and a power of the self that is separate from men; and in direct rejection of the feminine subjectivity produced by men in medical descriptions of menopause. Menopause, she says, provides an opportunity for the return to the natural, 'real' woman, the one who was lost into puberty when the constraints and imperatives of reproduction, femininity and patriarchy begin to impose themselves:

The climacteric marks the end of apologizing. The chrysalis of conditioning has once and for all to break and the female woman finally to emerge (1991: 440).

For Greer, Coney and Klein, feminist criticism, therefore, involves a subject position for women in which the rejection of medical intervention and power plays a key role. These feminist objections inform our identification of the general practice setting as a critical site for qualitative research about menopause. While other researchers have explored feminist issues through women's narrative accounts of menopause (see Daly 1995, Engebretson and Wardell 1997, Lock 1998) we argue that as the key focus for feminist concerns and as the key professional group involved in health care for women it is important to examine constructions of menopause as they occur within the context of general medical practice.

Semi-structured interview study with general practitioners

The focus of this article is on the shift in the construction of menopause away from a historical approach of primarily symptom treatment towards the preventive use of hormones and the implications of this for women. We identify issues raised by modernist feminist criticisms of the medical construction of menopause and examine these in relation to the construction of menopause in contemporary health care, specifically general practice, because this is the most commonly accessed setting by women for menopause. Based on a 'face-to-face interview study' (see Lincoln and Guba 1985, Grbich 1999), involving nine GPs in a rural area of South Australia, we provide illustrative examples of the ways in which menopause is constructed and explanations are given for the use of hormone replacement therapy. Our analytical framework employs post-structural concepts, including discourse and its constitution of objects/subjects, and technologies of power, based on Michel Foucault (Foucault 1972, Martin *et al.* 1988) and feminist post-structuralism (Weedon 1997).

Poststructuralism, working from Foucault's analysis of the production of subjects, power relations and discourse enables an examination of power relations and how power is exercised. Poststructuralism underscores the role of language in forming the interrelations between individual subjectivity, social institutions and power relations. Language is the site where meanings are produced; linguistic meanings play a major role in organising the self and social institutions. What interested Foucault about power was how particular kinds of subjects are produced as effects of discursive and power relations (Foucault 1982). Therefore, feminist poststructuralists, such as Weedon (1997), informed by Foucault (1982), reject the notion of the subject as unitary and fixed and focus on the *effects* on power relations of the gendered construction of subjectivity:

Different discourses provide for a range of modes of subjectivity, and the ways in which particular discourses constitute subjectivity have implications for the process of reproducing or contesting power relations (Weedon 1997: 88).

In this sense the subject and subjectivity are constructed; as are objects. Language is the site for that construction and therefore the subject, the menopausal woman, and the object, menopause, can be examined in language.

We demonstrate here that a shift has occurred in these general practitioner accounts away from a menopause dominated by a hormonal deterministic view towards discourses of prevention, choice and empowerment drawn from the women's movement and health promotion. Through an examination of the use of language we identify and analyse the ways in which these GPs use concepts and discuss the implications of this use in terms of key literature on contemporary health care. In this research, therefore, we raise two questions; first, 'How do GPs in this study construct menopause?' and second, 'What are the implications of these general practitioner constructions for women's health care at menopause?'

Sample selection and interviews

GPs were selected for interview because they constitute the key professional group responsible for the delivery of primary health care services to women. In rural Australia limited access to a range of health and medical care for women may serve to intensify the health care relationship with general practice. One rural region of South Australia was chosen because it was identified, in consultation with key stakeholders (women living in rural South Australia, health care providers and rural health policy makers), as a region characterised by especially limited access for women to a range of health services and health care providers. All GPs practising in this area ($n = 29$) were invited to participate in this study. A written invitation, which was accompanied by a supporting letter from the Mid-North Division of General Practice (the local professional organisation), plus follow-up phone calls was used to recruit participants. In response, 10 GPs agreed to participate in the study, one later withdrew prior to interview. Subsequent discussion with key stakeholders, when the researchers expressed concern about the low response, revealed a cultural divide that saw populations and health care professionals identifying with micro-regional boundaries. This may explain the absence of any participants from one town ($n = 7$) and the preponderance of participants along the main road and rail route between two major Australian cities. General practitioner participants in the study included four women and five men (compared to eight women and 21 men in the study population), ranging in age from mid 30s to early 50s. Proportionally more women GPs explicitly stated a professional interest in women's health in general and menopause in particular. This may explain the greater

proportion of women GPs participating in the study. With the exception of the one town mentioned above the geographical distribution of practices involved was representative and at least one GP from more than 75 per cent of the practices participated.

Face-to-face semi-structured interviews were conducted with nine participants in a location of their choosing; frequently their office or lunch-room. With the permission of each participant the interviews were audio-taped and transcribed in full. The interview schedule, developed through consultations with women, health care professionals (including GPs) and critical analysis of literature, employed open-ended questions, reflecting the exploratory nature of the research. The purpose of the interviews, their part in the interviewer's (MJM) doctoral research and the social science academic background of the interviewer were made explicit at the start of each interview. One of the authors (MJM) conducted all the consultations and interviews using a framework of feminist standpoint research (FSR). As Griffin (1995) states, FSR includes 'feminist objections to the positivist myth of the apolitical, value-free researcher' (1995: 119–20). The interviews were carried out using a standardised procedure, yet a certain degree of flexibility was required with which to respond to minor differences between individual respondents and their changes to the sequence of interview questions. During the analytic phase both researchers (MJM and JH) employed the concept of 'reflexivity' (see Griffin 1995, Burman 1990) in a systematic application of feminist post-structural theory to the analysis of interview data. Burman's (1990) work on reflexivity is discussed by Griffin (1995) as 'a self-conscious awareness of the ways in which what counts as "knowledge" and the whole process of research are structured by relations of dominance around gender, race, class, age and sexuality' (1995: 119–20).

Qualitative analysis

Discourse analysis was used to analyse the text produced by the interview transcripts. Burman and Parker (1993) describe discourse as being concerned with 'the ways language produces and constrains meaning, where meaning does not, or not only, reside within individuals' heads and where social conditions give rise to the forms of talk available' and that 'discourse analysis offers a social account of subjectivity by attending to the linguistic resources by which the socio-political realm is produced and reproduced' (1993: 3). Initial analysis took the form of close reading and subsequent categorisation of the text by content to allow detailed analysis of manageable sections. Each category was analysed systematically, examining the descriptions of objects in the text to identify the strategies used in their construction (see Potter 1996) and the subject positions produced by these descriptions (see Parker 1992, Burman and Parker 1993). Interpretation of qualitative research is a complex reflexive process (Denzin and Lincoln 1994). In this study tentative hypotheses regarding the discourses employed and their effects were developed and noted throughout the analysis. These

hypotheses were challenged by examining examples of the text for conformity and variation, and by posing alternatives to the proposed explanation. This development and examination of possible explanations was an iterative process. The resultant interpretation identified three predominant discursive themes: (i) the hormonal menopause – symptoms, risk, prevention; (ii) the informed menopausal woman; and (iii) decision-making and hormone replacement therapy. As an interpretation, these discourses (presented below) constitute one of a number of possible interpretations (Potter and Wetherell 1987). This being so, a representative selection of extracts with detailed interpretation is included so that the reader may assess that interpretation (*c.f.* Potter and Wetherell 1987).

I. The hormonal menopause – symptoms, risk, prevention

Asked for a definition of menopause, Dr. E. and Dr. D. described ‘oestrogen withdrawal’ and ‘hormonal change’ respectively as the basis for the onset of menopause and as an approach to treatment:

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

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

For Dr. D. menopause is an entirely physiological phenomenon definable and explicable in terms of a shifting hormonal balance. Dr. D’s description is illustrative of a construction of menopause as the end of a woman’s reproductive life.

A medical menopause is typified by the example of hormonal determinism found in these extracts. The end of reproductive life is heralded by an end to menstruation that is caused by the cessation of ovulation resulting from a decline in the sex hormones oestrogen and progesterone. Dr. D. and Dr. E. described menopause as a physiological process and, in doing so, established one premise in the understanding of medicine as being the most able to understand and respond to menopause. While Dr. D. used hormonal explanations of menopause in relation to symptoms of menopause, variation

in responses included the relationship of menopause to symptoms and long-term health risk.

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

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

In Dr. F.'s account of three main areas that comprise counselling women about menopause, hormone replacement therapy is presented both as a treatment for menopause as well as having the possibility of preventing long-term illness. The centrality of symptoms, unlike Robert Wilson's earlier writings on menopause, are not used to portray the depleted state of the post-menopausal woman, rather they build a case around prevention that links the lack of hormones with osteoporosis and cardiovascular disease. Menopause is constructed as a physical condition that could lead to related physical conditions. The changing construction of menopause from one dominated by femininity to one incorporating a discourse of prevention involves risks and choices: the risks of hormone replacement therapy; the risks of menopause to health; that it is the woman's choice to use hormone replacement therapy or not; 'I think it's their decision'; and, that women are responsible for their long-term health. Menopause *is* risk.

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

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

Using a discourse of prevention enables Dr. B. to present an argument for the use of hormone therapy regardless of the manifestations of hormonal change in menopause. Like Dr. F., the reporting of symptoms is no longer central in Dr. B.'s treatment of menopause. The discourse of prevention

enables the construction of a new menopause within medicine which acknowledges differences between women's experiences of symptoms, and the possibility of the experience of no symptoms: 'Well I don't talk about menopause if they don't have symptoms' (Dr. B.). The discourse, most importantly, continues the relationship between menopause and medicine because all women, because of the loss of hormones, are 'at risk' of debilitating diseases that require medical attention.

The function of this prevention discourse parallels that of the discourse of femininity used in medical descriptions of menopause from the late 19th century to the 1960s. In contemporary descriptions of menopause the importance of the experience of symptoms in establishing the consequences of menopause, particularly loss of femininity, is displaced by the concept of long-term risks to health. In each discourse a loss of hormones is presented as the universal biological truth of menopause and is identified as a problem requiring medical intervention. In this way, the effects of hormones are made to appear as if they are inescapable. Feminists and other critics of medical accounts of 'menopause as symptoms' argue that the emphasis on hormones constructs women as a homogenous group who are weak and vulnerable due to the loss of hormones (*c.f.* MacKie 1992, Coney 1993, Harding 1996). A similar criticism of the construction of menopause as a risk to long-term health can be made. While the 'menopausal woman', subject to the 'vagaries' of symptoms, remains a useful category to bring a woman within the medical gaze, it is not loss of femininity, but the long-term consequences of menopause, that now constitute the inescapable biological 'reality'.

Feminism, medicine and menopause

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

Further, similarities are evident, at an epistemological level, between the positions held by these feminist writers and dominant medical ideas (Leng 1997). Both lay claim to an immutable truth about menopause that rests in an assumption of a knowable, if not universal, reality. In both, an essential subject is produced; one is the 'natural' menopausal woman who should eschew medical intervention, the other is at the mercy of her hormones. In this way both the feminist and the medical positions put forward in this study restrict the discursive options available to women. Importantly, neither version accounts for diversity and difference among women nor for their experiences of menopause, given the changing construction of menopause as a long-term risk to health.

II. The informed menopausal woman

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

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

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

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

I get them to come back, fill out the chart, look at their score. Talk to them about their symptoms, talk to them about what they're reading, answer any questions they've got. And then talk about, well, do we want

to do anything . . . about this. I mean, you know, basically I try to coin it in terms of it's your choice at this point. I'm not going to say you have to take medication or anything, 'cause there are alternatives. You know, you might say, well, perhaps I want to try it or I don't (Dr. C.).

Basically our job again is empowering women to make the choice of what they want to do. And they'll do that anyway. Because in my experience if women don't like the answers they get from their GP they'll go to another one. And if, people nowadays are very well advised and they know what they want to do and they go and they basically do what they want to do (Dr. D.).

Drs C. and D., like Dr. F. earlier, position themselves as medical practitioners whose role it is to empower women to make a choice about hormone replacement therapy. Dr. C. explicitly presents the woman's choice as 'coined' in terms of 'it's your choice'. Dr. D. reinforces his role as well as the autonomy of patients by stating, 'they'll go to another one' (GP) if they don't like what you say, 'they know what they want,' and 'they (women) do what they want'. In these accounts the menopausal woman is not presented as the 'victim' of medical dominance, women are described as well-informed and active participants in their own health care. The discourse of choice demonstrated in the subject position of the informed menopausal woman is inextricably linked to discussions of decision-making and hormone replacement therapy taken up in the next section.

III. Decision-making and hormone replacement therapy

The discussion of the informed menopausal woman demonstrates the ways in which women are positioned as having choices in their health care decision-making. In the next section, we examine responses to a question put to the general practitioners about what they considered to be the best way to support women in decision-making. The quality of information about menopause was a key concern to some general practitioners who scrutinised information to determine whether it constituted 'good information'. The main focus was on information that included a balanced view, defined in terms of medical perspectives on the risks and benefits of hormone replacement therapy, or 'misinformation' defined as including information from mass media, non-medical health professionals and family or friends:

Menopause. The choice is the woman's. She can be advised, she can be given the information. I am supportive of hormone replacement because of all the positive advantages. I'm aware of the negative issues. I'm aware of how much they are overplayed in the press. And I'm aware of the great weight that the reporters place on medical opinions given by people

without medical training. However, the fact is that there is no scientific evidence to support major dramas as a result of that therapy. And there is good evidence of the positive benefits. And I think people need to see that (Dr. I.).

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

In contrast to other interviewees, Dr. A. states neither 'choice' nor a straightforward medical argument to promote hormone replacement therapy.

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

Dr. A. presents a reflexive position on the use of hormone replacement therapy through a direct reference to his own shift in thinking about whether or not hormone replacement therapy is a good treatment to offer women. He makes an explicit reference to his consideration of women's experiences of 'hassles' due to taking hormone replacement therapy as a basis to modify his practice.

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

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

The best way I can help them is to offer them hormone replacement therapy (Dr. G).

For Dr. H., the range of issues about menopause and hormone replacement therapy, the length of consultation time involved, and her belief in the 'well informed menopausal woman' are all considered to be important to decision-making. Dr. G. simplifies the above points by already having made

a decision that offering hormone replacement therapy is the best way to help them. While hormone replacement therapy is brought within each of the general practitioners' accounts as being pivotal to a woman's decision-making process, there are variations due to women's experiences of hormone replacement therapy use, the time allowed by doctors to consider a range of issues related to menopause and hormone replacement therapy, and the extent to which the decision about hormone replacement therapy has already been made by the doctor.

The breadth of medical, preventive, health promotion and feminist discourses places the woman considering menopause in an invidious position. Leng (1997) and Harding (1997) have identified that medical and modernist feminist positions offer women two opposing options which centre on the technology driving conceptions of menopause: to reject the medical position on menopause and thereby refuse hormone replacement therapy is to risk heart disease, osteoporosis and possibly dementia; to accept hormone replacement therapy is to risk breast cancer and to be a 'dupe' of the medical profession and medical power. However, in our examination of menopause in a medical practice setting, we identified a range of ways in which general practitioners' used language from feminists and the women's health movement that was not in opposition to medicine in the same way as work by, for example, feminist writers like Greer's conflicts with medicine. Instead, general practitioners made references to hormone replacement therapy as a 'woman's choice', thereby invoking the individual autonomy of the woman. Based on this observation we argue that women are presented with a *choice dichotomy*.

In the language of the women's health movement a choice exists. We do not deny that there still remains the possibility for a choice to be exercised that accepts or rejects hormone replacement therapy and in so doing also accepts or rejects medical power as this is conceived by feminist writers introduced earlier in this article. Medicine, of course, similarly offers a choice to accept or reject hormone replacement therapy, based on a different rationale. Thus, the concept of choice is problematic. What our study demonstrates is how general practitioners deploy concepts of choice and key concepts from health promotion and the women's health movement and, in doing so, produce and constrain options for women.

The new menopause: woman as active decision-maker

The approach to menopause in the 1990s medical literature bears many similarities to the changing focus of health promotion in that decade that assumed a population of rational autonomous citizens who make informed decisions about health and health care. The subjects of this health promotion are not passive recipients of health promotion information, they are active citizens who are to be supported in their efforts to reach their

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

The responsible citizen is obliged to consult numerous experts. But different groups have different interests in promoting particular risk factors and there is much disagreement about what constitutes risk, at what levels and how to respond. This results in much conflicting advice as there are rarely coherent sets of norms to which one may defer in the care of the self. The enjoiner to individual choice in this context is hardly an egalitarian step:

Conflicting and changing advice about sources and levels of risk means that the individual consumer of expert advice can never know for certain whether any particular set of advice is more likely to guarantee security than any other (Bunton and Burrows 1995: 18).

The consumer is nevertheless expected to discriminate among available competing risk messages (though not between competing alternative paradigms) and to be able to make some decision about appropriate preventive action as if some absolute truth about the risk factors can be established. What is evident is that notions of risk and self-regulation that accompanied the emergence of health promotion in the late 1980s also emerge in the changing rationale for the use of hormone replacement therapy in the case of menopause. The discourse of risk and prevention becomes evident in medical literature and in clinical practice.

In the new menopause women are no longer passive victims of a medical dominance they are responsible citizens making 'informed decisions'. In positioning women as being informed to make a choice and thereby empowered, an autonomous and therefore responsible individual is adopted by this new menopause and is structured through the discourse of prevention.

The medical construction of menopause as risk is important in understanding the deployment of 'autonomy' and 'choice', because the biological 'truths' of menopause remain central, and the language of health promotion is peripheral, or selectively employed. This is unsatisfactory because empowerment, autonomy and choice involve a much broader set of issues than those outlined in the new menopause.

We (Murtagh and Hepworth 2000, In press) and others (e.g. Harding 1997) have argued that menopause has come increasingly to be regarded as a risk to health during the 1990s. There were antecedents of this in medical literature since at least 1966 (see Nordin *et al.* 1966). The difference between these periods is the explicit conceptualisation of risk as part of the construction of menopause. In the 1990s the concept of menopause as risk has been strengthened by the biomedical relationships with disease and ageing. The association of menopause with heart disease and osteoporosis established in the 1980s has been supplemented by associations in the medical literature of menopause with dementia – Alzheimer's disease, urinary-genital problems and bowel cancer in the 1990s (Wren 1997). In this sense menopause is situated in what Bunton and Burrows (1995) call the 'epidemiological clinic', in which risk is calculated for specific communities. These calculations, a practice of the discourses of prevention and health promotion, are used to explain the new menopause and thereby extend the importance of hormone replacement therapy in contemporary culture and medical practice.

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

The recourse to femininity demonstrated by Robert Wilson, while in part still evident in the medical menopause, no longer dominates its construction. In particular, 'femininity' no longer serves its original purpose of providing a rationale for the use of hormone replacement therapy. The concept of menopause as a risk to health supplants the overtly sexist manifestations of femininity typified by Wilson's work, nevertheless maintaining the centrality of medical interpretations of menopause. A key shift in medical discourse has occurred away from conceptualisation of female bodies comprising

hormones and functions based on sex endocrinology towards an approach in primary medical care based on women's responsibilities and choices. Medicine has added-on aspects of prevention and health promotion discourses, while retaining an underlying recourse to biological 'truths' about menopause.

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

The construction of menopause as a risk to a woman's health locates the decision about hormone replacement therapy as necessary and important. The engagement between medical expert and patient is a process of medicalisation of the woman's experience. The subject position created through this process is defined by choice and an ethic of autonomy in women's decision-making which differentiates it from the subject position produced by the concept of 'medical dominance', described by Willis (1983) and some feminist critics (for example Coney 1993), in that the informed menopausal woman is presented as an active decision-maker in the process. By employing the discourses of prevention and choice these GPs have drawn on language from the women's health movement, health promotion and feminist ideas concerning issues of 'choice', 'informed decision-making' and 'empowerment'. These issues were foremost in the establishment of early women's health literature (see *Our Bodies, Ourselves* by the Boston Women's Health Book Collective 1976, revised British Edition 1978), health promotion (see Ottawa Charter 1986), and clinics that engaged a politics of health care (see Broom 1993). The language of prevention and choice has enabled these general practitioners to position themselves as being responsive to long standing calls from the women's health movement about the empowerment of women through the delivery of primary health care and in doing so, to some extent, they circumvent modernist feminist criticism.

Yet, the concept of women's choice presented in this general practice setting is unsatisfactory. The discourse of prevention has changed the terms of menopause from an all encompassing, physiologically and psychologically,

hormonally deficient body to a loss of hormones that is problematic because it is the cause of preventable morbidity and mortality. It is this problematic which appears to remain unquestioned by GPs in this study and in broader medical literature outlined previously. Social and cultural explanations of disease causality (see Germov 1998, Hardey 1998) are absent from the new menopause despite their being an integral part of the framework of the women's health movement and health promotion drawn on by these GPs. Further, the shift of responsibility for health to the individual woman reinforces practice that claims to empower women, but oversimplifies power relations and constructs menopause as a site of self-surveillance. This surveillance occurs within a framework that is constructed by medicine, and not, as might be suggested by the concept of choice, designed by women themselves.

Conclusion

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

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

Changes in the construction of menopause have implications for a feminist position that examines arguments related to medical management and the 'natural' ageing of women. Contemporary primary medical care is not a homogeneous, dominant medicine regarding its treatment of women and menopause, but as we have discussed in this article, involves variation that presents a new menopause constructed through discourses of hormonal determinism, prevention and choice. While GPs remain the key professional group in health care delivery for menopause, the language of primary care offers an apparent commonality of purpose with the women's health movement. The new configuration of discourses claiming that the empowerment of women is an integral part of health care for menopause opens the possibility for change in medical practice to broaden, strengthen and maintain this position.

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References

- Bell, S. (1987) Changing ideas: the medicalisation of menopause, *Social Science and Medicine*, 24, 7, 535–42.
- Bilezikian, J. (1994) Major issues regarding estrogen replacement therapy in postmenopausal women, *Journal of Women's Health*, 3, 4, 273–82.
- Blaxter, M. (1990) *Health and Lifestyles*. London: Routledge.
- Boston Women's Health Book Collective (1976) *Our Bodies, Ourselves*. 2nd Edition, New York: Simon and Schuster.
- Boston Women's Health Book Collective (1978) *Our Bodies, Ourselves*. Phillips, A. and Rakusen, J. (eds) British Edition, London: Penguin.
- Broom, D. (1993) *Damned if We Do: Contradictions in Women's Health Care*. Sydney: Allen and Unwin.

- Bunton, R. and Burrows, R. (1995) Consumption and health in the 'epidemiological' clinic of late modern medicine. In Bunton, R., Burrows, R., and Nettleton, S. (eds) *The Sociology of Health Promotion. Critical Analyses of Consumption, Lifestyle and Risk*. London: Routledge.
- Burman, E. (ed) (1990) *Feminists and Psychological Practice*. London: Sage.
- Burman, E. and Parker, I. (1993) (eds) *Discourse Analytic Research: Repertoires and Readings of Texts in Action*. London: Routledge.
- Bush, T.L. (1992) Feminine forever revisited: menopausal hormone therapy in the 1990s, *Journal of Women's Health*, 1, 1, 1–4.
- Bush, T.L., Barrett-Connor, E., Cowan, L.D. et al. (1987) Cardiovascular mortality and non-contraceptive estrogen use in women: results from the lipid research clinics' program follow-up study, *Circulation*, 75, 1102–9.
- Castel, R. (1991) From dangerousness to risk. In Burchell, G., Gordon, C. and Miller, P. (eds) *The Foucault Effect: Studies in Governmentality*. Hemel Hempstead: Harvester Wheatsheaf.
- Coney, S. (1992) The exploitation of fear: hormone replacement therapy and the menopausal woman. In Davis, P. (ed) *For Health or Profit?* Auckland: Oxford University Press.
- Coney, S. (1993) *The Menopause Industry*. Melbourne: Spinifex.
- Daly, J. (1995) Caught in the web: the social construction of menopause as disease, *Journal of Reproductive and Infant Psychology*, 13, 2, 115–26.
- Daly, M. (1978) *Gyn/Ecology: the metaethics of radical feminism*. Boston: Beacon Press.
- Denzin, N. and Lincoln, Y. (1994) *Handbook of Qualitative Research*. Thousand Oaks, CA.: Sage.
- Engebretson, J. and Wardell, D.W. (1997) Perimenopausal women's alienation, *Journal of Holistic Nursing*, 15, 3, 254–70.
- Formanek, R. (1990) (ed) *The Meanings of Menopause: Historical, Medical and Clinical Perspectives*. Hillsdale, N.J.: The Analytic Press.
- Foucault, M. (1972) *The Archaeology of Knowledge*. tr. Smith, A.M.S. London: Routledge.
- Foucault, M. (1982) The subject and power. In Dreyfus, H.L. and Rabinow, P. *Michel Foucault: Beyond Structuralism and Hermeneutics*. New York: Harvester Wheatsheaf.
- Germov, J. (1998) Class health inequality and social justice. In Germov, J. (ed) *Second Opinion: an Introduction to Health Sociology*. South Melbourne, Victoria: Oxford University Press.
- Grbich, C. (1999) *Qualitative Research in Health: an Introduction*. St. Leonards, N.S.W.: Allen and Unwin.
- Greer, G. (1991) *The Change: Women, Ageing and the Menopause*. London: Hamish Hamilton.
- Griffin, C. (1995) Feminism, social psychology and qualitative research, *The Psychologist, Qualitative Research Special Issue*, 8, 3, 119–21.
- Hardey, M. (1998) *The Social Context of Health*. Buckingham: Open University Press.
- Harding, J. (1996) Sex and control: the hormonal body, *Body and Society*, 2, 1, 99–111.
- Harding, J. (1997) Bodies at risk: sex, surveillance and hormone replacement therapy. In Petersen, A. and Bunton, R. (eds) *Foucault, Health and Medicine*. London: Routledge.

- Hunt, K. (1994) A 'cure for all ills'? Constructions of menopause and the chequered fortunes of hormone replacement therapy. In Wilkinson, S. and Kitzinger, C. (eds) *Women and Health: Feminist Perspectives*. London: Taylor and Francis.
- Klein, R. (1992) The unethics of hormone replacement therapy, *Bioethics News*, 11, 3, 24–37.
- Leng, K.W. (1997) Menopause and the great divide: biomedicine, feminism and cyborg politics. In Komesaroff, P., Rothfield, P. and Daly, J. (eds) *Reinterpreting Menopause: Cultural and Philosophical Issues*. New York: Routledge.
- Lincoln, Y. and Guba, E. (1985) *Naturalistic Inquiry*. Beverley Hills, CA: Sage.
- Lock, M. (1998) Anomalous ageing: managing the postmenopausal body, *Body and Society*, 4, 1, 35–61.
- McCrea, F.B. (1983) The politics of menopause: the discovery of a deficiency disease, *Social Problems*, 31, 1, 111–23.
- MacKie, F. (1992) The hidden ones: the despotic politics of menopause, *Arena*, 98, 15–22.
- MacLennan, A. (1991) Consensus statement. Hormone replacement therapy and the menopause, *Medical Journal of Australia*, 155, 43–4.
- MacPherson, K.I. (1981) Menopause as a disease: the social construction of a metaphor, *Advances in Nursing Science*, 3, 2, 95–113.
- Martin, L.H., Gutman, H. and Hutton, P.H. (1988) *Technologies of the Self: a Seminar with Michel Foucault*. Amherst: University of Massachusetts Press.
- Murtagh, M.J. and Hepworth, J. (2000) Medicine, feminism and menopause: constructing an ethic of choice and autonomy. Paper presented at *Narratives for a New Millennium*, 23–27 February, 2000. Adelaide. Australia.
- Murtagh, M.J. and Hepworth, J. (In press) Towards a feminist ethics of women's decision-making at menopause, *Social Science and Medicine*.
- Nordin, B.E., MacGregor, J. and Smith, D.A. (1966) The incidence of osteoporosis in normal women: its relation to age and the menopause, *Quarterly Journal of Medicine*, 35, 137, 25–38.
- Ogden, J. (1995) Psychosocial theory and the creation of the risky self, *Social Science and Medicine*, 40, 3, 409–15.
- Oudshoorn, N. (1994) *Beyond the Natural Body: an Archaeology of Sex Hormones*. New York: Routledge.
- Parker, I. (1992) *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London: Routledge.
- Potter, J. (1996) *Representing Reality*. London: Sage.
- Potter, J. and Wetherell, M. (1987) *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London: Sage.
- Rosenburg, L. (1993) Hormone replacement therapy: the need for reconsideration, *American Journal of Public Health*, 83, 12, 1670–73.
- Showalter, E. (1987) *The Female Malady: Women, Madness and English Culture, 1830–1980*. London: Virago Press.
- Smith, D.C. (1975) Associations of exogenous estrogens and endometrial cancer, *New England Journal of Medicine*, 293, 1164–67.
- Smith-Rosenberg, C. (1985) *Disorderly Conduct: Visions of Gender in Victorian America*. New York: Knopf.
- Utian, W. (1987) Overview on menopause, *American Journal of Obstetrics and Gynecology*, 156, 5, 1280–83.

- Utian, W. (1990) The menopause in perspective: from potions to patches, *Annals of the New York Academy of Sciences: Multidisciplinary Perspectives on Menopause*, 592, 1–7.
- Vandenbroucke, J.P. (1995) How much of the cardioprotective effect of postmenopausal estrogens is real? *Epidemiology*, 6, 3, 227–31.
- Weedon, C. (1997) *Feminist Practice and Poststructuralist Theory*. Oxford: Blackwell.
- Weiss, N.S., Ure, C.L., Ballard, J.H., *et al.* (1980) Decreased risk of fractures of the hip and lower forearm with postmenopausal use of estrogen, *New England Journal of Medicine*, 303, 1195–98.
- Willis, E. (1983) *Medical Dominance: the Division of Labour in Australian Health Care*. Sydney: Allen and Unwin.
- Wilson, R. and Wilson, T. (1963) The fate of the nontreated postmenopausal woman: a plea for the maintenance of adequate oestrogen from puberty to the grave, *Journal of the American Geriatric Society*, 11, 1, 1–12.
- Wilson, R. (1966) *Feminine Forever*. London: Allen.
- World Health Organisation (1986) Ottawa Charter for Health Promotion, *Health Promotion*, 1, 1, 1–5.
- Wren, B.G. (1997) (ed) *Progress in the Management of the Menopause: Proceedings of the 8th International Congress on the Menopause, Sydney, Australia, November 1996*. London: The Parthenon Publishing Group.
- Ziel, H.K. and Finkle, Z.D. (1975) Increased risk of endometrial carcinoma among users of conjugated oestrogens, *New England Journal of Medicine*, 293, 1167–70.