To Bleed Or Not To Bleed: Questioning the Biomedical Construct of Menopause

Christine Dol

The University of Western Ontario

Follow this and additional works at: http://ir.lib.uwo.ca/totem

Part of the Social and Cultural Anthropology Commons

Recommended Citation
Dol, Christine (2005) "To Bleed Or Not To Bleed: Questioning the Biomedical Construct of Menopause," Totem: The University of Western Ontario Journal of Anthropology: Vol. 13: Iss. 1, Article 6.
Available at: http://ir.lib.uwo.ca/totem/vol13/iss1/6

This Article is brought to you for free and open access by Scholarship@Western. It has been accepted for inclusion in Totem: The University of Western Ontario Journal of Anthropology by an authorized administrator of Scholarship@Western. For more information, please contact kmarcha1@uwo.ca.
To Bleed Or Not To Bleed: Questioning the Biomedical Construct of Menopause

Keywords
menopause, biomedical construct, disease

Creative Commons License
This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License.

This article is available in Totem: The University of Western Ontario Journal of Anthropology: http://ir.lib.uwo.ca/totem/vol13/iss1/6
To Bleed Or Not To Bleed?
Questioning the Biomedical Construct of Menopause

Christine Dol

What is menopause? This question is more complicated than it appears. Menopause is both a biological process and a cultural event in most societies around the world. All women, if they live long enough will eventually stop menstruating. The cessation of menses is experienced by women differently according to their outlook on life, their self-esteem, their nutritional status, their general health and their customary practices. Anthropologists who have studied the diversity of cultural experiences regarding this biological aging process suggest that menopause is a social construct differently perceived and exhibited in different cultures. The most significant find of these studies suggests, “that menopause is most remarkable for being unremarkable” (Davis 1996:68). There is no one typical, universal, menopausal woman.

Western “medicine is not interested in the cessation of menses per se”, but in the underlying hormonal changes associated with “the aging process during which a woman passes from a reproductive to a nonreproductive stage” (Davis 1996:68). Since the end of 1960s, doctors have been prescribing hormone replacement therapy to women for a multitude of physical symptoms related to the ideological
construct of menopause as a disease. The list of disease manifestations representative of menopause is a rather fluid concept which has been continually reinvented based on the latest scientific studies throughout the century. In North America, drug therapy has become the medical and culturally acceptable treatment for women in mid-life experiencing vasomotor symptoms, such as hot flashes, and as a prophylactic measure to prevent a host of diseases. The concept of women’s bodies as a diseased body has become so successful that menopause has been turned into a billion dollar a year industry (Fausto-Sterling 1999).

Recently, the Western biomedical paradigm of menopause as an ‘estrogen deficiency disease’ has come under fire as the harmful results of the hormone replacement study carried out by the Women’s Health Initiative have been reported. Over the last two years, numerous studies coming from this research suggest that the risk of hormone replacement therapy (HRT) outweigh the benefits. In fact, many of these results contradict most of the fundamental biomedical paradigms which promote HRT as a suitable ‘treatment’ for women during mid-life. The stark realization that HRT may be detrimental to women’s health has caused an explosion of biomedical discourse surrounding menopause. This proliferation of medical information available to women on-line and through medical health agencies is designed to educate women about their bodies and attempts to clarify the pros and cons of HRT. The latest pharmaceutical information available to women regarding HRT suggests that the lowest possible dose for the shortest duration of time, continues to be a suitable option and important treatment for the physical manifestations of menopause.

The medical construction of menopause as a disease of the female body continues to be the site of contention: a struggle between a paradigm shift in understanding women’s bodily changes during mid-life as a positive process, and the socio/political/economic interests which are dependant on maintaining the status quo in patriarchal gender domination. This essay will briefly outline the history of the biomedical construct of menopause since Victorian times in order to shed some light on understanding how certain disease processes became attributed to menopause. Medical assumptions and forms of treatment will be examined in relation to the wider global perspective of political, economical and social changes that affect women in America. I will argue that the surge of biomedical discourse after the Women’s Health Initiative hormone replacement study reinforces the menopause myth and reinserts the female body as the diseased body to be monitored, regulated and medicated as a form of socio-economic and political control.

Once upon a Victorian Time ......

Medical discoveries of biological processes have changed the way menopause as a medical issue has evolved throughout the century. In her essay, “Meno-Boomers and Moral Guardians”, Joy Webster Barbre examines the contemporary biomedical model of menopause as a cultural construct by juxtaposing Victorian medical and cultural assumptions regarding women’s bodies, menopause and aging against current ideologies (Barbre 2003). Over one hundred years ago as science replaced religion as the prime shaper of cultural values in the search for objective truth, the discipline of medicine became established as the knower of the known female body. It was at this time that medical language became authoritarian, recognized by both speaker and listener as rational discourse and empirical truth (Foucault 1994). The nineteenth century medical theory regarding the female body suggested that, “a woman’s reproductive organs governed her entire being; they dictated her personality, her abilities and limitations, and hence her social role” (Barbre 2003:272). Women’s subjectivity was medically constructed around reproductive functions; either bleeding and breeding or wasting and withering. Menopause was perceived as a time of reproductive failure, central nervous system disturbances, moral insanity and a host of various physical and psychological maladies. Menopause was fraught with danger ... the prescriptive model for surviving those dangers ...stressed and reinforced the delicate, nurturing, and moral qualities assumed to be a part of Victorian womanhood ...” (Barbre 2003:278). In the Late Victoria times, women’s bodies were prone to failing, unlike their minds which were habitually prone to disease.

The Menopause Myth Reconfigured

Michel Foucault argued that, “Disease, like the word, is deprived of being, but, like the word, it is endowed with a configuration” (Foucault 1994:119). The power of naming this thing called menopause as an ‘estrogen
deficiency disease' to be cured with hormone replacement therapy was first framed in 1966 by Dr. Robert A Wilson. In his so-called 'best seller', Feminine Forever, Wilson proclaimed that with continuous estrogen ingestion, "menopause is curable ... menopause is completely preventable ... Instead of being condemned to witness the death of their own womanhood ... [women] will remain fully feminine - physically and emotionally - for as long as they live" (Wilson cited in Barbre 2003:279). The language of menopause was engulfed in failure; declining hormones, withering ovaries, vaginal atrophy, diminished capacity and senility. Emily Martin suggested that Wilson's authoritative emphasis on the "negative aspects of ovaries failing to produce female hormones", created the image of women in mid-life as a time of 'system failure' when the female body would experience "regression, decline, atrophy, shrinkage and disturbances" (Martin 1997:26-27). Women's bodies would collapse like old dilapidated machines without oil and grease to keep the parts in working order (Martin 1997).

The central theme of the menopause myth was the notion that since every aging woman would eventually stop menstruating only to endure debilitating health, it was reasoned that all women regardless of class, sexual preference, occupation, race, and physical condition were, or would be, potential candidates for pharmaceutical products to control their failing, diseased bodies. By seeming concerned over the health of women's bodies and minds, biomedical discourse concentrated on finding solutions to the 'woman problem'. Margaret Lock argued, "however, this apparent concern for the welfare of society is, in many cases, a thin disguise for a vested interest in the potential profit that is to be made by attempting to keep women healthy" (Lock 1993:335).

The manufacture, promotion, and sales of estrogen skyrocketed right through the mid 1970s, making HRT among the top five pharmaceutical sales in North America (Fausto-Sterling 1999). Anne Fausto-Sterling writes, "the 'disease of menopause' is not only a social problem: it's big business" (Fausto-Sterling 1999:170).

Myths within the Myth

The empty nest syndrome was the first spin-off from the menopause myth. Similar to Victorian times, it was believed that menopause continued to cause major psychological problems for aging women. Women's role in society was still tied to her reproductive capacity. It was every American woman’s duty during the 1950s McCarthy era to be totally devoted to the family and repopulate the nation (Adams 1960). The empty nest problem occurred when these children were grown and left home. Once children were independent, women would experience the syndrome of feeling unneeded, unnecessary and would likely suffer from depression, low self-esteem and psychosis. This concept implied that mothering was the one of the main roles a woman had in Western society. Scientific/medical explanations were used to validate and justify cultural norms and values which reinscribed gender subordination for women in our society.

The negative views regarding the maturing female body coincided, more or less, with the second wave of feminism in America. At the same time that women were 'burning their bras' in the United States fighting for gender equality within the work force and within American society, biomedical discourse focused its attention on the maturing female body. It was much easier to prevent older women who were suffering from the debilitating physical and psychological effects from an unstable, fluctuating hormonal disease like menopause, from re-entering the work force after the children were grown and gone, than radical young feminists. Although many feminist studies focus on the power of older women, biomedical discourse supported the idea that as women grew older the loss of bodily function and mental acuity was inevitable. The only thing that mid-life women could hope for was medicated bliss.

A second spin off from the menopause myth was the linkage between the benefits of estrogen and coronary disease. For over two decades it has been reported in the popular press that heart disease has been the number one cause of death in our affluent society affecting men more commonly than women. Tunstall-Padoe challenged the assumption that the risk of heart disease in women increased post-menopause. He argued that, "there is a myth that risk in women is held low only until menopause, around age 50 years, when it rebounds, equaling, and later surpassing that in men" (Tunstall-Padoe 1998:1425). This myth is based primarily on "circumstantial evidence ... from studies of women with artificial or premature menopause ... to be at a greater risk than menstruating women of the same age; from studies of the changes in lipids ... and finally from observational studies on the apparent protective effects .... of HRT"
Wonder Drug Hiccups

A minor snag in the promotion of HRT as a viable treatment for all menopausal women occurred in the mid 1970s. Four separate studies linked estrogen replacement therapy with an increase risk of endometrium cancer in women with a uterus. By 1975, “hormone therapy prescriptions peaked at 30 million dollars” before the wonder drug hiccup caused sales to plummet to “approximately 15 million in the early 1980s” (Hersh, et al. 2004:47). Instead of discontinuing estrogen therapy for women undergoing ‘natural’ menopause, that is, women with a uterus, the rationale was that “this cancer could be prevented by antagonizing the estrogen with a progestin, and several estrogen plus progestin combinations were explored in the search for one that preserved the benefits of estrogen” (Hulley and Grady 2004:1769, my emphasis). The underlying medical and cultural assumption was that “the female body will be unable to attain its average life expectancy in reasonably good health unless it is regularly fueled with hormones” (Lock 1993:337) After the addition of progestin to the hormonal cocktail, ALL women, those with a uterus and those without a uterus, could benefit from continuous drug therapy for the rest of their lives.

Solving The “Global Woman Problem”

Coinciding with plummeting pharmaceutical sales and loss of revenue, in 1981, the World Health Organization, as a political body, asserted itself the ultimate rational, scientific, objective, authoritarian voice over the female body by declaring menopause an ‘estrogen-deficiency disease’. Male-stream biomedical misconceptions regarding women’s bodies as diseased bodies were solidified and extended universally to ALL women right around the globe (WHO, 1980). Foucault’s notion of biopower focuses on the institutional and state controlled power over populations with the body as a site of contention (Foucault 1990). By defining medical terms, providing a diagnosis, outlining menopausal symptoms, promoting HRT as an effective treatment, outlining screening protocols, suggesting behavioral changes and considering surgical intervention, the World Health Organization actually increased regulations and tightened the disciplinary regime regarding women’s bodies. Margaret Lock argued that, “the medicalized body (is) a manifestation of the potent, never settled, partially disguised political contests that contribute to the way in which the female body is ‘seen’ and interpreted” (Lock 1993:331). Menopause continued to be viewed as a physiological crisis in need of constant monitoring and self-surveillance to measure up to the 1980s model of the ideal woman that was young, physically fit, feminine and fertile. Women’s bodies became regulated like never before!

Following suit, in 1989, the American College of Obstetrics and Gynecology, “recommended that every woman be considered for HRT” (Barbre 2003:279). Barbre notes that “numerous medical and scientific experts and commercial drug companies” suggested that hormone therapy was not only useful in preventing a variety of symptoms associated with menopause but, more importantly, HRT was promoted as a prophylactic measure in preventing diseases (Barbre 2003:279). In the same year, Dr. Robert G. Wells wrote, “With so many benefits and virtually no dangers, it now seems reasonable to recommend that all post-menopausal women -- regardless of age or menopausal symptoms -- seriously be considered for hormone replacement therapy” (Wells cited in Barbre 2003:279). Pharmaceutical sales climbed to “36 million in 1992” (Hersh, et al. 2004:47). Pharmaceutical promotional campaigns and “designer” hormones in the 1990s, produced an increase in the prescriptions of hormones “by 57% from 58 million in 1995 to 91 million in 2001, and annualized to 89 million for January through June 2002” (Hersh, et al. 2004:49). Hormone replacement therapy was one of the most promoted pharmaceutical
Debunking Pseudoscience: The Women's Health Initiative Study

The Women’s Health Initiative (WHI) study which commenced in 1991, was designed as a fifteen year research program to address the effects of hormone therapy in relation to cardiovascular disease, cancer and osteoporosis in postmenopausal women. More than 160,000 generally healthy women, aged 50 - 75, took part in the study which consisted of several different clinic trials. The hormone trial carried out two types of studies: estrogen plus progestin, for women with a uterus, and estrogen alone, for women without a uterus. Women were randomly chosen to take a placebo or the correct hormone supplement. The key focus of these studies was to observe the effects of HRT on cardiovascular disease in postmenopausal women (WHI website).

The estrogen plus progestin study was stopped in July 2002, after 5.6 years due to an increase risk of breast cancer in the study group. The summary of results regarding the estrogen plus progestin as compared to the placebo showed an increase in coronary deaths, an increase in cardiovascular accidents, double the risk of venous thrombosis, an increased risk of breast cancer, and an increased risk of developing cognitive impairment and dementia. Estrogen plus progestin appears to decrease the risk of colorectal cancer and decrease the number of fractures women experienced. The estrogen alone study was stopped in March 2004, after 6.8 years follow-up and women in the study were asked to stop taking their study pills because the risks outweighed the benefits. The summary of the estrogen alone study revealed no difference in risk for heart attacks and colorectal cancer. However, the study did show an increased risk of cardiovascular accidents, an increased risk of venous thrombosis, and an increased risk of dementia. Questions still remain unanswered regarding the effects on breast cancer (WHI website).

The WHI study revealed two things; first, that decreasing levels of estrogen in post menopausal women is not related to heart disease as observed in the placebo group; and secondly, that use of pharmaceutical hormones, estrogen alone and estrogen plus progestin, administered to post menopausal women, actually contributes to a variety of illnesses such as, cardiovascular disease, venous thrombosis, cancer and dementia. Some wonder drug!

Deconstructing the Menopause Myth

The socio-economic fall-out from the harmful results of this study resulted in a decrease in the pharmaceutical promotion of HRT, a decrease in physicians’ prescription rate and women’s personal agency caused the sales of hormonal drugs to plummet (Majumdar, et al, 2004). By the year 2003, “HRT prescriptions declined to 57 million, from 89 million the year before” (Hersh, et al. 2004:50). Several physicians have admitted that, “many studies have documented that patterns of physician practice are often more aligned with promotional messages than with scientific evidence” (Majumdar, et al, 2004:1983). The research findings suggest, “that sustained promotional efforts prior to the WHI estrogen plus progestin study may have fostered the practice of hormone therapy prescribing in the United States” (Majumdar, et al, 2004:1987). This suggests that economic profits outweigh women’s health and well-being in Western capitalistic societies.

The participants of the WHI study were asked to stop taking their hormones, both the estrogen plus progestin and the estrogen alone group because the risks outweighed the benefits. Exactly what benefits does HRT provide to women who are experiencing vasomotor symptoms related to menopause? The FDA states that, “These products are approved therapies for relief from moderate to severe hot flashes and symptoms of vulvar and vaginal atrophy ... to be used at the lowest doses for the shortest duration needed to achieve treatment goals” (FDA News Website). What exactly is the safest, lowest possible dose to use? And how long is too long? A month? Ten years? A lifetime? No study has been done to determine the appropriate dose and duration for safe hormone replacement. Anne Fausto-Sterling writes that, “hot flashes and vaginal dryness are the only climacteric-associated changes for which estrogen unambiguously offers relief” (Fausto-Sterling, 1999:174). But there is a slight catch, “although estrogen does stop the hot flashes, its effects are only temporary; remove the estrogen and the flashes return” (Fausto-Sterling, 1999:174). So women have the option of ‘treating’ hot flashes by a) accepting the surges of heat as a normal physiological process, or b) taking estrogen for the rest of their lives. Fausto-Sterling notes that in time hormonal fluctuations level out and hot flashes subside naturally.

Pharmaceutical Spin Doctors
In October 2004, I attended a Heart and Stroke Foundation: HeartSmart Women’s Taskforce presentation in Brantford, Ontario on the results of the WHI and what these results mean to menopausal women. It is unclear to me why menopause continues to be associated with the Heart and Stroke Foundation since the WHI found no association between menopause and heart disease. There were approximately 200 women attending this presentation sponsored by Dell Pharmacy. A physician gave a presentation regarding heart disease and menopause, followed by a pharmacist who spoke about understanding HRT and exploring alternative herbal remedies for vasomotor symptoms. Circulating within this medical discourse was the idea that the results of the WHI were statistically insignificant to the individual woman, implying that being stricken with a heart attack or a stroke was as likely to happen as winning a lottery - a game of Russian roulette. The central message was that women should take responsibility for their own health risks and were encouraged to “know their numbers.” An increase in body self-surveillance and body policing was advocated; know your blood pressure, your BMI, your cholesterol levels, your blood glucose level, and maintain a waist circumference less than 35 inches. Women were encouraged to exercise for 30 minutes at least three times per week, stop smoking, eat a low saturated fat, high fibre diet, and visit their doctor for more in depth, personal assessment and an individualized form of treatment.

During this presentation, I noticed that pharmaceutical companies switched tactics by promoting vaginal estrogen creams to prevent the new ‘danger’ of vulvar and vaginal atrophy. Even well into old age, biomedical discourse focuses on keeping vulvar and vaginal atrophy at bay to preserve that ever receptive, sexually available female body for penile penetration. This notion reinscribes heteronormative (man and woman) sexual roles and gender performance that reinforce patriarchal ideology concerning women as the sexually receptive member of the species.

A recent corporate strategy of the Dell pharmaceutical company has been to certify and hire ‘Certified Menopause Practitioners’ for each pharmacy location to provide a personal, individualized health profile for each woman during a half hour consultation, for a fee of $45.00. Sacred biomedical knowledge and privileged information about women’s bodies is sold like a commodity. This practice elides the fact that pharmaceutical companies are shaping cultural practices within our society by deciding what women need to purchase in order to stay healthy. This practice also discriminates against low income women who cannot afford this service and women who are unaware that this information is withheld. Sandra Lee Bartky suggests that this practice reinforces subordination of women because it is, “orientated toward the production of isolated and self-policing subjects” (Bartky 1997:148). Current biomedical discourse reconfirms and reinscribes the female body as the pathological body, the body in constant need of vigilant monitoring and surveillance.

Conclusion

Many women all over the world from different cultures find the cessation of menses a pleasant and empowering experience (Fausto-Sterling, 1999). In Western culture, the medicalization of women’s reproductive capabilities have traditionally been used to justify social/political/economic injustices and inequalities faced by women in our patriarchal society. During the 19th century, Victorian women’s subjectivity was constructed around maladies of the reproductive organs, and treatment consisted of social/physical/emotional domestication and a life devoted to subservience. By the mid 1960s, the cessation of menses was rhetorically reconfigured into an ‘estrogen deficiency disease’ and pharmaceutical chemical compounds were medically and socially justified to control the hormonal fluctuations experienced by mid-life women. Today, women are being encouraged to take control over their own health. How ironic, we are being given supervised autonomy over our own medicalized bodies!

The problem with the recent surge of biomedical discourse surrounding menopause, especially after the negative results from the WHI study, is that women’s subjectivity continues to be constructed as a pathology of the reproductive cycle in need of medicalization, surveillance and discipline. Hormonal supplements chemically restrain the aging female body and preserve it, pickled in the perpetual state of youth and beauty, thus conforming to the perpetual patriarchal definition of femininity. Women are not allowed to grow old gracefully, the old patriarchal fears of the elderly, wicked hag prevail. Biomedicine as an institution of power perpetuates structural violence against women by reinforcing gender ideologies that sustain the notion that women’s reproductive cycle is central
to women's sense of self identity. How can Western women feel good about the cessation of menses in mid-life when this contradicts the Western idealized notion of the young and fertile woman? What is it about non-bleeding, non-breeding women that frightens the technocratic culture of Western biomedicine? As women, we must discipline our aging bodies to be healthy, thin, youthful and continuously sexually receptive. Foucault argued that, “discipline produces subjected and practised bodies, ‘docile’ bodies” (Foucault, 1995:138). However, I would argue that although biomedicine as an institution of power does produce a medicalized subjectivity for women to practice and perform, women are not docile bodies.

Many of the research papers reported a high degree of non compliance in the Women's Health Initiative HRT studies. Many women chose not to take their hormones for the duration of the study: they were the lucky ones. Allow me to explain. The results of the WHI study on hormone replacement therapy revealed that; a) estrogen plus progestin and estrogen alone are both associated with an increased risk of a host of diseases including; breast cancer, coronary deaths, cardiovascular accidents, venous thrombosis and dementia; b) that fluctuating levels of hormones in post-menopausal women is NOT related to an increase in heart disease as observed in the placebo group for both trails; and finally c) that pharmaceutical companies are shaping cultural norms by targeting women in their promotional campaigns, and driving the pattern of physician practice. Seeking to turn a profit, pharmaceutical companies continue to promote their deadly chemical products with little scientific justification at the expense of women who have been historically conceptualized as the diseased body in the eyes of Western biomedicine.

Anthropological cross-cultural research by Donna Davis, Margaret Lock and Anne Fausto-Sterling, among others, reveals that ALL women, in ALL societies, do not view menopause as a pathology of the body in need of medication. In many societies around the world women gain social status when they stop menstruating. Women’s bodies are not diseased by nature: pathology is the by-product of Western biomedical discourse. What right do pharmaceutical companies and the discipline of biomedicine have in monopolizing the discourse regarding women’s bodies and embodied experiences? It’s time to reject the medicalized construct of the female body created by the institution of biomedicine and reclaim our right to experience hot flashes as surges of empowerment and celebrate the cessation of menses like millions of women in different cultures around the world.

Bibliography


Hersh, Adam L., Stefanick, Marcia L., and


