

## **From Cure-All to Carcinogen:**

### **How Women Experienced the Rise and Fall of Hormone Drugs**

#### **Introduction**

In 1966, gynecologist Robert A. Wilson sold the idea to the public through the publication of his book, *Feminine Forever*, that women needed drugs at menopause, their last menses, to stay healthy, youthful, and sexy. Wilson effectively combined scientific facts with sexist stereotypes about aging to argue that menopause was a disease that robbed women of their femininity. He claimed:

*In short, menopause must at last be recognized as a major medical problem in modern society. Women, after all, have the right to remain women. They should not have to live as sexual neuters for half their lives. The treatment and cure of menopause thus becomes a social and moral obligation. At this point in history, medical science can no longer evade the responsibility of helping women remain feminine for life* (Wilson, 1966, p. 25).

The promotion of hormone drugs by Wilson in particular, and the medical establishment in general, demonstrates how social forces played a key role in the medical treatment of menopause. Menopause is much more than a physical change, particularly in light of the ways that U.S. culture has historically portrayed it as the decline of female worth or more recently as a major health issue. During Victorian America, for example, the lack of reproductive ability became the marker of old age, a devalued time in women's lives, because the uterus defined women's value to society (Barbre, 1993). In contemporary America, women are not as identified by their uteruses as their Victorian mothers, yet medicine, the media, and negative cultural assumptions about aging women's bodies continue to portray menopause as a loss and an illness (Bell, 1987; Winterich and Umberson, 1999).

Medicine shifted the definition of menopause as a personal matter to a health issue in the mid-20<sup>th</sup> century when researchers discovered and then doctors promoted hormone drugs as the key to a longer, healthier life. When medicine changes the definition of a bodily condition to a medical matter—a phenomena sociologists call “medicalization”—it has consequences for how

people experience their bodies and perceive their health (Conrad and Schneider, 1980). For menopause, women were faced with the decision whether to take hormone drugs because doctors treated it as a medical condition. Yet medical advice kept changing regarding the risks and benefits of the drugs. At two different times, doctors recommended hormones as the key to a longer, healthier life only to recant that advice as studies showed the drugs' risks for women's health were too great.

In this paper, I argue that the medicalization of menopause was not a result of objective medical evidence alone, but rather a confluence of three social factors: sexist science, the dominant role of medicine in defining bodily states, and for-profit pharmaceutical companies. I use excerpts from 42 in-depth interviews that I conducted with a diverse group of menopausal women to show how they experienced the medicalization of menopause when doctors promoted hormones as a health benefit, and later when they cautioned women to use them for a short time, if at all. Women reacted to hormone drugs in various ways, yet their accounts similarly highlight the power of medicine to influence their decision-making with consequences for their health and quality of life. I conclude by discussing the implications of this paper for future research.

### **What is Menopause?**

Menopause literally means the end of menses. On average, women in the U.S. stop menstruating by 52, and by 54, ninety percent of women are postmenopausal. Menses end because the ovary's role shifts from producing eggs and hormones to only producing hormones, which are a different mix than during the years of menstruation. So the ovary has two roles: it stores eggs and it produces hormones. After a woman's eggs run out, the ovary continues an important function by making hormones. Dr. Susan Love, author of *Dr. Susan Loves' Menopause & Hormone Book*, vividly describes the ovary this way: "The menopausal ovary is neither failing nor useless. It's simply beginning to shift from its reproductive to its maintenance function. It's doing in midlife exactly what many people do—it's changing careers" (Love with Lindsey, 2003:16). To understand why menses cease requires first understanding why they occur.

Approximately every month (this varies from woman-to-woman), the lining of the uterus builds and sheds; the shedding is experienced as a period. The pituitary gland plays a central

role in this process. It is located at the base of the brain and its purpose is to produce hormones as well as to tell other hormone glands what to do, including the ovaries. Every menstrual cycle, the pituitary puts out a hormone called follicle stimulating hormone, which tells the eggs stored in sacs—the follicles—to produce estrogen. When estrogen rises to a certain level, ovulation occurs; this is when an egg is released from the follicle. The follicle then moves to a new phase and secretes the hormone progesterone. This phase is short-lived and once progesterone dips to a certain level, the uterine lining sheds.

Eventually ovaries stop producing eggs but women can continue menstruating without ovulating because they have estrogen levels that continue to create a lining in the uterus. When hormone levels have changed so that menstruation has permanently ceased, women's bodies stop producing progesterone but continue to make estrogen at lower levels. Before the final menses, a transition period that doctors term perimenopause occurs, which can last from three to 10 years. During this time, estrogen levels soar and plummet as women's bodies move to their post-menstruation state.

Some women go through perimenopause unaware that anything is happening with their bodies, while others experience physical, emotional, sexual and/or menstrual changes that vary from minor to irritating to severe (Mansfield and Voda, 1997). For example, women may have hot flashes, night sweats, mood swings, vaginal dryness and/or changes in sexual desire. The research on menopausal "symptoms" indicates that most women check-off at least one item from a list of common changes, but just a minority suffers from severe or debilitating changes (Avis and McKinlay, 1991; Mansfield and Voda, 1997). In other words, most women do not experience menopause as a difficult time in their lives. When hormone drugs hit the market, they grew in popularity not solely because women felt they needed them to feel better, but because they were persuaded by medical advice and marketing campaigns that hormone drugs would help them live a long, healthy life (Jeffe, Freiman and Fisher, 1996).

### **The Politics of Women's Biology: Sexist Science and the Biomedical Paradigm**

The first social force that influenced the medicalization of menopause is the perpetuation of sexism, the discrimination of women, by science. Science and medicine are social institutions

that, in the past, reflected the interests of middle-class white men in research and practice, with consequences for how researchers conceptualized women's biology (Auerbach and Figert, 1995; Hubbard, 1990). History is full of examples of science legitimizing the lower status of women in society. For example, sexist interpretations of biology characterized men's bodies as strong, virile, and independent and women's bodies as weak, unstable, and in need of care (Hubbard, 1990; Martin, 1987). Consequently, the medical view in the 19<sup>th</sup> century that higher education would be too great of a strain on women's reproductive capabilities effectively kept women out of the public sphere (Hubbard, 1990).

For more than 100 years, medicine focused on women's reproductive processes, such as menstruation and childbirth, while paradoxically ignoring them in large clinical trials on health issues that are relevant to them, like heart disease (Auerbach and Figert, 1995; Hubbard, 1990). Medical researchers defined men's bodies as the norm in studies; they reasoned that women's hormonal cycles were too difficult to account for in clinical trials (Hubbard, 1990). Indeed, until 1988, researchers typically included only men in trials testing new medications despite the fact that women use 80% of prescribed drugs in the United States (Schiebinger, 2003). Researchers extended their findings on male-only trials to women's bodies with various consequences, such as standardized dosages based on men's weight and metabolisms, which put women at risk of overdose (Schiebinger, 2003).

The federal government recognized the unequal treatment of women in medical studies, and established regulations in 1990 and 1993 that required all federally-funded clinical trials to include men and women, unless the topic under study was unique to men (Greenberger and Marts, 2000). A non-profit organization, The Society for Women's Health Research, evaluated the success of the new rules by reviewing the findings of clinical studies published from 1994-1998 in the top four medical journals. They found that even though the vast majority of studies included women in their trials, less than 25 percent conducted a comparative analysis (Greenberger and Marts, 2000).

Sexism in science is relevant to menopause in the ways that medical perspectives and language reinforce cultural views about menopausal women and aging as a time of decline

(Barbre 1993; Martin 1987). For instance, gynecology textbooks routinely describe menopause as “reproductive failure” or “ovarian failure,” which implies that women’s bodily processes inevitably breakdown over time rather than grow and succeed (Love and Lindsey, 2003, p. 25). This characterization reflects cultural definitions of femininity by framing it as a passage from a youthful, and therefore valued body (Davis, 1995) to an aging or “failed” body.

Menopause is also another example of medicine’s unequal focus on women’s reproduction at the expense of other health issues. Furthermore, the medical establishment has encouraged those women with resources to pay attention to their health and to view their life challenges in medical terms (Nathanson, 1977). Therefore, seeking help in the health-care system is culturally constructed as feminine behavior while the research and practice of medicine are constructed as masculine endeavors (Courtenay, 2000). Overall, the medical bias that women’s biology is inherently weaker than men’s, and that women should attend to their bodies, contributed to the medical view that menopause is a negative time that could make women sick and distressed. Therefore they should seek medical help.

The ways that medicine is taught and practiced in the United States is the second important social factor contributing to the medicalization of menopause. Doctors are trained according to the biomedical model, which means that they treat diseases in individual bodies as if they were machines (Turner, 1992) and are not trained in diet, exercise, and lifestyle (Love with Lindsey, 2003). Prescribing a pill to treat symptoms and to prevent future diseases is easier and faster than treating the whole patient, such as educating them about diet and exercise (Love with Lindsey, 2003). According to Love (2003), the rise of the gynecologist’s role within medicine influenced the high prescription rate of HRT. Medicalizing the transition from reproduction to post production provides doctors an opportunity to monitor women’s bodies for the rest of their lives (MacPherson, 1990; Ferguson and Parry, 2000). Once a woman begins HRT, she must consult her gynecologist every six months to refill her prescriptions. Women who take HRT are more likely to undergo endometrial biopsies; dilatation and curretage, a procedure that scrapes the uterus of its lining; and hysterectomies, the removal of a woman’s uterus through surgery (Love

with Lindsey, 2003). Consequently, taking long-term HRT means that women maintain an on-going relationship with their gynecologist due to possible complications from the drug.

### **The Discovery of Hormone Drugs and Menopause as an Illness: What Went Wrong**

The third social factor that influenced the medicalization of menopause is the role of for-profit pharmaceutical companies. Medicine has not always defined menopause as an illness or a medical problem, that changed occurred after researchers developed hormone drugs in the 1930s and 1940s. It took hold when pharmaceutical companies marketed them in the 1960s to treat the physical, emotional, and sexual changes at menopause (McCrea, 1983). One consequence of medicalizing menopause was that doctors redefined the physiological changes of menopause as “symptoms,” and thus women came to see their hot flashes and vaginal dryness as symptoms of an illness, rather than expected changes (Worcester and Whately, 1999).

Pharmaceutical companies played a critical role in marketing the idea that menopause should be treated with medication. Why do these companies have so much power? The United States has a unique health care system because it is for-profit, so it relies heavily on the deep pockets of pharmaceutical companies for drug research and development.<sup>1</sup> In turn, pharmaceutical companies spend a lot of money marketing their drugs to doctors and the public. When estrogen replacement therapy (ERT) hit the market, the first company to produce it, Wyeth-Ayerst, paid Dr. Wilson to promote their drug, which he did through the publication of his book, *Femininity Forever*.

Wilson was an aggressive and sexist promoter of ERT. He combined gendered interpretations of women’s biology with cultural assumptions that aging deprives women of their femininity to sell ERT. He claimed that menopause was a disease caused by a deficiency of estrogen similar to other deficiency diseases like diabetes. Just as diabetes is caused by a lack of insulin produced in the pancreas, Wilson argued, menopause is caused by a lack of estrogen produced in the ovaries. He maintained that the body’s lower production of estrogen made women sick, and that if women replaced their estrogen levels by taking hormones, they would feel better. Consequently, those women who took hormone drugs would be assured an enjoyable sex life as well as a “youthful appearance and vigorous energy” (Wilson, 1966, p. 207).

Even though Wilson's claims for risk-free eternal youth may seem extreme today, at the time, his book was popular in the United States and in Europe (Coney, 1991; Love with Lindsey, 2003).

During the 1960s and 1970s, many practicing physicians prescribed estrogen drugs. According to the U.S. Bureau of the Census, sales of estrogen quadrupled between 1963 and 1973 (McCrea, 1983). This drug was wildly popular and profitable; in 1975, estrogen ranked as the fifth most frequently prescribed drug in the United States. That same year, however, medical researchers made a frightening discovery: the drug gave some women cancer. The *New England Journal of Medicine* published the results of two studies that found a link between postmenopausal estrogen drugs and endometrial cancer, a cancer of the lining of the uterus. By 1980, nine more studies concluded that women who took ERT increased their chances of developing endometrial cancer four to 20 times more than women who never took it (MacPherson, 1990; McCrea, 1983). In response, physicians dramatically reduced the number of ERT prescriptions in the early 1980s. The drug touted by Wilson as a cure-all, a femininity pill that would keep women young, sexy, and healthy, was actually a carcinogenic; it increased their risk of cancer.

The sobering discovery that estrogen pills gave women cancer did not close the chapter on hormone drugs. Medical researchers, funded by pharmaceutical companies, worked to develop a supposedly safer pill (Love with Lindsey, 2003). After years of research, they created a new drug: hormone replacement therapy (HRT). HRT differs from ERT because it combines two hormones, estrogen with progestin, which is a synthetic progesterone. Progesterone is the hormone responsible for ridding the uterine of the lining, which results in menses. The synthetic hormone, progestin, works the same way: it signals to the body to slough off the uterine build-up caused by estrogen, which would eliminate the abnormal cell growth caused by estrogen alone, thus eliminating the risk of cancer. In fact, medical studies suggested that this new form of hormone therapy *protected* women from uterine cancer. Prescriptions for HRT soared. Throughout the 1990s, other studies claimed that women who took hormones had stronger hearts and bones, and possibly clearer minds and skin (Love with Lindsey, 2003). Once again, doctors and drug companies promoted hormone drugs as a cure-all. By the 1995, Premarin, the most

popular type of estrogen used in HRT, became the most prescribed drug in America (Love with Lindsey, 2003).

Pharmaceutical companies have another unique role in the U.S. compared to other countries; they use the media to disseminate information and to advertise their drugs. Before HRT's risks became clear, the media played a significant role in promoting HRT through its unbalanced reports, which were often the result of news releases and interviews with pharmaceutical companies (Love with Lindsay, 2003). Since advertising rules were relaxed in 1997, ads for menopausal drugs increased dramatically. In fact, the pharmaceutical industry spent more than \$1.8 billion on advertising for all drugs in 1999 (Worcester, 2004).

Also, pharmaceutical companies hired advertising agencies that increasingly used younger and younger women in ads to tout the benefits of HRT (Love with Lindsey, 2003). This marketing is problematic in a culture that defines femininity and beauty with the young, female body (Davis, 1995). The marketing of HRT and estrogen products was and is part of a larger cultural consumer culture that invokes women to "fight" aging. Indeed, marketing analysts predict that anti-aging products and services, including weight-loss programs, will gross 56 billion dollars in 2007 (FIND/SVP 2003). Ironically, the package insert in Premarin contradicts the "forever young" message. It says: "You may have heard that taking estrogens for long periods after menopause will keep your skin soft and supple and keep you feeling young. There is no evidence that this is so and such long-term treatment may carry serious risks" (Love with Lindsay, 2003, p. 41). By promoting HRT as a healthy way to prevent the signs of aging, marketers played on women's fear of menopause and physical change, and becoming debilitated and dependent on others (Worcester and Whatley, 1999).

However, the proclaimed benefits of HRT were based not on clinical trials, the gold standard in medicine, but rather on observational studies. Through sophisticated statistical analyses, observational studies can suggest relationships between people's behaviors, the drugs they do and do not take, and their health status. One problem with observing what people do and making claims about what is affecting their health is that the claims are not definitive. Not until researchers conduct an experiment, a clinical trial, in which they randomly give some people the

drug that they are testing while others receive placebos, can they be certain how the drug helps or hurts people's health.

The federal government initiated the first clinical trial, the Women's Health Initiative (WHI), to test the benefits and risks of HRT in 1991, including whether they helped women reduce their risk of osteoporosis (thinning of the bones) and heart problems. It enrolled 27,500 participants from 1993-1998 and planned to stop the study in 2006. However, the preliminary results stunned the medical community and those women who were taking HRT: they indicated that the most prescribed drug in the U.S. actually put some women at an increased risk of developing blood clots, strokes, heart attacks, and breast cancer (Worcester, 2004). As a result, the principal investigators stopped the clinical trial in 2002, three years ahead of schedule. Now several medical groups give the most conservative advice they have ever given for hormone drugs: if women feel they need to take the drugs to help with menopausal changes, then they should take the lowest dose for as little time as possible (Harvard Women's Health Watch, 2007).

The medicalization of menopause occurred in a complex cultural, social, and medical context. Before and after the WHI, menopausal women who sought medical help had to decide within this context whether to take HRT. In the next section, I analyze in-depth interviews with women about their experiences with doctors and hormone drugs. My analysis shows some consequences of the medicalization of menopause for women's experiences at two times of medical protocol: before the WHI, when doctors said the benefits of HRT outweighed the risks, and after the WHI, when doctors said the risks were too great for long-term use.

### **The Interviews**

I conducted interviews with 30 women before the WHI, in 1999 and 2000, and 12 women after the WHI, in 2004, to examine how women experienced the medicalization of menopause. I re-interviewed five women and conducted interviews with seven new women for my post-WHI research. This research is part of a larger project on heterosexual and lesbian women's experiences with menopause, midlife sexuality, and HRT. The full interviews consisted of open-ended questions about physical and emotional changes during menopause, whether changes affected sex, and how women experienced medical care and hormone drugs.

### **Women's Experiences with Doctors and Hormone Drugs: Before the WHI**

Before the WHI, half of the women I interviewed were taking HRT and five others had tried it and then stopped. The overwhelming primary reason most women took HRT at all was because their doctors recommended it. This finding supports past research which suggests that most women took HRT as a result of medical advice, not for specific health reasons (Jeffe, Freiman and Fisher, 1996). The following excerpts demonstrate how some doctors participated in a medical and cultural climate that promoted life-long HRT as the best means to prevent osteoporosis and heart disease. In particular, these accounts show how doctors used their medical authority through persistent discussion of HRT and power-laden language, an over-emphasis of the benefits of HRT, and dismissal of alternatives.

#### *Persistent Discussion of HRT and Power-Laden Language*

Many women said that their doctors either pressured them to stay on HRT or persistently discussed the drug's benefits. Although not all women complied with their doctors' recommendations, their accounts similarly show how the doctor-patient interaction strongly affected their decision-making process, with consequences for their health and quality of life. For example, a conflict Carol, a 71-year-old white heterosexual, had with her doctor demonstrates how some women took HRT for reasons other than health issues.

When Carol first started HRT, she spotted but could not contact her doctor because he was out-of-town. Since she was a practicing nurse at the time, she stopped taking the hormones since it "seemed like the smart thing to do." When she met with her doctor, he strongly disagreed with her decision. She explained:

In fact, when I stopped taking it that time, when I had the bleeding, Dr. Jones is my gynecologist and he said to me, checking off everything as he went down the checklist, and he said, "Are you taking your Premarin?" I said, "No." I had stopped taking it because of the bleeding and he was out-of-town, so I just quit taking it. And then I knew it was the lowest dose so I just slowed down and I just didn't take it anymore. And he said, "Well, I want you to take it and I don't want you to get osteoporosis." And he got really upset with me....

(JW) Why was he upset with you?

Because I stopped taking it totally. And he had ordered. So then I started taking it again.

Carol's doctor tapped into the power of medical authority through his use of language; he "ordered" Premarin for Carol and he expected her to follow his instructions. Carol's response was: "I try to be obedient and do it because it's the thing the doctor says I'm supposed to do." Carol took HRT because her doctor told her it would prevent osteoporosis. However, Carol neither had osteoporosis nor did it run in her family. This account suggests that some women may have taken HRT because of the power dynamic between doctors and patients, not for a specific health reason. The consequence in Carol's case was that her doctor made her feel "bad," and she felt obligated to take a drug even though she preferred to avoid medications.

Another woman described her doctor's unrelenting recommendations to take HRT and the personal cost she experienced to resist. Kate, a 60-year-old white lesbian, said that before her periods stopped, her female gynecologist persistently talked about HRT as a medication Kate should take to maintain her bone and heart health. Kate explained:

I argued with my gynecologist who I saw for about 10 years....because every time I saw her she was talking about hormone replacement therapy. I eventually went through menopause and I kept saying, "No way." And she kept talking about it in terms of osteoporosis and heart and all this and I just said..."Look, if it will shut you up, I will go and have a bone density test done. If they tell me that I've got osteoporosis or look like I'm on my way to it, I will reconsider." I went at my own expense because of course insurance wouldn't cover it, because that was considered experimental at the time, I went and had it and everything was normal. So I figured, "Get off my back, I'm not taking it."

(JW) And what did she say?

Well, she still talked about it....

(JW) And how did you feel when she kept bringing it up?

Annoyed you know, but she was such a good-natured person. I mean I really couldn't get angry with her....She felt as a physician she had to do her duty and try to convince me to do this.

Kate's account highlights two complex issues about the medicalization of menopause. First, Kate had to spend her own money for a medical exam to respond to her doctor's determined promotion of HRT. Although Medicare started covering bone density screening tests in 1998 (National Osteoporosis Foundation: [www.nof.org](http://www.nof.org)), not all private insurance companies cover the test's costs, which range from \$150-\$350 ([www.spine-health.com](http://www.spine-health.com)). Medicalizing menopause defines women's bodies as if they all pose the same risks for osteoporosis and heart disease (Ferguson and Perry, 2000). As this account suggests, some women who resisted medicalization resorted to significant measures to maintain their resistance.

The second point this account underscores is that before the WHI, some doctors may have pressured all of their patients to take the HRT even when medical tests indicated it was not necessary. Yet this pressure cannot be simply understood in terms of individual doctors' behavior. As Kate said: "She felt as a physician she had to do her duty and try to convince me to do this." In other words, her doctor's medical training resulted in her strong belief about the advantages of HRT. Until the WHI, medicine trained doctors about the benefits of HRT for all women, continually researched their benefits, and promoted HRT through medical writings (Love with Lindsay, 2003). Therefore, the medical view of HRT as a net positive for all women may have outweighed individual women's risk profiles.

*Over-emphasis of HRT Benefits; Dismissal of Alternatives to HRT*

Many women's accounts demonstrated how some doctors over-emphasized the alleged benefits of HRT and downplayed the risks. Consequently, women felt conflicted about HRT and could have jeopardized their long-term health in the process. For example, Brenda, a 58-year-old Caucasian lesbian, had been taking HRT for seven years. Her sister had breast cancer but her family has heart disease too, so she felt conflicted about continuing HRT. She explained what her doctor said to persuade her to stay on hormone therapy:

...my doctor explained it, she said, "If you take 1,000 women here that use Premarin, 1,000 women that don't, this 1,000 is going to live longer because they are taking Premarin." She said, "This group will not because of heart circulation and that sort of thing." And she said, "This group that takes Premarin will have a slight increase in breast

cancer but looking at it overall, it's a healthier group of women." So that made me feel better just last year. The last time I went.

Brenda's doctor relied on the best observational data available at that time. However, for years the research on HRT and women's hearts was mixed, with some studies showing benefits while others indicating risks (Love with Lindsey, 2003; Worcester and Whatley, 1999). In light of the WHI findings that HRT increases breast cancer, Brenda's account shows the serious risk that some took because of medicine's belief that HRT was a benefit for all women. In fact, the year after the WHI's preliminary findings when most women stopped taking HRT, new breast cancer rates significantly declined (Women's Health Network, 2007).

Several women said that they wished their doctors considered other options to HRT. One consequence of medicalizing menopause is that doctors dismiss what they characterize as alternatives because they view hormone treatment as the only legitimate treatment (Ferguson and Parry, 2000). For example, Anna, a 56-year-old white heterosexual, took Rejuvex, a vitamin supplement, which she said: "I really like...I thought it was great. I was feeling really good." When she told her doctor about it, she "poo-pooed it like crazy and told me I should go on (HRT)...she (her doctor) thought, 'That's just one of those scams.'" Anna followed her doctor's advice, stopped Rejuvex and started HRT, which caused heavy bleeding. She said that she felt much worse taking HRT compared to Rejuvex, but she did not want to ignore her doctor's advice.

This account points to an important issue with research on HRT and so-called alternatives. Because pharmaceutical companies fund the most research on Premarin, the type of estrogen commonly used in HRT, little research is conducted on different types of estrogen or herbs (Love with Lindsey, 2003). Formulations of estrogen and progesterone that cannot be patented receive less research money and use in the United States compared to other countries (Love with Lindsey, 2003). In fact, Europe has a much larger choice of HRT products than the United States (Rozenberg et al., 2000).

Women's accounts suggest that they did not conduct an objective, cost-benefit analysis of their health risks to decide whether to take HRT, but instead primarily relied on their doctors'

advice. Their experiences point to the power of medicine to frame their choices about HRT, even when it caused problematic side effects or posed risks to their long-term health.

### **After the WHI**

All of the 12 women I interviewed were taking HRT when the WHI researchers released their preliminary findings. My questions focused on how women reacted to the WHI, what their doctors recommended, and whether they continued HRT. Women primarily responded to the WHI findings with confusion or anger. For example, when I re-interviewed Brenda, who took HRT to help with her heart health, she said: “Oh shoot!...Well, what’s the point here? And what do I do?” Lynn, a 58-year-old white lesbian, said: “I was annoyed, I was angry...because there’s so much working done on male bodies.” Lynn was frustrated that the drug’s safety was not determined before it was prescribed to women as good for their health, a phenomena that she perceived as a pattern of sexism in medicine.

Most women’s doctors did not tell them to stop the drug, but they did not promote it as strongly as they did before the WHI. Instead, most said that it was up to each woman to decide for herself. This change in advice was perplexing for some given the previous medical climate that so strongly framed HRT as a necessary drug. When I re-interviewed Anna, she said that before the WHI: “Doctors were really pushing them (hormone drugs) and usually, the doctor tells me something, I usually think, ‘we’ll do it.’” After the WHI, her doctor said that Anna should: “Wait a while, and not jump to any conclusions right away.” Anna initially followed her advice because of her medical authority, but then changed her mind when her friend, who was “in excellent shape” had a “heart attack, and they blamed it on the hormones, and she told everybody to get off of them.” Anna’s doctor did not resist Anna’s wish to stop, and she helped Anna come off of them gradually so that her body adjusted.

Not all doctors dismissed the study’s findings. When Jenna, a 58-year-old white heterosexual consulted her regular doctor, she said that the study “was interesting, but...that the statistics weren’t really as alarming.” Jenna questioned that interpretation because: “By the fact that they stopped it in the middle that made it seem like (it was) pretty significant to me.” So, she consulted a second doctor who recommended that she stop taking HRT, which Jenna did.

Overall, most women stopped HRT, but some preferred to take a “wait and see” approach because they feared a return of hot flashes or they generally felt better on HRT. Even though HRT increases women’s risk for heart incidents and breast cancer, that risk does not mean that every woman who takes HRT will inevitably have those problems. For those women who experience difficult menopausal changes, some are grateful that a medication exists to help them. A key problem with the medicalization of menopause in a biomedical system is the “one size fits all” approach, that is, medicine deemed HRT as the best way to treat menopause for all women. When the WHI questioned the safety of HRT, most women responded by avoiding hormone drugs (Harvard Women’s Health Watch, 2007), but not all women reacted this way. This variation underscores the particular problem of medicalization and generalization. When medicine defined the minority of women who had difficulties (Avis, 1991) as a problem of menopause itself, then they treated all women the same, regardless of how each individual woman experienced menopause.

### **Conclusion**

Doctors and pharmaceutical companies told women that hormone drugs would rid them of the so-called symptoms of menopause and keep them “feminine forever.” When those promises rang hollow as women increasingly contracted uterine cancer, medicine sold the new and improved drugs as a preventive not only for uterine cancer but also for osteoporosis and heart disease. Once again, the bubble of excitement over hormone drugs’ benefits burst when the WHI showed that the drugs increased women’s risk for breast cancer, strokes, blood clots, and heart attacks. All along, the reasons doctors and drug companies promoted hormone drugs were not because of medical ones alone.

Other social factors were at work including the influence of pharmaceutical companies in developing, marketing, and selling drugs; the biomedical approach to health; and science’s sexist treatment of women’s bodies. My research indicates that the consequences of the medicalization of menopause include women who felt pressured from their doctors to take HRT, who compromised their quality of life, risked their long-term health, and felt confused about how to maintain their health when medical advice drastically changed.

While pharmaceutical companies play a key role in medicalization, they are not the sole problem. These companies are operating logically in a for-profit health care system; their goal to sell drugs to earn profits is not surprising. For consumers to make informed decisions, however, policy reform is urgently needed. Most fundamentally, pharmaceutical companies should be barred from educating doctors about drugs and from paying them to promote drugs without acknowledging their financial relationship (Worcester, 2004). At a minimum, the Food and Drug Administration should approve the content of drug advertising to consumers (Worcester, 2004); in my view, such advertising should be banned. In the meantime, as consumers, we need to be aware how the institution of medicine is organized and how it shapes our choices about medication.

Future research could investigate how doctors and women have responded to the WHI findings. Soon after the preliminary WHI results became available, one study found that general internists were more likely to caution women against long-term HRT use than gynecologists (Brett, Carney and McKeowan, 2005). Depending on specialty, medical care practitioners may either diminish or further the medicalization of menopause; future studies could research this possibility. More broadly, medicalization is increasing as a result of new technologies, increasing diagnoses, insurance companies, drug companies' products, and patients as consumers, while medical practitioners have relatively less influence (Conrad, 2007). We need research to investigate how these social factors work together to create new definitions of bodily conditions as medical matters and to document how these new definitions help or harm people's health.

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<sup>1</sup> An overview of the history of the medical system in the United States is beyond the scope of this paper; Paul Starr's book, *The Social Transformation of American Medicine*, (1984), Basic Books: New York, provides an excellent, detailed account of how the U.S. medical system began and evolved over two centuries.