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Menopause Exposed: Women Surveying Women

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At the time of its publication in *The Lancet* in 1933, a report entitled 'An Investigation of the Menopause in One Thousand Women'¹ caused little comment. Retrospectively, however, in the context of the changing ideas of menopause throughout the last century, it deserves re-appraisal not just for its findings but also for its approach. The survey which preceded the 1933 report and the report itself are the subjects of this article. While these demonstrated many of the central definitional issues and paradoxes explored in earlier medical discussions of menopause they challenged the dominant thinking and approaches to the subject. They approached menopause as a natural, rather than a pathological, occurrence. They presented the experience of going through the process of menopause as a subject inherently worthy of academic interest, and crucially allowed women themselves to help shape the definition of menopause. This brought the knowledge of ordinary women into the realm of medical knowledge and in this the study differed from most earlier and indeed much other contemporaneous work on the menopause. It also, whilst working within the dominant bio-medical model, acknowledged the social context in which women's mid-life experiences could be understood.

The article 'An Investigation of the Menopause in One Thousand Women' was the publication of the results of a survey, started five years earlier in 1926, collecting evidence from a large cohort of post-menopausal women. Its stated purpose was to

improve doctors' understanding of the clinical aspects of menopause and to 'further our knowledge with regard to the prevention and treatment of any disabilities that may exist'.² This was the first time such a large scale survey of women's experience of the menopause had been collected and accorded the considerable importance of publication in such a prestigious medical journal; and while this represented a valuable advance, the article is still part of the ongoing medicalisation of menopause, albeit with a different and less strictly clinical focus, which continued throughout the rest of the century and beyond.

Significantly, the report was compiled by an organisation of women doctors, the Medical Women's Federation (MWF), whose history, aims, activities and composition are discussed briefly below.³ The prestige of publication in *The Lancet* would seem to suggest that it was seen as a significant piece of work within the contemporary medical community. However, a consideration of later work on the menopause, including work published soon after in journals like *The Lancet* and the *British Medical Journal (BMJ)*, suggests that its findings and approaches, some of which questioned more traditional ideas of menopause as pathological, were not taken up by others working in the same field. Over the next ten years the report was not mentioned in the key medical journals; the only reference was a citation in an article in 1936.⁴

The report provides us with a remarkable snapshot of contemporary understanding of menopause. It alerts us, in its language and its processes as much as in its findings, to the tenacity of some myths and beliefs lingering from Victorian times as well as shifts in thoughts and behaviour. Similarly, continuities between attitudes in the 1930s and today, as well as evidence of some changes, are evident in the report. As a survey by women

about women, it continues to have a singular significance, different to previous work done on menopause, not only because it represented, to some extent, an early prototype of feminist research, but also because it sought to challenge the idea that women were disabled by menopause.

A number of studies looking at the development of modern attitudes to menopause identify the 1960s and the commercial development of HRT as the period in which menopause became an issue of mainstream medical attention.⁵ While that era certainly saw wider public awareness of menopause as a medically defined syndrome, other writers have suggested that the modern medicalisation of menopause occurred much earlier than this, in the first two decades of the twentieth century when endocrinology developed as a medical specialisation.⁶ However, there is evidence that the increased medical interest in menopause in these decades was in fact part of a longer process: while endocrinology may have changed the physiological explanation for the cessation of the menses, the broader idea of menopause as a subject of medical discussion and intervention was well established by this time. Research into menopause in turn-of-the-century medical journals suggests menopause was already being medicalised, part of a growing interest in women's health, 'the woman question' and the growth of gynaecology.⁷

By the 1920s and 1930s discussions of menopause retained some traditional ideas of what menopause was and its implication for midlife women: menopause was conceptualised as a dysfunction of the menstrual cycle, the cessation of menstruation as a cause of potentially serious physical and mental ill health in women, and links were made between women's reproductive and mental states. However, developments within

medicine had begun to change some of the ways in which menopause was approached. Looking at work on menopause published in a number of medical publications, primarily *The Lancet* and the *British Medical Journal*, in the years between 1920 and 1950 it is possible to identify similarities both in the nature of the investigations and in their content.

A number of these articles focus on traditional areas of concern for those looking at menopause: the age at which women experienced menopause, its relation to the age of menarche and the impact of marriage and childbearing to women's experiences of menopause.⁸ Even more common, is the consideration of menopause in terms of the pathology of the female body. Whether the menopause is described as 'natural' or 'artificial', the later being induced either by surgery or radiation, the main focus of these articles is the discussion of the range of pathological conditions facing women at this time. The articles, while mentioning milder symptoms like flushing, focus primarily on more extreme conditions including breast cancer, arthritis, menorrhagia, psychotic and neurotic breakdown, and insanity, all of which are attributed to pathological changes taking place at the menopause.⁹ Reflecting the developments in the field of endocrinology there are some discussions of the role of hormones, or 'internal secretions', in women's experience of menopause and of their potential role in treating associated symptoms.¹⁰ Other writers consider more traditional approaches to the treatment including gynaecological surgery, still referred to by some as 'castration',¹¹ whilst others discuss the efficacy and use of the application of X-rays and radium in various forms to places inside and on women's bodies¹².

Until the publication of the MWF report in 1933, the clinical understanding of menopause had been compiled by doctors from the presenting symptoms of their patients, women, or their families, disturbed enough by these symptoms to turn to their doctor. There is little consideration given to the idea that some women may suffer no ill health at menopause or acknowledgement that the cases chosen may be unusual. The choice of ‘subjects’ and the focus and content of the articles alongside a failure to discuss any type of ‘normal’ menopause, all reinforce the idea of menopause as a pathological condition.¹³ Moreover, the samples used in these clinical investigations were small, usually between ten and thirty. The MWF report gave the medical profession access to the menopausal experiences of large numbers of women, predominantly women who were not from clinical settings, i.e. not patients. Furthermore, these many different experiences were collected and interpreted by women.

It is helpful to locate the survey within this historical continuum, since the report seeks to develop new knowledge, and to embrace a different methodology and rationale while it continues to work with older ideas about the nature of menopause and its effects on women. It carries the traces of conventional beliefs about menopause seen in other contemporary studies, for example, its concerns with the relationship between the age of menarche and of menopause, as well as prefiguring future ones, relating to how far menopause should be seen as an incapacitating condition that could effect women’s working lives. The purpose and composition of the MWF, to the extent to which it can be seen as both radical and conventional, gives its work on menopause a particular resonance in the continuum of knowledge.

Women had been entering the modern medical profession officially since the last decades of the nineteenth century when medical schools gradually began to allow women to study. However, by the first decades of the twentieth century, despite some progress particularly during World War One, women still faced huge challenges in entering and progressing within the medical profession.¹⁴ The MWF grew from the perceived need of a number of women doctors for a national body to promote and protect the interests of women doctors in a profession which continued to be organised and dominated by men.¹⁵ It was formally established in 1917, registering as a limited company and publishing its articles of association. In its first published newsletter its stated rationale was ‘to safeguard and promote the professional interests of medical women’ and ‘to enable them to speak as a body and so to extend a greater influence on public policy, in regard to those matters, such as health administration, in which they are directly concerned.’¹⁶ Acknowledging their minority status within the profession and their marginalisation in its power structures, the Federation helped medical women to increase their power and voice through collective action. In addition, it supported work in areas of medicine and socio-medical issues which were of particular concern to them, such as venereal disease, prostitution, maternal welfare, sex education, menstruation and menopause. Its concern with such issues, and the desire to influence public policy linked it to the principles and activities of the contemporary women’s movement, as well as reflecting the limited access women had to the more prestigious areas of hospital medicine.¹⁷

In 1926 the Western and South Wales Association, one of the local organisations which formed part of the MWF, suggested forming a sub-committee on menopause. This sub-committee, according to its letter-head, comprised nine women: two Misses, five

Doctors, one Professor and one Lady, with the letters M.D. after her name.¹⁸ The terms of reference for the committee's work were, as outlined in the MWF newsletter for 1926, firstly 'to investigate the incidence and nature of the symptoms definitely attributable to the menopause and to consider the question of prophylaxis and the treatment of such symptoms', and secondly 'to make a report with the objective of correcting any prevalent misconceptions about the inability suffered by women during the menopause resulting in the loss of employment.'¹⁹

These aims, thoroughly compatible with the principles of the MWF, reflected both clinical and socio-economic areas of concern. They also highlighted the hybrid meaning of menopause itself. The first aim focused on the clinical aspects of menopause, constructing it through the presentation of signs and symptoms and the subsequent treatment or prevention of these physiological occurrences. The second objective treated menopause as a socio-cultural phenomenon, going beyond the purely clinical to include other discursive constructions and potentially discriminatory practices.²⁰

Explaining their project in a letter to participating 'medical women', the Menopause Sub-Committee of the MWF outlined their purpose as 'to ascertain facts with regard to the incidence of symptoms definitely attributable to the Menopause, and to further our knowledge with regard to the prevention and treatment of any disabilities that may exist.'²¹ They wanted primarily to get data from what they called 'women in normal health...in whom the menopause occurred five, or more, years ago.'²² The women who were the subjects of the MWF survey were selected, as far as possible, by other routes than that they had sought medical help for conditions likely to be associated with the climacteric or menopause. This indicated an attempt to gain a wider knowledge of

women's experience of menopause, rather than a narrow view based on those cases in which women experienced ill health at mid life severe enough to present to a doctor.

The survey sought to discover how widespread certain symptoms were among their informants, and how far certain select social and biological factors impacted on the incidence and severity of these symptoms. Data relating to 'symptoms directly attributable to the menopause', were collected, and studied against the marital status, number of pregnancies and previous health of the informants, and their self-recollected menstrual histories. Interestingly though data was collected on the social class of the women informants and its relationship to menopausal symptoms showing that the compilers recognised a potentially significant variable, this data was not followed up or commented on in the report.²³

The MWF was faced with the challenge of finding a good variety of informants and reliable information. One of their approaches was to send a letter to women doctors, with a request for the findings of any special study of menopause they themselves might have done and two different questionnaires. The first of these forms, Form A, was for the women doctors to distribute to 'any friends and relatives whom you could trust to fill it in correctly'²⁴ which of course, in the light of the class make-up of doctors, would stack the deck towards middle class informants. Form B was for doctors to complete, to provide 'details which can be supplied by medical practitioners only.'²⁵ Sensing the problem both of skewing the survey by class and by the medical context of knowledge, these details should be 'in reference to as many women as possible, in all sorts and conditions of life, *not necessarily from your patients.*' [original emphasis]

The rest of the informants – and they ultimately numbered 1,220, ranging between twenty nine and ninety one years of age - are referred to in the body of the report as ‘of various social status’, with different work backgrounds²⁶. These included women ‘leading an ordinary home life, women engaged in or retired from the various professions, intellectual and manual occupations and domestic work’. They were drawn from women residing in urban, industrial and rural areas of England and Scotland.²⁷ Two particular places for finding informants are referred to: ‘public assistance institutions’ and ‘business houses’, both places in which groups of women could be easily accessed based on criteria other than health. While the report explained the choice of public assistance institutions it said little about their choice of what the report terms ‘business houses’ or how they gained access to these institutions.

The report noted that knowing which women to approach in some settings was challenging. The survey explained that one of the difficulties in collecting data for the investigation from other than patients, had been the uncertainty of heads of departments in business houses as to which of the women employed should be questioned, since in so many over fifty years of age, ‘no signs of having passed ‘the change of life’ had been detected. The survey also noted a related difficulty in identifying women of all classes who may be experiencing menopause. Going against commonly held ideas that menopause was clearly identifiable in women’s appearance or demeanour, they explained how many women ‘in daily contact with others, had revealed no menopausal disturbance, such as irritability of temper, commonly thought to be inseparable from this phase of a woman’s life.’²⁸ However, while the compliers acknowledge that irritability of temper was commonly assumed by many to be a telling index of the menopausal state, they did

not include it as a symptom on the checklist they presented to the informants. This absence is not explained, leaving us to wonder whether their experience suggested it was not a significant symptom, or if there were other reasons for its omission. If this was generally perceived to be a particularly common symptom of menopause it could have been a useful exercise to test it out on the informants.

There were many problems with the methodology of the survey, and thus the soundness of its findings, some of which the compilers recognised themselves. Explicit in the report is their own concern about the reliability of data from sources other than doctors' patients. Apart from implicit class prejudice alluded to earlier, there is the question of memory. They admit that for many of the women, the vast majority over fifty five, a large amount of time had elapsed between the phenomena they were commenting on and the moment of the survey. This, they felt, undermined the accuracy of their data – an inference that was probably correct. Certain details, like the date of their first period and the early experiences of menstruation, were clearly remembered by women of all ages, while other details, significantly their age when periods ceased, were not: "Several were unable to state their exact age at the last period, even if only five years previously."²⁹ This is not perhaps surprising in that if women do not know which period is their last until several months – even years – have elapsed, the date will not be fixed in their minds in the same way. Indeed, the report remarks that the high incidence of women claiming fifty as the age of their menopause was probably due to a tendency to use 'round figures' or perhaps a perception that fifty was the 'right' age for menopause. The report also mentioned the difficulties they experienced in women self-reporting on their previous health – a question that was asked in order to try to relate previous health to the

type of menopausal symptoms women experienced. They noted that ‘in many cases the histories were indefinite and the value of the statements regarding past illnesses difficult to assess.’ Thus in their analysis of the material they classified the results in terms, that they themselves admitted were crude, of good, fair and bad.³⁰

There are also from our modern perspective some problems associated with the terms used by the survey. Firstly, there is constant slippage around the term menopause itself - then, as today. Although the survey identifies a range of bio-medical symptoms associated with the loss of fertility, there is no clear demarcation between some of these symptoms and ones associated merely with ageing, for example, rheumatic pain which can affect both sexes. Menopause takes place, after all, at a period of life, middle-age, when other signs of ageing appear, such as deterioration of eyesight and hearing and flexibility of joints, and no keys are given to distinguishing those ‘symptoms definitely attributable to the Menopause’.

Secondly, and connected with this, is the problematic term ‘normal’. It is used in the survey in respect both of menstruation and menopause to indicate the opposite of dysmenorrhea and severe symptoms. However, the figures relating to such ‘normal’ experiences of these two physiological phases show them not to be normal at all. In every case – for married and single women, for menstruation and menopause – the “normal” response rate is lower than the “severe” figure, sometimes considerably so, which undermines the normal/severe dichotomy and challenges the normativity of the normal.

Another methodological issue is the relationship between the use of the closed choice questionnaire, which of course limits the range of possibilities in potential answers, and the more open-formatted questionnaire. In Form A women were asked

about their experiences in an open-ended way and relatively non clinical way, ‘Had you any trouble which in your opinion was due to the Change of life? If so what was its nature?’³¹ This allowed them an opportunity to express their experiences in their own terms. Form B, for the medical women themselves to fill in, in contrast offered a list of symptoms for them to confirm, which would limit and to some degree prescribe the conditions reported, asking them to confirm or deny a range of symptoms which can be assumed to have been derived primarily from previous ideas about what happened to women at menopause.³²

The results of the survey were organised under the following headings;

1. The proportion of women free from menopausal symptoms;
2. The frequency of [named] symptoms;
3. Incapacity due to the menopause;³³
4. Age of onset and cessation of the menses;
5. The effect on the prevalence of symptoms and age at the menopause of:

Age of onset of the catamenia³⁴

Miscarriage and childbearing

Menstrual history

Previous health;³⁵

6. Comparison of points above in married and unmarried women.

These headings reflect long-held concerns about women at menopause, in terms of age of menarche and its relationship to menopause, impact of menstrual history and a concern with the impact of marital status on all the results ascertained. This final category is less an individual category and more a variable applied to all the findings listed in numbers

one to five. The concern with marital status reflects perhaps an attempt to connect menopausal symptoms with sexual activity, assuming that marriage implies regular sexual activity with one other person. Concomitant with that the term *unmarried* assumes – often erroneously no doubt – sexual inexperience and absence of pregnancies. In the report’s findings, pregnancy and childbirth are discussed within the ‘married’ category and the notable areas of difference between the figures for the married and unmarried are interpreted as pointing to factors connected with bringing up and running a family rather than as simple biology and sexual history. Thus *married* stands for motherhood too.

The first three categories described above seek to identify the incidence and severity of ill health experienced by women at menopause and, very significantly in light of common and earlier medical assumptions, a possible lack of ill-health. The interesting finding here is that the menopause *was not* perceived or remembered as the severe ‘disturbance of health’ that most folk knowledge and earlier medical knowledge assumed it to be. Close to sixteen per cent of the informants reported themselves ‘free from all menopausal symptoms,’ a figure which rose to just over twenty per cent when flushing was the only symptom. Moreover, nearly ninety per cent of the women ‘carried on their usual occupation without any interruption.’³⁶ Indeed, the report notes: ‘In view of the general impression acquired from the literature on the subject, it was somewhat surprising to find that 900 out of 1000 unselected women stated that they had carried on their daily routine without a single interruption due to menopausal symptoms.’³⁷ This opinion reinforced the accounts mentioned earlier of women within ‘business houses’ who struggled to identify women they felt were facing the menopause, once again

questioning the idea that menopause was very evident on the body and in the demeanour of the middle aged woman.³⁸

Here, again, we are faced with a terminological question: how far did the informants see the menopause itself as a contributory factor to their sense of general health during the crucial years, and how far can menopause be dissociated from other aspects of ageing, and the social, domestic and personal issues associated with the mid-life years? Clearly, the contemporary opinions provided by the 'literature on the subject' were based on ideas of the *disabling* effects of the menopause, part of the dysfunctional model that dominated earlier medical studies.

The variables between the data for married and unmarried are interesting, not so much for the biological differences, but for the possible psycho-sociological readings we can make of the responses. For example, in terms of symptoms altogether, the single women seemed considerably less affected than married women; but in terms of incapacity for work the figures were much the same.³⁹ Married women, a large proportion of whom may well not have taken a paid job, had no choice, presumably, than to carry on regardless with their domestic responsibilities in the home. Regarding individual symptoms, both married and unmarried cohorts were most affected by *flushing*, then by *headaches* and *giddiness*. But after this, married women were almost twice as likely to be bothered by *obesity* than single women were; single women, with no husband and children observing them, and bodies un-stretched by childbearing, were more disturbed by *nervous instability*, their mental and emotional state, than by their fattening figures, but only slightly more than their married counterparts.

Although some differences were found between the overall figures for married and unmarried women, the significance of these differences was, on the whole, minimal. This raises the question of why the comparison was written into the structure of the survey, what findings were expected and what they hoped to be able to claim as a result of the findings. The conclusion of the report made scant mention of differences between married and single women, and no reference to it as being an important distinction in this context.

Other findings related to what were traditional areas of interest regarding menopause and the health of mid life women, the age at which women experienced menopause and factors that might affect this, primarily the relationship between the age of the onset and cessation of menstruation. Consideration was also given to the impact of childbirth on age of menopause. The report concluded that ‘there was little or no correlation between the age of onset of menstruation and the age of last period,’ and that childbearing had no impact on age of menopause.⁴⁰ There were also a range of factors relating to women’s experience of ill health at the menopause. Here the findings considered age at final period, number of miscarriages, number of pregnancies and previous health. Previous ill health ‘was a factor of no marked importance in influencing the onset or severity of menopausal symptoms.’ There was no significant relationship found between the number of miscarriages on menopausal symptoms, and childbirth only became a significant factor for those women who had ten or more pregnancies.⁴¹

Finally the report considered was another common area of interest, the relationship between menstrual and menopausal symptoms. The question was posed “Is a woman who suffered from dysmenorrhoea more likely to suffer from symptoms during

the menopause than a woman in whom menstruation was normal?” The conclusion drawn is that “there was some evidence that normal menstruation tended to be followed by a normal menopause and a history of dysmenorrhoea by more marked menopausal symptoms.”⁴² Here, as in other areas of the survey, the use of the term “normal” remains relatively undefined and therefore problematic. If normal means most frequently occurring, according to this survey ‘normal’ menopause means women suffer some discomfort to varying degrees but that this discomfort still allows ninety per cent of them to continue their daily lives.

The Medical Women’s Federation report stands in a strategic historical position with regard to the development of menopausal discourse in medicine. It was written as endocrinology was offering new ways of looking at and interpreting menopause and the ill health some women experience at this time. It was written at a time in which ideas about women’s social, economic and political position in British society were changing. Ideas about women’s reproductive biology, health and ill health were, as always, significant factors in the ways in which women were able to negotiate and position themselves with the wider social, economic and political context. For example, the idea of menopause as potentially disabling for women clearly has implications for issues related to mid-life women’s competence and suitability in the public and professional sphere.

The social meanings of menopause are complex and dependent on a range of bio-medical, social and cultural factors. The way in which menopause is discussed and written about, the symptoms and behaviours included in its scope, the connotations of the term, and the consequent treatment, social and medical, of those women involved are all

part of its 'meaning'. As Jacqueline Zita argues 'Language is used to negotiate and interpret women's subjective menopausal experience;' here it is the existence of the survey itself that sets the agenda for describing and potentially 'treating' the experiences.

⁴³ It is not language alone, but the soliciting, validating and publishing of the women's experiences that allows new interpretation and negotiation to be conducted.

Herein lies the significance of the Medical Women's Federation survey; the subject of the report was women, and women's knowledge about themselves and their bodies. Traditionally the construction of knowledge of menopause had been the work of male physicians exploring the pathologies of the female body. Here, though, was a report, offering statistics designed to find out more about women's experience of mid-life to help in the treatment of menopausal conditions, based on information gathered by women doctors from healthy women. This new approach offered by the survey in seeking the views and experiences of women who were not under medical treatment at this time allows the medical profession to see that significant numbers of women experienced no or few symptoms at menopause. It clearly demonstrates, in a way that challenged the dominant contemporary ideas, that most women were not so severely incapacitated by menopause that it prevented them doing their daily activities. The report is also significant in the way in which it allowed the women involved to become more active participants in the research process rather than the objects of male clinical observation and investigation. While the survey leaves some areas frustratingly vague and underdeveloped, particularly those relating to social class, it does try to see beyond the purely clinical focus of menopause by looking at environmental, social and economic issues relating to women's mid life experience.

This survey allowed medical professionals access to the experiences of large numbers of mid-life women, significantly more than in other contemporaneous or earlier studies. It was considered important enough to be published in a journal as eminent as *The Lancet*, yet the report and its findings are not mentioned by contemporaneous and subsequent articles. Articles published in *The Lancet* and the *BMJ* over the next decade and a half make only one brief reference to the findings of the survey⁴⁴. Many of the articles continue to focus on more traditional and narrowly clinical aspects of menopause, ignoring the more social and environmental approach the MWF survey sought to include within its brief.

We interpret the neglect of the findings of this survey, and of the survey itself in later medical research, as likely to be related to the relatively marginal status of women in the medical profession and within medical research. Their research may be deemed less important than male research. Indeed this feeds into the ways in which menopausal and post menopausal women were marginalised within the medical professional and society at large at a time when there was more interest in the health of women of childbearing age than in the health of women whose childbearing years were over.

¹ Medical Women's Federation, 'An Investigation of Menopause in One Thousand Women', *The Lancet*, 221, 5707, (14/01/1933), 106-108.

² Contemporary Medical Archives Centre (hereafter CMAC) SA/MWF/B.4/6/1 Box 18: Menopause Subcommittee of the Medical Women's Federation, letter 1, April 1927 and Questionnaire Forms A & B.

³ For more on the Medical Women's Federation see Lesley Hall, '80 Years of the Medical Women's Federation', *Medical Women*, 16, 2, (Summer 1997), 6-9, and Kaarin

Michaelson, 'Union is Strength: The Medical Politics of Professionalism, 1917-1930', in *Women and Work Culture: Britain c.1850-1950*, ed. Krista Cowman & Louise. A. Jackson (Aldershot, Ashgate, 2005), 161-176.

⁴ Editorial, *Clinical Excerpts: A Medical Journal Devoted to Therapeutics*, 10, 189, (1936), 189-191.

⁵ These include the works of Judith Posner, 'It's All in Your Head: Feminist and Medical Models of Menopause, Strange Bedfellows', *Sex Roles* 5, 2, (1979), 179-190, K. I. Macpherson, 'Menopause as Disease: The Social Construction of a Metaphor', *Advances in Nursing Science*, 3, 2, (1981), 95-113, Linda Mittness, 'Historical Changes in Public Information about Menopause', *Urban Anthropology*, 12, 2, (1983), 161-179.

⁶ These include the works of S. E. Bell, 'The Medicalisation of Menopause', in *The Meanings of Menopause, Historical, Medical and Clinical Perspectives*, ed. Ruth Formanek, (Hillside, New Jersey, Analytic Press, 1990), 43-62, Margaret Lock, *Encounters With Aging: Mythologies of Menopause in Japan and North America*, (Berkeley, University of California Press, 1993).

⁷ J.W. Barbre, 'Menoboomers and Moral Guardians: An Exploration of the Cultural Construction of Menopause', in *The Politics of Women's Bodies, Sexuality, Appearance and behaviour*, ed. R. Weitz, (Oxford, Oxford University Press, 1998), 25-45, M Lock, *Encounters with Aging: Mythologies of Menopause in Japan and North America*, (Berkeley, University of California Press, 1993), Marie-Clare Balaam, 'Representations of Menopausal Women in turn of the Century British Medical Journals', *Women's History Network Notebook*, 7, 1, (Winter, 2000), & unpublished research. Louise Foxcroft's recent book *Hot Flushes and Cold Science: A History of Modern Menopause*,

(London, Granta, 2009), provides a wider over view of medical views of menopause and menopausal women since the eighteenth century.

⁸ 'The Menopause Age in Finland', *The Lancet*, 199, 5153, (3/6/1922), 1110.

⁹ E. K. Dawson, 'The Menopausal Age and the Mammary Carcinoma', *The Lancet*, 219, 5676, (June 1932), 1251-3, 'Menopausal Arthralgia', *The Lancet*, 232, 6026, (25/2/1939), 462, T. F. Todd, 'Radiotherapy of Menopausal Menorrhagia', *The Lancet*, 232, 6006, (October 1938), 821-823, 'Oestradiol Benzoate Therapy in Depressions', *The Lancet*, 229, 5919, (6/2/1937), 320-322, D.N. Parfitt, 'Hysterectomy in Menopausal Insanity', *The Lancet*, 222, 5736, (5/8/1933), 292-293.

¹⁰ Guthrie Rankin, 'The Climacteric of Life', *BMJ*, 1, (18/01/1919), 55-58, 'The Control of Surgical Menopause', *The Lancet*, 198, 5120, (15/10/1921), 815, 'Oestradiol Benzoate Therapy in Depressions', *The Lancet*, 229, 5919, (6/2/1937), 320-322, 'Menopausal Arthralgia', *The Lancet*, 232, 6026, (25/2/1939), 462, B. C. Murless, 'The Effect of Follicular Hormone on Menopausal Flushes', *The Lancet*, 233, 6039, (27/05/1939), 1205-1206.

¹¹ G. Fitzgibbon, 'The Menopause and its Complications', *BMJ*, 1, (21/05/1932), 924-928, D. N. Parfitt, 'Hysterectomy in Menopausal Insanity', *The Lancet*, 221, 5711, (05/8/1935), 316.

¹² 'The Treatment of Menopausal Menorrhagia', *The Lancet*, 232, 6006, (08/10/1938), 821-823, Malcolm Donaldson, 'Cervical Cancer after Artificial Menopause by Radium', *BMJ*, (07/1934), 2, 38-39, M. L. Kreitmayer, 'After effects of Intrauterine Radium for the Production of Artificial Menopause: Report of an Investigation', *BMJ*, 2, (11/1930), 815-

816, also Frederick Parkes Weber, 'Re: Amenorrhoea and Climateric Disorders,'

CMAC/PP/FPW8/4: The Menstrual Cycle and its Disorders.

¹³ Whilst this is the dominant position one author does in fact highlight the tendency for his contemporaries to see menopause as pathological. G Fitzgibbon, 'Menopause and its complications', *BMJ*, (21/05/1932), 924-928.

¹⁴ The fight women faced to enter the medical profession has been well documented in a number of studies including Cynthia Blake, *The Charge of the Parasols: Women's Entry into the Medical Profession*, (London, Women's Press, 1990), Anne Digby, *The Evolution of British General Practice, 1850-1948*, (Oxford, Oxford University Press, 1999), Carol Dyhouse, 'Women Students and the London Medical Schools, 1914 -39: The Anatomy of a Masculine Culture', *Gender and History*, 10, 1, (April 1998), 110-132, Carol Dyhouse, 'Driving Ambitions: Women in Pursuit of a Medical Education, 1890-1939', *Women's History Review*, 2, 3 (1998) 321-343.

¹⁵ Lesley Hall, '80 Years of the Medical Women's Federation', *Medical Women*, 16, 2, (Summer 1997), 6-9.

¹⁶ CMAC/SA/MWF B 4/6: Medical Women's Federation Newsletter.

¹⁷ See Anne Digby, *The Evolution of British General Practice*, and Carol Dyhouse, 'Women Students and the British Medical Schools'.

¹⁸ It is presumed here that the 'misses' mentioned were qualified medical women specialising in surgery, who according to convention were known as Miss rather than Dr.

¹⁹ CMAC/ SA/MWFB4/6,1: Report to the Council on the Menopause Investigation, p.5.

²⁰ This second objective is particularly interesting because it raises questions about the ideological position of the research. Its interpretation is ambiguous. On the one hand it

could have emanated from a discussion of absenteeism among menopausal working women; on the other, it could have been a response to women's claims that employers unjustly perceived women of this age as a liability. Either way, it is clear that there was a veiled economic question behind the survey, which makes it all the more interesting that the class-variables in the data, available in the initial survey, were omitted from the published report.

²¹ CMAC/ SA/MWF/J.23/1: Letter to medical women from the Menopause Sub-Committee of the Medical Women's Federation.

²² *Ibid.*

²³ CMAC/ SA/MWF B 4/6: Table II.

²⁴ CMAC/ SA/MEF/J23/1.

²⁵ CMAC/ SA/MWF/J.23/1: Letter to Medical Women from the Menopause Sub-Committee of the Medical Women's Federation.

²⁶ The age range of the women involved is interesting starting as it does at 29, well below the usual age for menopausal symptoms. The survey does not comment on this issue but it may be that these women either experienced early natural menopause or were experiencing 'artificial' menopause brought about by surgical intervention.

²⁷ CMAC/ SA/MWFB4/6,1: Report to the Council on the Menopause Investigation.

²⁸ *ibid.* p. 3.

²⁹ *ibid.* p. 3.

³⁰ *ibid.* p. 6.

³¹ CMAC/SA/MWF/J.23/1: Form A.

³² Symptoms reported were; flushing, haemorrhage (excessive uterine loss at least once), giddiness, headache, nervous instability, pain in the breasts, Rheumatic pains (including Arthritis and Fibrosis), changes in the thyroid gland and obesity.

³³ Incapacity here means being 'obliged to lie up or absent themselves from work' on one or more occasions because of 'some disturbance of health attributed to the menopause'.

CMAC/ SA/MWFB 4/6: Report to the Council on the Menopause investigation p.3.

³⁴ Catamenia = menstruation.

³⁵ In number 5, the relationship between menstrual and menopausal symptoms is sought. The informants' symptoms were graded according to normal and severe. Who did this grading and the criteria under which severity is assessed are not discussed in the survey.

³⁶ The figure is 89.7 %. CMAC/ SA/MWFB 4/6: Report to the council on the Menopause Investigation p.3.

³⁷ *ibid.* p. 1.

³⁸ *ibid.* p. 3.

³⁹ Those who had conceived were relatively more likely to report having symptoms than those who had not; but the number of their conceptions did not seem to have a bearing on the scale of the symptoms, until a significant rise is noted in women who had had 10 or more pregnancies.

⁴⁰ CMAC/ SA/MWFB 4/6: Report to the Council on the Menopause Investigation p.7.

⁴¹ It would seem likely that women who had over 10 pregnancies (and some women in the survey had 17 pregnancies), may have already been at higher risk from a range of ill health than those women with significantly fewer pregnancies. The survey makes no comment on these figures.

⁴² CMAC/ SA/MWFB 4/6: Report to the Council on the Menopause Investigation p.7.

⁴³ Jacquelyn Zita, 'Heresy in the Female Body: The Rhetorics of Menopause', in Joan C. Callahan, *Menopause: A Midlife Passage*, (Bloomington, Indiana University Press,1993), 59-78.

⁴⁴ See footnote 4.