Making Menopause:

An Ethnography Inside and Outside of the Clinic

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I, Lauren Redfern, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

ABSTRACT

In recent years, the UK has seen an unprecedented rise in public interest and awareness surrounding the topic of menopause. Occupying a fraught and often contradictory landscape, discussions of menopause have moved beyond the clinical context and increasingly can be seen to have become embedded in political, educational, and economic domains as well. As the boundaries of what constitutes menopause care become increasingly blurred, important questions are raised regarding the meaning of menopause in contemporary culture.

This ethnographic study describes the navigation of menopausal treatment and care in a private UK based menopause clinic and beyond, exploring how the category of menopause is constructed through temporally and culturally specific practices. Accounts of the daily routines of health care professionals interacting with patients highlight the complex cultural issues that arise, particularly in relation to the use of Hormone Replacement Therapy (HRT), including the use of testosterone. Research moves beyond the clinic in order to focus on what happens when conventional medical narratives about menopause and hormones stop 'making sense', while descriptions of the role of mainstream media and influence of social network platforms spotlights the role key individuals have in shaping contemporary menopausal discourse.

Overall, this original research foregrounds the ways in which long-standing gendered ideologies influence both patient and professional perceptions and expectations of menopausal care and treatment, questioning the extent to which the current drive to put menopause centre stage truly is a force for change.

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time to pursuits that serve others. She has extended unwavering support throughout the PhD process and held me together during innumerable crises of confidence. She celebrates my successes and shortcomings as if they are one and the same, and reminds me, when I am most critical of myself, of all the reasons why it’s important to extend kindness not only to others but also to ourselves.

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PREFACE

The Redfern's have always been bookmakers. My father, my father's father, my father's father's father. Generations of men passing down the wisdom for selecting the right horse.

My grandfather, Frank, was known for dogs as opposed to horses. Frank knew before a dog had even walked the first lap of the track whether it was going to take the race. He died before I was born, but I remember asking my father as I looked at the black-and-white photograph of him standing next to a regal grey hound, cigarette dangling from one lip, how he knew this – how he knew what made that dog special? My father thought for a moment before answering – "it's a quality". When pushed a little further he elaborated, "it's not just *one* thing, it's not even that the dog is superior, it's just… a quality".

Unfortunately, my grandfather's ability to spot that 'quality' seemingly skipped a generation. Addicted to gambling and appeasing his animal-loving daughter, my father left the tracks on my 7th birthday with a dog named Cassie and a mounting sum of debt that would hang around until, like his father before him, tobacco claimed him in his mid-50s.

When I made the decision undertake an ethnography focussing on perimenopause and menopause a quick decision needed to be made – the clinician I intended to 'follow' throughout the course of this research. Whether luckily or unluckily, I did not however pick just any doctor, I picked *the* doctor. When I started this PhD, Claire Mansfield[1] had a small landing-page website, and consulted privately two days a week. She was in the process of thinking about opening her own menopause clinic to better serve an increasing population of women she felt were failing to have their needs met by their GPs.

Fast forward to present day, Dr Claire Mansfield has successfully: built out her clinical practice from a few part-time GPs to over a hundred; developed an

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[1] Throughout this thesis, pseudonyms have been employed when referring to *anyone* that actively participated in the research. The name of the clinic and the associated company name have also been changed. The decision to adopt pseudonyms was employed as a protective mechanism to ensure the anonymity of those that were involved in this research.

online menopause library with countless downloadable resources; created and launched a successful menopause tracking application that has garnered over a million downloads; secured herself a regular role as a menopause expert on a popular daytime television programme; written and published four mainstream books exploring the best means of navigating perimenopause and menopause; produced and sustained a top ranking menopause and wellbeing podcast; founded and launched her own menopause society (a decision that was made as a result of feeling that the British Menopause Society (BMS) did not adequately address the needs of its members nor the British public); opened a number of other clinics nationwide; and accrued nearly half a million followers on social media platforms.

It's perhaps also worth mentioning that Claire accomplished all of this, whilst the world was in the grip of a global pandemic. Seemingly, Claire Mansfield has not only made a name for herself in the UK as something connected to menopause. She arguably has *become* menopause in the UK today.

It would seem that Frank Redfern's ability to spot a frontrunner didn't skip a second generation. Whether intentionally or not, just like my grandfather, I sensed that special something and arguably, jumped to the jackpot. However, I'll leave it to you decide – as a medical anthropologist, where anonymity is everything and keeping a low profile proves key, did I bet on the right horse?

TERMINOLOGY

For the purpose of this thesis, I have adopted use of the descriptors ‘men’ and ‘women’ and ‘male’ and ‘female’ as opposed to more gender neutral and inclusive terminology such as ‘person experiencing menopausal symptoms’. The rationale for this decision is two-fold. Firstly, it adopts the language that the persons participating in this research used to self-identify during observations, namely – ‘men’ and ‘women’. Secondly, it provides greater linguistic ease to discuss conditions that are typically gendered and largely associated with cisgendered persons (cis meaning to identify as the sex one was assigned at birth).

It is important to highlight however, that the use of this terminology is not adopted without clear consideration as to the ways in which it sustains gendered paradigms. I fully acknowledge that gender identity is not by definition, a precursor to a medical state such as menopause. Indeed, those that identify as men or non-binary, may still go through perimenopause and menopause as they may identity as a gender incongruous to the sex they were assigned at birth.
With this in mind, it is important to proceed with a reading that accounts for the level of inflexibility within scientific terminology and medical discourse and in doing so appreciate a plurality of experience when it comes to gender and sexed identity. To do so, accounts for the complexities facing individuals that identify as a gender that defers from the sex they were assigned at birth when having to navigate medical environments that are profoundly gendered. As this thesis will illustrate, normative gendered ideologies remain deeply embedded within the scientific *and* social landscape, not only communicating patriarchal oppression, but troubling inflexibility and inaccessibility for those that identify beyond a cisgendered state.

For further information regarding the power of language and its ability to shape our perceptions of other people, reference to the PFLAG’s glossary of terms is helpful to review (PFLAG 2021).

In tandem, I have utilised the terms ‘clinician’ ‘patient’ and at times, ‘participants’ as descriptors within this thesis. I have done so as it is thought to align with the circumstances of the interactions depicted. In the context of ethnographic vignettes presented in the clinic for example, I wished to foreground the ‘roles’ that were adopted as opposed to identifiers such as gender. I appreciate however that in doing so, a certain level of ‘hierarchy’ becomes embedded within this discourse and a separation of status may feel more pronounced.

It is important to stress that in every way, ‘actors’ were considered equal within this research. Efforts were made to reduce any sense of ‘status’ by focussing analysis on the *interaction* as a collective endeavour (both between myself as a researcher and those I spoke with, and between the clinicians and patients observed).

Finally, the terms perimenopause and menopause are used throughout this thesis to refer to the temporal state in which a person’s periods change and eventually stop as a result of changing hormone levels. Perimenopause is understood as the time leading up to menopause, when symptoms such as irregular periods, anxiety, vasomotor symptoms and brain fog may be occur. Menopause is understood as the 12-month period in which periods stop. After these 12 months a person is thought to have gone through menopause. In defining perimenopause and menopause in this way it is appreciated that it may appear a biomedical understanding of this state is being proffered. However, these categories will be explored and problematised throughout this thesis.

INTRODUCTION

A Captive Animal

"When people talk about menopausal bodies, they are often cruel. There are the base names: dried-up cunt, old hag. Some doctors peddling hormonal solutions have called us castrates, neuters, roadkill. Websites list off endless symptoms phrased in the meanest way possible: sagging skin, atrophied vagina, senile ovaries. The lists are both intimate and cold, like a scientist's field notes on an aging, captive animal." (Steinke 2019)

In her profoundly candid autobiographical account of menopause, Darcey Steinke vulnerably lays bare the contradiction embedded in discussions of menopause. Menopause is both intensely personal yet navigated under specific forms of scrutiny. Regardless of whether this scrutiny is that of a doctor, society, or even self-scrutiny, the menopausal woman is often positioned and repositioned in line with a changing social discourse. She is laid bare for the world to see and asked to become a point of discussion for those that 'view' her. She is both hyper visible and – equally – invisible. She is, as Steinke puts it, a captive animal.

Sociological exploration of the body, its practices and its associations have demonstrated the varying ways in which patriarchal power (both directly and indirectly) affects women's embodied experiences. (Bordo 1993; Kukla 2005, 2006; Orbach 2010). Women are often positioned as experiencing their identity in a more embodied way. Critically, this 'being in the body' is linked to the subordination of women's status. Feminine bodies leak: they transgress appropriate boundaries. They are unruly, untrustworthy, and in need of consistent intervention. They are, simply put, 'too much' (Martin 1987; Bartky 1988; Bordo 1993; Carson 1995; Kukla 2005; Orbach 2010). Feminist scholars have considered how women's 'closeness' to the body is inextricably linked to their continued intellectual subordination. In thinking of the Cartesian mind/body dualism, we are able to better understand how such a dichotomy has led to the continued marginalisation of women's status throughout history (Lloyd 2002; Prokhovnik 2012; Scheman 2014; Cleghorn 2021). Crucially, the body has been produced and reproduced as something that needs to be controlled, regulated, and understood. Historically, this ‘role of regulator’ has been assigned fairly exclusively to men, and whilst embodied experiences are not gender specific, discursive body accounts tend to disassociate men from the body in ‘problematic’ terms (Scott & Morgan 1993), resulting in contexts where men observe, document, and attend to women’s bodies as opposed to becoming subjects of their own bodily work. Where men do feature in embodied capacities, it is most often in a context of improvement – they are bettering the self and contributing to an existing patriarchal model in which men in their natural embodied state are ‘enhanced’ as opposed to corrected.

This context – the one in which men are improved and women are fixed – is a central premise within this thesis. The distinction is not always straightforward to explicate, but it is pervasive, and has arguably endured throughout the history of menopausal care. Menopause has, in both subtle and explicit ways, been positioned by a variety of actors as a bodily state in need of intervention; it requires fixing. However, the power dynamics within the context of contemporary care provision are arguably changing. We are, as this thesis examines, entering an epoch in which women are reclaiming agency in decision-making surrounding their bodies, and their decision to pursue hormonal treatments should not be overlooked, nor underemphasised. What remains in question, however, is the complex patriarchal underscoring that may accompany narratives surrounding the menopausal body. Thus, whilst women may have been made passive in the context of medicine and of menopause throughout history, this thesis shall examine the current circumstance and highlight it as potentially now being in a period of flux. Though the history of ‘limitation’ that women have experienced as a result of ‘being embodied’ is not to be marginalised, we must address the ways in which women are reimagining menopause as a period of time that may prove empowering, celebrating the fact that they may no longer feel agentless in their own skin.

In recent years, there has been a pronounced rise in public interest regarding menopause. Coining this the *menopause turn*, Deborah Jermyn (2023) highlights how menopause exists beyond the remit of the clinical. The menopause turn, the author notes, has been “in operation throughout multiple and intertwined cultural spaces, across education, politics, employment, medicine, retail, publishing, journalism, and more” (Jermyn 2023: 2). When this PhD began in 2018, the sociocultural interest in menopause was arguably just awakening. The findings presented in this thesis span the period of time in which conversations concerning menopause were growing, and movements were forming. Not only were women discussing menopausal care as a right, requests for it to be attended to in other capacities were taking centre stage. Menopause was petitioned in parliament to be included as part of the National Curriculum, employers were tasked with making reasonable adjustments to workplaces to support menopausal women, and – astonishingly – a bill addressing the cost of NHS prescription charges for Hormone Replacement Therapy (HRT) was actioned. After the legislation was passed, women in the UK were able to apply for an HRT Pre-Payment Certificate (PPC) that would cover the cost of their HRT for a year, at a charge of £19.30 (NHS 2023). This collective consciousness that made 'menopause matter' (Danzebrink 2018) led to increased coverage in the national press (both in print media and on national television). A major documentary was filmed by television network Channel 4 (2021). It was hosted by the celebrity Davina McCall and offered information as well as a personal glimpse into her lived experience of menopause. In tandem, other celebrities were exploring their menopause moment. Products, podcasts, and popular fiction have all populated public health discourse. Menopause can increasingly be found guilty of making messy the parameters of what separates the clinical and the cultural. In the blink of an eye – or perhaps more appropriately, the switch of an HRT patch – menopause has arguably shifted from the parameters of shameful to stimulating.

Fundamentally however, this turn (and arguably this thesis) reflects a particular vision of menopause: menopause as an experience that most impacts white, middle-class women most. The advocacy and change-making that has occurred, therefore, must be understood as existing within a prism of privilege. Menopause has been moved into the mainstream (whether intentionally or not) by a subgroup of persons that reflect the lives of a specific type of woman. Accounts of menopause that account for intersectionality have largely remained absent in the mainstream.

This thesis is underscored and written from a position that considers how, in a postfeminist context, betterment of 'self' can often be conflated with betterment of body. The body becomes a site inscribed with value, and additional pressures are placed on menopausal women to conform to particular health narratives (Berger 1999; Coney 1994; Gill 2007; Foxcroft 2010; Greer 2018; McMahon

2023). An expectation to monitor and 'treat' the body appears but is also conflated with concepts of moral and social value. Risk is positioned within narratives as politically pertinent, with the choices women make about treating their menopause extended beyond the remit of the self to wider society. To treat or not to treat, that is the question.

The increased awareness surrounding menopause has also brought with it an increased scrutiny surrounding the mismanagement of symptoms by NHS based GPs. This narrative in which GPs are failing patients has led to a pronounced polarisation between private and public healthcare in regard to menopause, with women (as is reflected in this research) citing their rational to seek care privately to have stemmed from necessity as opposed to desire. Joyce C. Harper et al.'s (2022) survey of the experiences of perimenopausal women highlighted how one of the major concerns women had in seeking support pertained to concerns that their GP had little knowledge of the subject matter. They describe how women "would repeatedly come away from their GP feeling increasingly abandoned, unsupported, and would be left reeling with confusion, as though they were going mad" (Harper et al. 2022: 8). The widening gap that is established, in which women are unable (or feel unable) to access the appropriate care they require from their GP, has led to increased divisions in conversations about menopause – conversations in which hierarchies within the clinical community have become more pronounced. This 'widening' and criticism of expertise will be explored throughout the thesis. However, it is essential to outline as a significant concern, as although work has been undertaken by the 'menopause movement' to enact change and ensure that all women are able to access support, the consistent nature of the testimonies of the women/persons feature in this report' beyond highlight that women are still left feeling underserved by public services. The option to pursue private consultations is ultimately not an option for many women – they do not possess the capital (educational, cultural, financial, or otherwise) (Bourdieu 1973), and thus, menopause remains a contentious space in which the quality of care that a person receives depends on their privilege.

Building a Body

Before outlining how and in what context menopause has been explored in this ethnographic endeavour, further explanation surrounding the conceptual positioning of the body and menopause is required, as it features as a preoccupation throughout. A large proportion of this thesis (as has already been implied) will engage with and consider how our perceptions of menopause and the menopausal body may be understood as mediated through the language of our society (Oudshoorn 1994; Martin 1994). Biological discourse is appreciated in this research as shaped by perceptions, interpretations and understandings of the body that are "not objectively given, but collectively created" (Oudshoorn 1994: 4). The assumed 'natural body' therefore is understood as not truly existing but as created by investigators as a product of research and shared perception (Duden 1993). The metaphors used to describe a bodily practice, function, or phenomenon (such as menopause) will be considered as exceptionally powerful. They are presented as determining the ways in which we think about the menopausal body and its function. Critically, this determination is understood as implicating how we develop the accompanying rhetoric that shapes social attitudes toward the menopausal body – whether these attitudes are discursively positive or negative.

Appreciating the discursive technologies at play within the biomedical allows us to question the state of the body as 'natural'. It allows us to understand how scientific research constructs, reconstructs, reflects, and develops established understandings of the body in concurrence with the sociological imagination (C Wright Mills 1959). The researchers cited thus far have tended to use the distinctions drawn between male and female bodies to illustrate the impact that employed descriptors can have on our understandings (Butler 1993; Nicholson 1994; Alcoff 2006; Longino 2018, 2020,). Though sexual binaries are a relatively contemporary concept (one sex vs two gender model (Laqueur 1990, Harrison & Hood-Williams 2002), the body has always appeared as something with a sex. Sex and sex assignment has been identified as an "unequivocal, ahistorical attribute of the body that once unveiled by science is valid everywhere and within every context" (Oudshoorn 1994: 16).

Fundamentally, by the end of the nineteenth century, the biomedical community can be seen to have extended sexualisation to all parts of the body – bones, blood vessels, veins hair and brain. There was a shift from similarities to differences, and the female and male body were increasingly conceptualised in terms of opposites, incommensurably distinct in their organs' functions and feelings (Laqueur 1990: 7). Thus, and as a consequence, the desire to localise the essence of femininity in the body has been a product of this intrigue with the binary. Feminist scholars' detail the highly misogynistic language accompanying thoughts on the female in pursuit of determining the essence of gender: "Remove the ovary and we shall have before us a masculine woman, an ugly half form…all that we admire and respect in women…is merely dependent on her ovaries" (Mederi 1983: 215).

The biomedical distinctions drawn between men and women in the Global North in recent centuries have served to mould nature to fit with emerging ideas in which bodies reflect our gendered assumptions – masculinity and femininity. Academics have demonstrated that stressing the importance of sex differences has intensified gender disparities and often resulted in elevating male bodies to be viewed as superior; once again, men are improved, but women are fixed. Using Emily Martin's work as an example, we may consider how many 'natural' processes in biological literature contain socio-normative gendered narratives. In *The Woman in the Body*, she describes how medical language depicts women's bodies in ways that promote socially constructed assumptions about women and their life's purpose (to conceive, to bear children, to nurture etc.).

Acknowledging the influence of the socio-cultural on medical rhetoric allows us to undertake an analysis that considers how the presentation of different bodily phenomena in a clinical context (including discussions of hormones) contains specific gendered messaging (Ortner 1972, Oakly 1991). The literature review in this thesis will spend time considering the history of the synthesisation of sex hormones, and how, by the later part of the 20th century, these hormones were increasingly called upon as a means to communicate gendered ideals – they were depicted as chemical messengers of femininity and masculinity. As a collective term however, it's important to highlight how the term 'hormone' or 'hormonal' is predominantly called upon in relation to women and women's bodily experiences.

Biomedical descriptors position women as prescribed to their hormones as opposed to the other way around. A hormonal model has been adopted when talking about women's bodies and behaviours with a myriad of media narratives utilising the term 'hormonal' as a shorthand descriptor for behaviour that is emotional, or perhaps more appropriately termed ‘erratic’. These actions are related to femininity and to ‘being a woman’, whilst ‘being a man’ is routinely positioned in relation to testosterone levels. Common phrases such as ‘testosterone-fuelled environments’ are called upon as a way to describe hypermasculine activities and environments in which dominating behaviour occurs. All of this features as part of our colloquial repartee. Hormones are anthropomorphised in a distinctly gendered manner, and the collective understanding that hormones are fundamentally associated with behaviour strengthens gendered narratives for both men and women (Fine 2010, 2017).

Whilst the implications of these experiences are problematic and have been observed as such in the literature, the insinuations for what this anthropomorphising means for the navigation of hormonal care and treatment has garnered limited attention beyond the context of queer authors exploring the topic in relation to changing ones sexed and gendered identity.

Thus, when women reclaim their hormones in the context of menopause, when they seek to bring about ‘balance’ to an otherwise ‘unpredictable’ hormonal state, new narratives are needed. As opposed to the previously ill-managed ‘natural’ hormonal body – where hormones ebb and flow and move without containment – the new hormonal body is controlled, cared for and contained. Yet in reality, of course, there is no separable version of the hormonal body. There is no body in which hormones move in the correct way – no one version where the body is ‘fixed’. Underscoring all of this research is a simple but pertinent observation – hormones are not static. Hormones remain in motion. Shifting through spaces, places, and communities, hormones flow. Hormonal ‘thinking’ however – and in contrast – remains static. Underwritten by gendered assumptions, understandings about our hormonal makeup, what it means to be a woman and other related conceptual questions and positions, there can arise a view in which particular hormones and thus particular treatments belong to particular bodies and should be prescribed in particular ways. As such, hormones used in the wrong way – given in the wrong amount, or worst of all, put into the wrong body – are and can be symbolically rebellious.

In the context of this research – and perhaps what marks this investigation as unique – is its exploration of and interest in the use of testosterone as a means to support the management of menopausal symptoms. Predominantly positioned as a ‘masculinity maker’ (Hoberman 2006), testosterone is increasingly now called upon by clinicians as a key component of many women’s HRT treatment. The use of testosterone in the context of menopausal treatment not only challenges the archaic rhetoric in which testosterone underscores concepts of masculinity, it complicates gendered models of care and challenges assumptions about what it means to be menopausal. Though ‘divorcing’ hormones from particular bodies is a difficult task, in doing so or in attempting to do so, we may observe the pervasive ways in which the biomedical can form the seat of a gendered identity. Equally, in challenging conceptions of the concrete body, we are able to stress how it may be manipulated via research practices in order to produce specific forms of knowledge dependent not only on the emergence of explicit ideas or ideologies, but on complex procedures, material testing practices and instruments used to collaboratively create data. In short, bodies “have to be manipulated to make them produce knowledge” (Oudshoorn 1994: 12-13).

This process is important in the context of the research undertaken and is a fundamental part of the way that the menopausal body and menopause is thought to be discursively produced. Ideology, technology, and access to research materials work in parallel to inform and constrain forms of discourse emanating from scientific practice about menopause and its functionality (Lowy 1999; Milam & Nye 2015; Irni 2016). In this sense, menopause does not simply ‘exist’; it is collectively created – it is made. As Latour indicates, there is no real “readymade science and technology” (Latour, 1987: 258); rather, there are complex networks of actors who build a paradigm in which certain knowledges come to exist and subsist. The displacement of an understanding that there was only one hormone per sex with the understanding that both men and women contained ‘male’ and ‘female’ sex hormones is argued by Oudshoorn to have led to a conceptual shift resulting in “a drastic break [from] the dualistic cultural notion of masculinity and femininity that had existed for centuries” (Latour 1994: 26). She suggests that this “new model”’ of the hormonal body transformed the “biological definitions of sex”, suggesting that it reveals how “chemically speaking, all organisms are both male and female” (ibid: 39).

The revolutionary ‘impact’ Oudshoorn discusses, however, remains out of sorts with contemporary understandings, and equally with the observations that formed the basis of this research. Whilst her application of theory in considering the manner in which hormones and the hormonal body may be collectively created is astute, her identification of a shifting paradigm is not convincing. Though the knowledge we carry the same hormonal makeup may exist, perceptions of the body still fall in line with bilateral understandings (Lowy 1999; Karkazis 2008; Irni 2017; Milam & Nye 2015; Karkazis & Jordan Young 2018). Oudshoorn herself extends an analysis contingent upon binary thinking. Her continued use of possessive pronouns and identification of hormones themselves as ‘male’ or ‘female’ appears incongruous to a line of analysis that considers the body holistically. Further, her analysis of relative amounts of ‘masculinity’ or ‘femininity’ being transported and measured through the blood continues rather than subverts established paradigms of bodily sex. Drawing attention to this is not to suggest she is ‘wrong’ to do so, but to highlight how conceptions of hormones still exist in line with gendered identities. Thus, rather than a collective consensus of assumed similarity, there is still a theoretical appreciation in which ‘male hormones’ and ‘female hormones’ are distinct and the ‘property’ of their corresponding sex. They appear often not even as objective chemical messengers but as quite the opposite – as a reduced chemical concentration of the sex itself (Karkazis & Jordan Young 2018; Fine 2017).

In this thesis, the ways in which this plays out will be explored in relation to how hormones are packaged and presented in line with gendered ideologies. It will consider how they are ‘made’ suitable for the patient and the ‘sense-making’ that accompanies this. Fundamentally, it considers and cautions against biological reductionism or interpretations of the body that fail to recognise the process as inherently social and cultural. Rather, it appreciates the menopausal body as a site of symbolic interpretation, where personal and social identity coalesce (Hong 2013). Further to this, it draws upon interpretations such as Haraway’s (2013), which argues that personal and social bodies are not natural but part of a self-creating process. In the context of hormones, such an interpretation is extended to elucidate the process by which they may acquire their own agency, one that exists in conversation with the social, that shifts and changes as it moves across a variety of domains (Mol 2002). Fundamentally, given the meanings that are ascribed to bodies, it recognises that the ‘actions’ of hormones can be interpreted as imbued with sociocultural significance.

Throughout this thesis, the menopausal body is understood to exist in conversation with the political, aesthetic and moral dimensions of social life, all of which coalesce within a specific gendered regime. The achievement (or failure to achieve) a menopausal ideal is explored as manifesting in the accumulation of what Bridges (2009) refers to as 'gender capital' by different groups. That is, the cultivation, achievement and embodiment of specific gendered ideals may transform the menopausal body into a bearer of specific gender capital. 'Physical' improvement in particular – and the willingness to treat and be treated – implicates the menopausal body, rendering it a multidimensional project of the self and a subject of patriarchal power; menopause becomes a space where power is both targeted and produced (Wagner 2015: 235).

Many of the observations within this thesis highlight how a message in which specific hormones deliver specific results was communicated in the context of menopausal care. Categorical differences between hormones and between bodies was crystallised, and in many ways an existing model of gender was firmed up. This firming-up of gender roles is revealed to be a highly profitable endeavour for participants in the medical market – one that capitalises on feminine ideals, and through the rhetoric of science, 'fixes' women so that they conform to the gender roles and as such may be deemed to be desirable.

Despite all of this, it equally appreciates that hormonal ordering – in which certain chemicals belong to certain bodies – offers a means by which we are able to make sense of our surroundings (both external and internal). As hormones are neatly placed in pink and blue boxes, the highly complex nature of the endocrine system, formed of multiple collaborative relationships, is able to be forgotten in our consciousness. Hormones are taken in from the periphery, and their fluid nature is made static. We categorise according to inherited sociocultural structures. We manipulate and bend complexity, asking it to comply with structures that 'make sense'. Seeking out these correlations – and many others – is understandable. When we are able to observe and label natural phenomenon in a manner that supports deep-seated cultural assumptions, our understandings of the world are sured up. We are provided with an empirical touchstone – something that feels sound and real. But is it?

Making Menopause

This research began as an ethnographic investigation of the experiences of women navigating perimenopause and menopause under the care of a private clinic in the UK, but conceptually its focus shifted. Though the use of HRT, and in particular, the use of testosterone, women were observed to engage in acts of rebellious body behaviour and construct their own sites of resistance.

Whilst popular culture and clinical literature tends to emphasise the importance of ‘balance’ in relation to HRT treatment, observing the persons involved in this research demanded a reconsideration of this. The behaviour of the participants posed questions about whether a hormone, a hormonal body – and by extension, menopause – can ever truly be situated or ‘studied’ in isolation. Or rather, whether it is through the mixing and the multiple that we see menopause for what it truly is –uniquely complex. The way that the concept of menopause is composed of these different – and unsituated – sub-concepts renders an individual’s menopausal experience distinct and specific.

This work considers how menopause – be that the embodied experience, the treatment for it, the social-media post depicting it, the tabloids covering it or the clinician diagnosing it – is formed of multiple renderings and parts that all coalesce to tell a story, not only about the menopausal body but about relationships – relationships between self, other and society. It reveals menopause to be a temporally specific phenomenon, one that does not ‘evolve’ over time, but one that changes, adapts and responds to the climate in which it is occurring. Menopause made now will not be menopause made tomorrow, or ten years from now. It is unique in its malleability and prescribed in its personality. This thesis is, of course, a story about menopause, but it is most importantly a story about people. It explores the experiences of individuals (both present and past), the stories they tell, and the ways in which those stories are rarely value free.

How are these stories detailed? For over a year, the everyday practices of clinicians, patients, administrative staff and other health care professionals working in a UK-based, private-practice menopause clinic were observed. These observations, along with others from other relevant clinical and non-clinical spaces were compiled and examined. This thesis details the complex and often misrepresented experiences of women navigating perimenopausal and menopausal treatment in the UK, and those considering the consequences of what it means to use HRT to treat menopausal symptoms. The role of the clinicians involved in providing said care (one in particular) is examined, as is the wider sociocultural backdrop against which the menopausal discussion takes place. Pertinent and painful conversations were undertaken, and this thesis is the product of a range of views given by different groups of stakeholders in the process of treating menopause and menopausal symptoms.

How will this be communicated? We begin, as all things do, at the very beginning – or at least, a sort of beginning. Chapter One explores the history surrounding the synthesis of sex hormones, dedicating particular attention to the context and history surrounding the synthesis of testosterone. The decision to provide ample room to discuss testosterone was a *specific* decision, as women's use of this hormone as a means to treat and address their menopause and menopausal symptoms is novel, exciting, and wholly under-explored. It is contended that only in documenting the gendered circumstances in which hormone-hunting (by which I mean the early synthesis of sex hormones undertaken by endocrinologists in the early part of the 20th century) happened, are we able to appreciate that the use of hormones by menopausal women in contemporary culture remains complex interwoven with this historic context. Following the consideration of testosterone, a brief account of the history of menopause and its treatment in the Global North in the 20th and 21st century is provided before attention is afforded to the anthropological canon that this ethnographic research is informed by.

Chapter Two provides insight into the navigation of research and how the ethnographic practice that underpinned accounts presented in this thesis was undertaken. It equally affords space to a consideration of the ways in which this research was impacted by the circumstances of the pandemic in 2020. Highlighting COVID19 to have both propelled conversations about menopause, it also considers the logistical complications that arose, and how these relate to the completion of the initial research intention/focus. It asks us to consider the ways in which the menopausal landscape may exist in both pre and post pandemic terms in the context of this thesis.

Chapter Three presents ethnographic observations that consider the ways in which space and place (specifically in the context of the clinic) inform and impact women's navigation of menopausal care and treatment. It considers how physical space informed and contributed to the ‘making of menopause’. In the context of the clinic, where ethnographic observations were gleaned, the impact of space as ‘non-clinical’ is explored in tandem with women’s accounts of their experiences. The clinic’s spatial ‘makeup’ is highlighted as a contributing factor that helps in facilitating the building of a conception in which women may be positioned as people as opposed to patients. It looks to highlight the role of physical space in giving rise to certain conceptions of and differences in care, and how and how our physical environment can prove pertinent in providing this.

Chapter Four examines how menopause is ‘made’ in the context of the clinic. It pays attention to the ‘rituals and practices of care’, considering how the interactive dynamics that play out between patient and practitioner in the clinic help to shape the ways in which menopause is both understood, and subsequently experienced by those undergoing treatment. Interactions are examined from a feminist position, with particular attention paid to the ways in which patriarchally oppressive narratives of ‘transformation’, ‘return’ and ‘improvement’ are self-subscribed as a rationale for seeking care by patients, and equally discursively affirmed by clinicians within the clinical interactive context. The ways in which menopause may be conceived of uniquely by individuals is considered, in tandem with an appreciation as to the impact that prevailing sociocultural discourse has over women’s want and need to intervene upon their menopausal body.

Chapter Five moves discussion outside of the clinic and presents ethnographic observations from the European Menopause and Andropause Society (EMAS) conference that took place in Berlin in May 2019. This chapter provides a critical consideration of the dynamic interactive relations that exist between clinical actors – namely, pharmaceutical companies and representatives, the products displayed and promoted at the conference, professionals presenting their research and attendees working within the menopausal field. Within Chapter Five, the materiality of hormones is attended to, with discussion drawing inspiration from the field of Science and Technology Studies (STS). Under these parameters, the hormone itself is understood as a central player within the interactive dynamics that unfold in the context of the international conference (Latour 1987, Callon & Latour 1992, Harman 2009).

Chapter Six considers the context of the *menopausal turn* referenced in this introduction in greater detail. Analysis of accounts collected from women outside of the context of the clinic is undertaken, along with a consideration of the role that media (defined in the multiple) adopts in shaping the discourse surrounding menopause. This chapter takes pause to consider how clinical hierarchy is shifting within the context of menopause and highlights the changes in the dissemination of power regarding decision-making. Efforts are made to highlight the increasingly blurred and contentious position of 'expert' within menopausal discourse. In tandem, the clinical aspects of menopause as presented in the media are highlighted as undergoing specific forms of 'translation' that bear relevance to women's subsequent experience of menopause.

We end with Chapter Seven, a discussion of the main analytical strands that persist throughout this thesis. Underpinning critiques is an understanding that, while a reclamation of 'body power' is, in the menopausal context, something to be celebrated, it is also something to be queried. The complex inscription of specific types of experience upon the menopausal body is highlighted as central to understanding how, as a concept, menopause is not determinedly based in biology; rather, there is an inextricable link between the menopausal experience as determined by the cultural context and women's embodied experiences. As Pierre Bourdieu highlights in *Outline of a Theory of Practice* (1977), a walk, a movement or indeed a whole bodily practice can relate to a collective cultural 'script' (Simon and Gagnon 1986), and that is the process by which menopause may be fused to concepts such as femininity and gender in a specific relational manner. The menopausal body is thereby understood and explored in Chapter Seven as inscribed with history, culture and capital (Bourdieu 1986), determining that menopause is, in this sense, so much more than a biological process.

Before beginning, it is important to briefly reemphasise a central position, which is this: menopause and the way we perceive it is temporally specific. It is part of a long history that is, as opposed to being a linear modern march to progress, more of a disjointed discovery that often involves cyclical return. In a recent illuminating conversation with a physician at Yale fertility, she considered how, in the late 1980s and 1990s, she was prescribing HRT in large quantities to patients under the assumption that it was 'good for one's health'. Colloquially, this period of time is often referred to as the ‘menoboom’ (Anderson 2021) and was termed as such because ‘baby boomers’ born in the period following World War II were reaching the age of menopause, and represented a sizeable demographic. Popular culture covered menopause and its impact in extensive detail, and the marketing opportunities expanded accordingly. Then, the Women’s Health Initiative (WHI) was published (2002), and fear struck. However, this had happened previously. In the 1970s, concerns surrounding the dangers of HRT peaked, and progestin was introduced as an accompaniment to estrogen in order to attend to the need to protect women’s endometrial health. I make this point to stress that these conversations about health are not linear. They are not even cyclical; they are free moving. They develop across time and space in line with the political subcultures and cultural discourse at a particular time.

Thus, whilst it’s seductive to believe that we are in a watershed moment for menopause that is unprecedented, this assertion is less accurate than we may assume. Moreover, it is essential that we consider the trajectory of historic rhetoric. We are in a moment of change, but that too will change – it will ebb and flow in parallel with the allocation of funding, the development of medication, women’s position under a patriarchal regime, and so on. This thesis thus may only be understood as a contribution to an incomplete canon of work that remains in progress. It represents a moment in time, an experiential process, and a series of unanswered questions. It asks you to proceed in reading with an appreciation of the temporally ill-defined – a knowledge that menopause, just like the hormones provided to treat the symptoms, will never truly be able to be captured or examined in a static manner. Menopause remains in a constant state of physical, cultural, political and social flux. The convergence of all of these factors, it is argued, is what truly ‘makes menopause’.

CHAPTER 1

Synthesising Gender

Judith Houck (2009) delineates that there are seemingly three major periods in which the history of menopause in the Global North loosely falls into. The first is 1897 – 1932 – a period in which women’s bodies and the bodies of those of marginalised status (e.g., migrant men, men of colour, men in prison etc.) were subject to distressing and violent eugenic intervention in the name of scientific progress. It was also a period in which investigation into synthesising hormones reached its peak and where the crystallisation of gender was increasingly attributed to hormonal function and the actions of said chemicals on the body and our behaviour. 1938 – 1962 marks the second period, and this was underscored by major developments in the production and subsequent use of HRT in the Global North. Women were more routinely encouraged to treat there menopause with medication and conversations in which menopause was an affliction that implicated not only oneself but their surrounding social network permeated advertising and wider social discourse. The final period depicted by Houck is 1962 to 2002 – the year in which the Women’s Health Initiative (WHI) was published and fear exploded. The WHI found causal associations between the use of HRT and a variety of comorbidities including breast cancer, cardiovascular disease, and dementia. Since 2002, a fear culture has persisted and the trajectory of conversations about the use of hormones to treat menopausal symptoms has been slowly recovering and recalibrating; gathering momentum in order to reach where we have today – a momentous moment for menopause in the Global North (Guillén, Gutman & Lopez 2020, Organ & Rottenberg 20023).

The first part of this chapter shall pay mind to the first two major periods of which Houck highlights. This historic consideration is thought beneficial as it enables us to appropriately grasp the context out of which contemporary understandings of menopause stem– in particular the racially and patriarchally charged circumstances from which conversations about hormonal function began. Concentrated efforts to synthesise sex hormones sit within a distinct period of history.

Hormone Hunting

The beginning of the 20th century was characterised by a commitment to the pursuit of knowledge, rationale, and logic. Encroaching themes of modernity and a collective 'march to progress' typified the scholarly imagination (Weber 1905; Habermas 1981; Harvey 1989; Giddens 1991; Baumann 2010). Consequently, Endocrinology, like many other emerging fields of study at this time can be seen as eager to establish itself as a sincere discipline; one invested in promoting the betterment of mankind through the pursuit of scientific, medical, and technological discovery (Cooter 2011; Giddens 1990; Baumann 2013; Habermas 2015).

This process proved challenging for the field of endocrinology. At its inception, not only did it fail to get the recognition it desired within the scientific community, it also (and potentially as a consequence) developed a disturbing underbelly that is important to acknowledge. The darker dimensions of 'hormone hunting' (De Kruiff 1945) and its place within medical advancement are intimately connected to themes of domination, eugenics and 'social hygiene'; a tarnished history that is often excluded from contemporary discourse. Such exclusion is arguably an oversight. As will be explored, considering the history of hormone synthesis helps to shed light on how we have come to learn about and conceptualise our hormonal makeup and indeed menopause today (Conrad 2007, Tone & Watkins 2007). Equally, it speaks to the ways in which access to hormonal treatments has always existed in conversation with concepts of privilege. As opposed to being temporally specific, the question of who gets to obtain hormonal treatment for what and why, has long existed as a point of debate, and one historically reserved for those in an elite position within society. Thus, when considering contemporary concerns regarding homogeneity in representations of menopause and access to treatment and care, we can, in looking back, appreciate where considerations of menopause being a white middle-class issue may stem from (Singh, Kaur & Walia 2002, Kohn et al. 2019, Mills 2022).

In order to examine the sinister interlude in sex hormone research, a consideration of endocrinology's beginnings is essential. To do so, we will first explore the synthesis of testosterone as it articulately reveals the dystopian desires of researchers, and the ethical gambles they were willing to make in order to understand hormonal functions (De Kruiff 1945). Through this analysis, testosterone is revealed to be a ‘masculinity maker’ and therefore is exposed as having high sociocultural and patriarchal value. This understanding allows us to consider the ways in which testosterone’s ‘value’ may still be communicated today via the limited access women find themselves having to the hormone for the treatment of menopausal symptoms. Equally, it reveals why undertaking cultural ‘work’ is necessary to distance testosterone from concepts of masculinity, in order to counter the negative effects of this conception of testosterone on women’s use of and access to the hormone.

Following this, the history of hormonal treatments for menopause will be explored in tandem with the historic ways in which women’s bodies are consistently represented as in need of stabilisation (Chrisler 2014). The analysis will argue that ‘thinking’ about menopause is not a new trend, but rather, a cyclical one. Thematic similarities will be explored with particular attention paid to the ways in which women’s value has been intrinsically tied to youthful exuberance and beauty (Foucault 1977; Wolf 1990; Bordo 1993; Urla & Swedland 1998; Black & Sharma 2001; King 2004; Atwood 2009; Holland 2010; Walter 2010).

It is worth acknowledging that by beginning this analysis with an exploration of testosterone there is a risk of foregrounding men as biologically superior – inadvertently displacing women by leading with discussions centring on men. To counter this, it is stressed that, to date, there have been few examinations exploring the history of testosterone at all. Those that have been undertaken have almost exclusively tied both the history and future use of the hormone to the male body (Fine 2017). Whilst the historic analysis undertaken in this thesis examines cases pertaining to men, it goes beyond this. It suggests that hormones are not the exclusive property of either sex, but rather that they fluidly exist in all bodies as part of a complex endocrine system. Despite this position, it equally identifies how hormones (and testosterone in particular) have been problematically utilised as a means to impress narratives pertaining to gender upon society. Through this analysis, hormones are revealed to have been utilised throughout modern history (The British Academy) as a mechanism to shore up identifiable binaries – a means to affirm biologically determinist understandings of the world that enforce patriarchal oppression.

Endocrinology (and in fact the term 'hormone' itself) is a relative newcomer within the scientific and medical field. In fact, the discipline of endocrinology was only established in the early 1900s, following successful discoveries in the treatment of myxedema and cretinism (Wass 2018). Prior to this, 'escapades' into excavating hormones were not married to a distinct medical field. Though forays into what we may *now* refer to as endocrinology were undertaken, they were not associated with the concept of an endocrine system (in which hormones exist in conversation with one another). Rather, researchers attempted to tie hormonal function to other arenas of medicine – to tie hormones to specific parts of the body under which 'investigation' was already taking place.

The desire for endocrinology to prove itself a legitimate science is important to acknowledge, as its birth occurred against a backdrop of historic scepticism. Though the revolutionary discovery of insulin by Frederick Banting in the 1920s (Tan & Merchant 2017) did much for the discipline (gaining endocrinology not only a Nobel prize but a sought-after 'seat at the scientific table') understandings of what hormones actually *did* were still rudimentary (Bliss 2007; Wass 2015). What's more, explorations into sex hormones held a certain unsavoury 'sexiness' within the medical community. Early explorations in sex 'hormone hunting' were not only understood as distasteful, but seemingly arbitrary (De Kruiff 1945). Sex-gland secretions would not be considered 'proper science' for some time, and explorations looking to isolate sex hormone properties (specifically testosterone) were routinely accompanied with accusations of quackery (Hoberman 2006). Though damning, these claims were not *entirely* unwarranted. In fact, they are infamously tied to the life and work of Charles Edward Brown Sequard, whose efforts must be acknowledged in order to understand the complex path endocrinologists have taken in attempting to discover, understand and synthesise sex hormones.

In 1889 Charles Edward Brown Sequard announced – to the dismay of his esteemed colleagues – an experiment he was undertaking that he claimed provided him with more strength, stamina, mental energy, and renewed concentration (Hoberman & Yesalis 1995; Hoberman 2006, Sequard & Dunbar 2018). Sequard claimed that self-administering injections of the blood of the testicular veins, semen and 'juice' extracted from the testicle (crushed immediately after it had been taken) from a dog or a guinea pig, were the key to a renewed vitality. Caught in a media frenzy, the public flocked to obtain the benefits of his miraculous discovery. Even the respected Sigmund Freud and poet William Butler Yeats expressed interest, with Yeats claiming that his sexual appetite and literary abilities (previously) in decline were miraculously renewed after receiving these injections (Aminoff 2011). Sequard's discovery promised to deliver a cultural phenomenon we are still preoccupied with today: an 'elixir of life'. Although some argued that Sequard's magical concoction truly did work and was the 'break-through of the century' (Depasse 2016), it was soon debunked, and the narrative quickly turned sour. With a lack of appropriate evidence, the scientific community saw this experiment as a demarcated example of pseudoscience – a sad old man looking to reclaim his youth.

Though 'ousted' by the scientific community, the theory laid out by Sequard has been described as a 'call to arms' (Wass 2015) that signalled an intense interest in the testicles and other related organs whose extracts were increasingly considered useful for medical purposes. The phenomenon termed 'organotherapy' included the injection of various glandular secretions into people for curative purposes and continues in a variety of contexts to this day (Borell, 1976, 1985, Nieschlag & Nieschlag 2023).

Although it is well established that Sequard's watery extracts did not have the effects that he claimed for them, interest in gland extracts has had tangible consequences for endocrinology. Shaking the shame associated with early explorations into sex hormone synthesis would prove tricky, and, though we may consider the disdain of the scientific community to be little more than playful fun poked at an 'aged' academic (De Kruiff 1945), the consequences of Sequard's 'research' were implicated in the study of hormones for decades. De Kruiff goes as far as to claim that "the scientific world broke into a roar of derisive laughter that subsided into sneering snickers that echo down to the present day" (ibid: 56).

The purpose of mentioning Sequard's work (other than to provide the humorous image of an aged Parisian injecting himself with Guinea-pig-testicle matter) is to demonstrate the struggle for scientific legitimacy that endocrinology faced as a consequence of academic derision. It contextually frames our understandings of sex hormone research and allows us to appreciate the competitive edge that can be born out of ridicule – an important factor for us to appreciate upon examining the means researchers took in order to obtain measurable 'results'.

The investigation of hormones synthesis at the turn of the twentieth century sought to distance itself from any hint of charlatanism. The discovery of pioneering treatments for diabetes assisted in advancing credibility. The isolation of insulin is ultimately recognised as an irrefutable medical breakthrough. Regardless of this, however, attempts to place sex-hormone research in the same category of medicine was confusing to many. It raised uncertainty regarding what endocrinology actually *was.* For those at the forefront of innovation however, proximity between seemingly *unconnected* parts of the body was not understood as problematic. In fact, such a way of conceptualising the body as connected, intertwined and relational, promised something new and exciting – a provocative shift in medical thinking:

> "*It was plain that the science of life and death was now passing out of the hands of doctors resigned at the bedsides of the dying, that the other new science was bubbling in the flasks and stills of the organic chemists. These were a new breed of men, thinking, talking and working in a new human language, highly esoteric and expressed in the hieroglyphics of structural organic chemistry*" (ibid 1945: 36)

For others, endocrinology remained a distasteful modern alchemy (ibid) unproven, unquantified, and unashamedly modern. Sex-hormone research, as a consequence of this scepticism, was required to work slowly and diligently to earn respectability. A job that was not for the faint of heart, given the associations and engagement with testicles that continued to accompany forays into research.

In 1927 two thinkers embarked on a mission to synthesise what we now refer to as testosterone. After a windfall in which Fred Koch and trusted student Lemuel McGee gained access to a hefty supply of bull's testicles, the researchers went about trying to distil from the testicles a chemical formula. Out of what we can roughly estimate totalled a ton of bull's testicles, Koch and Mcgee were able to isolate 20mg of, to use DeKruiff's words, "manhood… trapped in a test tube" (De Kruiff 1945: 70). Whilst Koch and McGee remained convinced that the answers to the essence of 'maleness' were to be obtained from the testicle, the feat of procuring mammoth amounts of animal gonads with which to conduct experiments was simply impractical. Though they had arguably demonstrated that an 'essence' was extractable, men's obsession with their balls sadly foiled them once again. It was further research in Amsterdam and Germany (using both testicles and urine) that finally provided researchers with an isolated and pure form of testosterone from which Dutch researchers quickly determined the precise structural arrangement of the hormone. It was named testosterone. Observing the impracticality and fixation on the testicles, Leopold Ruzicka found an alternative solution. Using cholesterol, Ruzicka managed to synthesise testosterone, and provided a practical and procurable source from which to obtain the hormone[2] (Kenner 1977).

The efforts undertaken to synthesise testosterone are important to observe. Researchers were locked in a 'battle of the sex hormones' that mirrored the structure of the Cold War. Just as the Soviet Union and the USA took on the task of sending a man into space, so too did our endocrine ancestors embark on an attempt to synthesise the substance we know today as testosterone. Whilst one would like to assume that Neil Armstrong's mission had far less to do with testicles, there is simply not sufficient evidence to attest to this.

Yet the question remains: why was there interest in synthesising testosterone in the first place? Unlike its rather successful sibling insulin, testosterone had yet to 'prove itself' with the same grandiose sentiment. Though rudimentary studies had been conducted in order to demonstrate *why* synthesising the hormone was important, there had yet to be a definitive eureka moment – in other words (and to put it rather crudely), testosterone had yet to find its diabetes. Early studies appear to have adopted a sort of cause-and-effect approach, safe in the understanding that as testosterone is produced in the testes[3] and thus connected to men, it must be something important. Although researchers did not exactly adopt a 'let's throw it at the wall and see what sticks approach', the little evidence that had been collated meant that, in many ways, the possibilities for ball-related research projects were limitless. This may consequently help to

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[2] The compound of testosterone, as it was called, (or more accurately a whole family of this compound's derivatives) was discovered throughout the 1950s and 1960s, so this synthesis from cholesterol was not the final chapter of testosterone's story.

[3] As we now know, women naturally produce testosterone, so it cannot be produced exclusively in the testicles.

explain some of the more bizarre research undertaken. If there was any concern that there would be a departure from elongated tangents about testicles, fear not, there is more to explore when it comes to the exasperating fascination men have with their balls.

Gland Larceny

Though endocrinology had managed to demonstrate the value in developing medical technology that could work to manage chronic conditions (as in the case of diabetes), there was simply little evidence to suggest that testosterone could or would be as useful. Though the synthesis of the hormone was in and of itself a scientific achievement, testosterone had not, in initial research, presented itself as beneficial to treating any one condition in particular. Regardless of this however, researchers remained steadfast in their intent to attain similar accolades for testosterone as those that had been won by insulin.

The lack of limits to research questions and ideas that were trying to demonstrate the usefulness of testosterone meant there were turbulent times ahead for testicular enthusiasts. Research interest for the most part appeared rooted in investigators' understandings of what they thought testosterone *ought* to do. This is important to note, as although researchers may have been motivated by a myriad of different interests, it was fairly unique at this time to be involved in studies that were not presented as curative. Whilst explorative research may be celebrated contemporarily, in the climate in which early hormone synthetisation occurred, there was a ubiquitous belief within the medical community that one's work should be dedicated to the 'eradication' of an ailment or affliction. In the case of research into the usefulness of testosterone, researchers had ideas, but investigations were speculative – a curious and explorative endeavour as opposed to an attempt to cure.

In this sense, early explorations into the effects of sex hormones were progressive. They offered few answers but raised a great number of questions. As researchers had no definitive evidence of a causal relationship between the administration of testosterone and an improvement in any one particular medical malady, investigators were able to assume a hypothesis and test it. This is highly relevant in relation to the trend that can be observed in behavioural sciences today. Many of the studies that have correlated levels of testosterone to behaviours such as aggression are rooted in the concept of 'pre-theory' (Lloyd 1993, van Anders 2013). This is the idea that a researcher has a preconceived notion or belief that is implied in the research they undertake – in the context of testosterone research, this would be connecting levels of the hormones to particular behaviours, such as a predisposition for aggression. The structure of pre-theory has been highlighted as being shaped by biased assumptions and are often patriarchal in nature. Extending this concept, the assumptions that these scientists chose to investigate are thus a product of biased beliefs about what maleness is. The pre-theory 'chosen' echoes patriarchal concerns and beliefs.

During the period in which the 'usefulness' of testosterone as a treatment was being explored, we can begin to see two distinct arenas of 'interest' emerging in explorative research. The first is the cry for a forgotten youth. Whilst researchers may have initially been keen to distance themselves from the work of Sequard, echoes of his hypothesis rang through the testaments of his contemporaries. There was without a doubt a draw to the concept of vitality, youth, and vigour. Increasing, interest in the idea of 'potent maleness' and the promise of a return to a lost exuberant adolescence piqued the interest of researchers and acted as a call to arms. This actionable interest in understanding how to 'reclaim' marks an important shift in the pursuit of medical advancement. It denotes a refocusing – away from treatment and toward enhancement. The second and correlated arena of interest that appeared alongside and intertwined with narratives of restoration, were concentrated efforts to 'correct'. Under and through the development of these arenas of interest, the 'character' of hormones can be seen to take shape. Researchers envisioned that in the case of testosterone, it could be magical – restorative *and* corrective.

Within the field of hormone research there was an observable focus on distinguishing between desirable and 'worthy' persons vs non-desirable and 'unworthy' persons. In this sense, the creation of a treatment that could help to restore vitality and vigour was understood as an endeavour that would eventually benefit society, but only those of a particular social class or standing. Research operated under a hierarchical risk ratio principal – administer tests and experiments upon undesirable subjects in order to obtain results that would benefit desirable persons. Thus, sex hormone research is, upon exploration, firmly positioned within the social hygiene eugenics movement of this time.

Ethan Blue (2009) explores the fixation with curing various crises of manhood by documenting the work of Leo Stanley, the chief surgeon at San Quentin's state penitentiary between 1913 and 1951. Prisoners under Stanley's care were subject to a variety of eugenic treatments which included sterilisation and the implantation of testicular matter from both executed prisoners and animals. Convinced that the research would not only provide insight into how to control and curb criminality, but Stanley's methods also promised the limitation of reproduction among the 'undesirable' social classes and the rejuvenation of the aged male population.

For Stanley, the eugenic practices offered potential solutions to better understand criminal behaviour. He developed an endocrine theory of crime in an attempt to explore potential correlations between crime control, medicine, and social hygiene. Rather than the conceiving of the whole person being accountable for behaviours, however, Stanley looked to isolate malfunctioning organs, believing that through the power of medicine, morally defective prisoners could be transformed into better men who could add value to society. In performing procedures on criminals, Stanley was able to harness and refine potential treatments that could benefit the wider population of men, believing "he would help a new, ideal man emerge – physically and sexually vigorous, as well as morally upright" (ibid: 212).

As a Eugenicist, Stanley campaigned for the effective use of sterilisation among certain parts of the population. The combination of working-class movements, women's suffrage, immigration, and urbanization were a perfect storm in fostering anxieties about not only male power, but an increased feminisation of men. The crises of masculinity was not only threatening the elite, but the middle and working classes too. In response, discourses on masculinity in which manhood became inextricably linked to themes of physical power and prowess, vigour and strength emerged, with popular culture eroticising muscularity as a mechanism to create distance from the effeminate and further stress a binary distinction between men and women (Mumford 2002). In the case of Stanley's experiments, the moral Victorian manhood remained imperative for managing criminality (Blue 2009).

Sterilisation was, for Stanley, a form of moral preservation; he mused that it would save “much subsequent expenditure and human suffering” (Stanley 1940: 157), declaring that many of his prisoners simply “should never have been born”, feeling that their degenerate behaviour was being passed on and that this was, therefore, a situation in need of intervention. His arguments were framed in such a manner that women were positioned as in need of protection and that, as such, men were the culprits for passing on delinquent behaviours (Blue 2009). “Sterilisation [said Stanley], when given a chance, will do much to stamp out crime” (Stanley 1940: 157).

The interesting departure in Stanley’s approach, however, came in his shift from Lombrosian medical criminology (Blue 2009) – in which particular parts of the body (brows, skulls etc.) could be associated with deviant behaviour (Lombroso & Ferroro 1895; Lombrosoet et al. 2004; Gibson 2002; Horn 2003). Viewing the visibility of physical markers to be too crude an approach for identifying criminal ‘types’, he turned his gaze inward, feeling that the answer may lie in the internal glands and blood of the person. Though Stanley was broadly interested in the endocrine system, he was particularly known for being “fascinated by the testicle” (ibid: 224), feeling that secretions from these glands in particular might hold the key to curbing criminal behaviour, and thus offered solutions for criminal reform. The most notable of Stanley’s experiments included “engrafting human testicles from recently executed prisoners to senile recipients” (Stanley 1921: 710). He also – when executed prisoners were unable to provide sufficient material – used testicles from a variety of animals, including boars, goats, deer and rams (ibid).

The investigative interest in endocrinology that Stanley pioneered is telling. Not only do these experiments represent the darker side to modernity, but they also show crystallised perceptions of manhood that are visible in contemporary narratives on masculinity. Virility, youth, strength, vigour and violence all feature as critical components of contemporary understandings of maleness and are equally tightly woven through the narratives of Stanley’s explorations and experiments. There remained potential in virile prisoners, whilst clear reproduction of their ‘sort’ was considered most unsavoury. Stanley’s work offered hope and the possibility of rejuvenation to a ‘threatened’ manhood via the implantation of testicular substances. Stanley claimed that “Some of those receiving this treatment claim that their eyesight is improved, the appetite is increased, that there is a feeling of buoyancy, a joy of living, an increased energy, loss of tired feeling, increased mental activity, and many other beneficial effects" (ibid: 713).

Thieves Rob Chicagoans Of Glands; Believe Rich Man Seeks Rejuvenation

DEMAND FOR YOUTHFUL GLANDS CAUSES THUGS TO DRUG, MUTILATE 2

Expert Surgeon, Seeking to Return Vitality to Clients, Operates After Kidnaping, Theory

SURGEON STEALS A VITAL GLAND

Chicago Medical Profession Aroused Over Frightful Crime

VICTIM SHANGHAIED

Virulent Young Veteran Is Mutilated by Expert Surgeon

RICH SUSPECT IN THEFT OF GLAND

GLAND VICTIM

CHICAGOAN KIDNAPPED AND GLAND REMOVED BY SKILLFUL SURGERY

REVENGE IS SUSPECTED IN GLAND OPERATION

WAVE OF GLAND PIRACY IS NOW FACING CHICAGO

This Is Fear of Officials as They Try to Solve Case of Kidnaped War Veteran, Victim of Operation.

POLICE HUNT FOR SECOND VICTIM

Doctors Disagree on Whether Work Was Done by Surgeon or Lunatic, But Agree 'Twas Skillful Job.

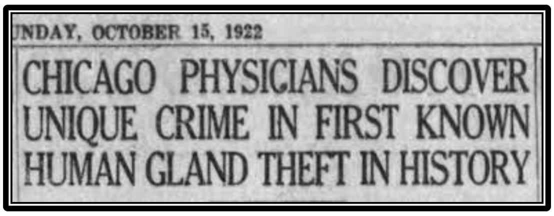
POLICE NET TIGHTENING ON AGED MILLIONAIRE ACCUSED IN CHICAGO GLAND THEFT

Figure 1: Image from "Gland Larceny: Testicle theft a real problem in 1922 Chicago." (Brumfield 2020)

One of the most consistent effects Stanley noted was sexual feeling and increased sexual activity (Blue 2009). Many undergoing the experiments claimed their virility was restored and that for the first time in years, their erections returned, and they were able to achieve orgasm (ibid). These were of course important claims, as virile heterosexuality was fast becoming an important part of masculinity. By 1940 Stanley had conducted over 10,000 implantations and had stopped thinking of the procedure as experimental; instead, he increasingly referred to his work as 'treatment' (ibid).

Whilst it was professed that a number of these procedures were 'voluntary', the outbreak of the Second World War brought with it demands of bodily sacrifice, and for these men, a loss of national and masculine identity that likely motivated any 'voluntary' status. Nevertheless, Blue (2009) notes that there may well have been an "allure in receiving… an extra shot of masculinity". He correlates this to the supposedly 'raw' form of testosterone they would be receiving.

There are other interesting cases in the early part of the 1900's that demonstrate the 'value' associated with testicular matter. In his comically titled article 'Gland Larceny' (2020), Brumfield details a number of incidents in which men in Chicago suffered at the hands of 'gland larceny': testicle theft. In the 1920s, Joseph Wozniak reported to the police that whilst at a bar drinking, a bag was thrown over his head and four men wrestled him into a car before chloroforming him. He woke up to discover he was without his testicles. Wozniak reports: “when I came to, my mind was befuddled… I did not know I had been operated on. I thought I had a hangover. I had the taste of ether or chloroform in my mouth. I felt intense pain.” (ibid) It is thought that Wozniak is one of the first known victims of illegal organ harvesting in the United States, however the reporting of the incident later revealed other victims in the area.



NDAY, OCTOBER 15, 1922

CHICAGO PHYSICIANS DISCOVER UNIQUE CRIME IN FIRST KNOWN HUMAN GLAND THEFT IN HISTORY

Figure 2: Image from "Gland Larceny: When Testicle Thefts Took Chicago by Storm" (Dontinga 2020)

Testicles were, it would seem, in short supply. The local mortuary could only donate so many (Dotinga 2020), yet researchers required them to continue their explorations into the potential life-affirming effects that testicle extracts or secretions may have upon the body. One such researcher was a urologist named Frank Lydston, who was known for sewing a cadaver’s testicle into his own scrotum. Lydston was based in Chicago, so it’s not a huge leap to assume him to be the prime suspect in this case of testicle theft, in conjunction with the fact that Lydston described his surgery as quickly producing “a marked exhilaration and buoyancy of spirits”. Ultimately, however, he was not as buoyant as he had initially hoped, noting that his surgery did little to ease his chronic constipation – and was forced to remove his transplanted testicle because, and to use his own description, it “went bad.”

Lydston’s experiments were not well received by the medical community at large, mainly due to his interest in eugenics and particularly his experiments involving the castration of African American men. Contemporarily, we may also reflect on Lydston’s problematic positioning of homosexuality; he proffered the belief that transplanted testicles could cure the ‘affliction’.

Kate Lister examines the phenomenon of testicle theft in her book *A Curious History of Sex* (2020), considering the historical relevance of the removal of testicles and its cross-cultural significance. Lister discusses how removing a man's testicles has, throughout history, been connected to a loss of virility, strength, and masculinity. Thus, Lister positions the practice of testicle removal as occurring predominantly as a form of punishment, or as a supposed cure for various ailments (such as epilepsy or mental health issues). Lister examines historical accounts in which the concept of testicle theft has been used as a mechanism to demonise and persecute particular groups or individuals, highlighting how this is particularly the case during periods of moral panic. Lister examines the emergence of 'testicle thieves' as a trope in folklore and equally reveals its 'threat' to persist in popular culture. In particular, Lister examines how the intensifying of concerns surrounding testicles (or the lack thereof) may reflect deep-seated fears and anxieties pertaining to an emasculation or a reduction in men's sexual power at a particular point in history – a concern highly relevant in the context of the period following the first world war.

Whilst the pursuit of knowledge does not excuse the ethically appalling practices that endocrinologists have undertaken in order to understand testosterone's function, understanding the concurrent desire for total social progress that typified scientific endeavour at this time is significant. For many, it appeared to act as a moral caveat for questionable practices - actions were tied to the pursuit of moral progress and knowledge, which meant, as such, that these actions were positioned as acceptable. Themes of modernity related to military power are embedded within the discourse. The idea of testosterone as a weapon is embedded within the research – something that could be abused when in the wrong hands. Equally, conversations around eugenics that occurred within this period positioned hormones as 'potent', and therefore a dangerous force if handled incorrectly.

Considerations of unethical practice occurring in the USA at this time are useful to consider as they refute the myth that the want for 'social progress' at the cost of particular subgroups of society was not a phenomenon that gripped the states in the same ways it did other contexts (namely Nazi Germany). Eugenic practices were undertaken without hesitation. In De Kruiff's *The Male Hormone* (1945) he describes a particularly disturbing incident in which an outrageous experiment on a young African American boy occurs. In the hope that testosterone would cause the shrinking of tumours, de Kruiff details how a researcher he observed injected the hormone into the prepubescent boy, who, as a result, entered puberty quickly and intensely. The researcher quickly realised testosterone had no effect on shrinking the tumours but was so intrigued by its other effects that he continued the trial, causing concerning consequences for the young boy. In the structure of the episode that De Kruiff describes, we are able to see the development of a narrative in which testosterone becomes linked to masculinity and extractable – something that can be taken out of the wrong type of person and given to the right type of person: a person with a social conscience that will use its power for good.

Whether it was the want of endocrinology at inception, research reiterated understandings in which functions of the body may be connected to different parts of the anatomy – a perception that persists today. We still *think* about the body in divided terms – the brain is one part; the womb is another and so on. Increasingly, this concept is being challenged. We may think of the fact that the microbiome produces a large proportion of our serotonin in our gut, with the gut now often colloquially referred to as our second brain (Gershon 1999, Young 2012, Powley 2021). We know that neurodivergent conditions such as ADHD are actually impacted by hormonal instability and complex neurochemistry that fluctuates cyclically in each individual (Mosley Druce & Turner-Cobb 2020, Groenman et al. 2021). Despite this, however, undoing the belief that we can fix the body, distil its products, grasp them in our hands and inject them back in – in order to deliver stable and knowable results – persists.

Yet, during a time in history in which a sense of a loss of power persisted, the reclamation of youth and vigour and a restored manhood was ultimately desirable, particularly if it were able to be obtained via ‘man’s’ own body. Whilst it is convenient to ‘divorce’ scientific investigation from its surrounding cultural context, its development must be viewed as intimately tied to these circumstances. Though the field of endocrinology may have advanced beyond the grafting of testicles onto prisoners, or gland larceny against Illinoisans in dive bars, the echoes of these practices reverberate in the cultural assumptions held about testosterone and hormones more broadly today. Not only do Stanley’s assertions of testosterone’s ability to promote potency, vigour and youth appear time and time again in cultural depictions of masculinity, his interest in deviant or undesirable behaviour is also relevant. Throughout his career, Stanley was pursuing links between glandular ‘defects’ and a number of criminal behaviours (most notably murder and forgery). Mass murder was correlated by the surgeon with sexual ambiguity, as was aging and senility to the sexual abuse of children and other problematic behaviours. Glandular imbalances were thus cast as potentially responsible for deviance, with the glands themselves often afforded greater agency than the person who committed the acts.

Though the severity of claims may not be as extreme in contemporary society, the links between testosterone and violent behaviour have not only been established in contemporary cultural narratives but continue to be perpetuated via the investigation of such correlations in studies, lending ‘credibility’ to the argument (Book, Starzyk and Quinsey 2001; Archer, Graham-Kevan and Davies 2005; Kuepper et al. 2010; Geniole et al. 2019; Sturmey 2022). Whilst testosterone is known to influence behaviours, there is limited evidence to suggest it ‘causes’ them. Whilst this distinction may not seem particularly important to emphasise, it draws attention to the misconception we have about hormones, and about testosterone in particular. While, evidentially speaking, it is the actor who acts and the hormone that ‘follows’, (van Anders 2013) both the research produced, and common cultural discourse often present this link in reverse. The hormone acts and the person responds.

Thus, in the case of women using testosterone (as will be a point of focus in this thesis) the historic link to undesirable behaviours (perhaps most importantly the risk of sexual promiscuity or aggression) potentially reveals something about the reluctance of physicians to prescribe. Perhaps, as shall be discussed, there is simply not enough evidence to support claims that testosterone may be useful in relieving menopausal symptoms. Rather, and as this review would suggest, there are perhaps more likely echoes of a historic past in which testosterone, when in the hands of women, could complicate the patriarchal goal of managing sexuality. To draw upon the context of testosterone’s discovery, women must ultimately be found as in need of protection from its potent force. Its use by women destabilises the correlation between glands and gender. It no longer remains the key to virile male potency if women use it for *their* libido; it becomes, rather, just another hormone.

Something to note as we approach the end of this section exploring the concepts of gender that are visible in the context of early testicular investigation is the historic irony of Sequard’s original hypothesis over a century ago still showing up in narratives about testosterone today. Not only was Sequard exploring the concept that testicular matter could rejuvenate a waning libido, but he was also convinced that it reinvigorated – that it provided more energy and a zest for life. Whilst colloquial evidence is often dismissed, there is a great deal of it throughout this research that echoes these sentiments. Testosterone is positioned in a number of narratives, particularly by physicians, as the missing link – the provider of a potent power to not just restore, but to enhance. Testosterone will never be just another hormone. It will always be valuable.

Ovary-n-Out a 'Brief' History of Menopause in the Global North

In the late 18th and early 19th century, 'women's health' increasingly became a space that drew interest from male physicians. Practices that were previously the domain of midwives and traditional healers can be seen to shift into the hands of men. Reproductive and sexual health was subject to a 'masculinisation'; a gynaecologic and obstetric 'take over' that solidified gendered ideologies that positioned women's minds and bodies as interconnected, and thus subject to 'disruption'. Within this cannon of enquiry, menopause began to be investigated as something in need of intervention and treatment (Coope 1996; Deeks 2003; Marnocha, Bergstrom & Dempsey 2011; Sievert 2013).

Whilst there has been extensive consideration of how women's bodies were pathologised during the Victorian period (Craton 2010, Stone 2012, Munford 2019), specific explorations as to how the *menopausal* body was positioned have garnered less significant attention. In general, menopause was positioned in tandem with the reproductive body, which of course has evoked deep distrust for millennia because of that pesky wandering womb (Meyer 1997, Wiesenberg 2023). In the 19th century, physicians doubled down on the debate and reported clear connections between women's wombs and brains. The consequences of this trend were that women were often seen to be particularly susceptible to insanity and this is an idea of which we still see in the etymology of 'hysterical' and 'hysteria'. However, it was seemingly especially the case for the menopausal woman, who were believed to suffer with a condition termed climacteric insanity, for which the only logical treatment was, (of course), institutionalisation in an asylum (Showalter 1980; Beveridge 1995; Wright 20016 Campbell & Davis 2022).

In 1865 Francis Skae, the assistant medical officer at Borough Asylum in Birmingham, wrote:

> *"Insanity occurring in women at the climacteric period… has been noticed by most writers on female diseases as one of the gravest and most important of the morbid conditions which are incident to that time of life… the frequency of insanity in women at that period… referred to the "change of life" … cause… a large proportion of those cases of insanity which are met with between forty and fifty years of age."* (Skae 1865: 275)

Conducting research within an asylum, Skae observed 200 patients he believed were suffering with climacteric insanity and published findings that explored the commonalities between patients in presentation. Along with noting similarities in age (between forty and fifty years) and an absence of menstrual periods, Skae details the following unifying symptoms:

> *"Depression of spirits, sleeplessness, restlessness, and inattention to ordinary domestic affairs, followed by fear of undefined evil, with suspicion of the patient's most intimate friends and relations. From this the patients gradually pass into a state of profound melancholia, accompanied by various delusions, such as, that they have committed the unpardonable sin; that they are doomed to eternal punishment; that evil spirits constantly surround and haunt them; that their food can no longer nourish them; that they are unworthy to live any longer: they constantly express themselves as weary of life, and this, together with the conviction of their own unworthiness and wretchedness, leads to the development of one of the most dangerous, and at the same time one of the most prevalent of the symptoms of climacteric insanity, namely, suicidal tendency."* (ibid)

What's perhaps most interesting is that Skae's accounts of patient symptoms somewhat mirror contemporary accounts of perimenopausal and menopausal symptoms today. While we tend to refrain from locking women in asylums[4] we evidently do still treat symptoms. Although at this time hormones were a faraway thought for helping women solve their "inattention to domestic affairs" (ibid: 276), a heavy dose of narcotics remained on the cards. Skae notes that for

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[4] Unless you count the conditions of the patriarchy.

some, nonconsensual drugging seemed to aggravate their “restlessness and excitement”, while for others it seemingly acted “like a perfect charm in procuring sleep and allaying nervous irritation and despondency”. So, what were the outcomes of Skae’s observations? Of the 200 patients, “104 recovered. 44 became demented. 24 removed improved. 22 died. 3 removed unimproved. 3 convalescent”. So, in good news, over half were seemingly released under the condition that they would adhere to the “judicious administration of narcotics”.

Skae’s observation regarding menstruation is important to note. The belief that a woman’s reproductive system, and in particular her ovaries, were intimately connected to her wellbeing was a theory that attracted growing interest. Fundamentally, it was thought that if the ovaries were ‘diseased’ or stopped working (as in the case of menopause), a woman may be deemed of unsound mind (Goodell 1882; Daniel 1893; Scull & Favreau 1986; Schlich 2015).

Associations drawn between illness and ovarian function were not only related to circumstances in which the ovaries were thought to have become ‘diseased’ (such as in the case of menopause), clinicians equally proffered concern that ovaries could become ‘overactive’ and began to link this concern to the development of multiple ‘maladies’ The primary solution at this time to combat such concerns was to remove the ovaries, as it was assumed that in doing so, a woman would become more malleable – less ‘agitated’ and distressed by her circumstances (ibid).

The majority of ovariotomies[5] were undeniably a eugenic practice as well as a misogynistic one. The procedure sterilised women that disproportionately came from marginalised communities (e.g., those that had been institutionalised or enslaved) (Ehrenriech 2008, Prather et al. 2018, Downham Moore 2022). Procedures were infamously performed without consent and embodied the eugenic disregard for women deemed by physicians as unfit to reproduce. Of course, the procedure sent these women immediately into menopause, meaning they would suffer exponentially with symptoms as a consequence.

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[5] Ovariotomy is a term used to refer to the removal of the ovaries, it is used more commonly however to refer to procedures that were non-essential vs an oophorectomy that would indicate clinical need.

The first ovariotomy is documented to have taken place in 1809 in Kentucky (performed by Ephraim McDowell) (Ridenbaugh 1890). The procedure was considered novel in that the incision needed to be made via the abdomen to access the pelvic region. As such, many professionals at the time deemed the endeavour not only dangerous but exceptionally challenging to attempt. Surgeries involving the ovaries were undertaken in their infancy as curative endeavours. They were performed in order to treat gynaecologic conditions causing physical symptoms. Over the coming decades however, the removal of the ovaries for other illnesses was also explored.

In 1872, Robert Battey performed the first bilateral oophorectomy (the removal of both ovaries) for a *non*-ovarian condition. The patient in question had been struggling with endometriosis. Following the procedure, the 30-year-old is reported to have not only survived, but to have symptomatically improved. Battey published the findings and coined the term “normal ovariotomy” to refer to the practice of removing ovaries for non-ovarian-specific conditions. The procedure came to be known as ‘Battey’s operation’ (Longo 1979, Komagamine Kokubun & Hirata 2019, Brooks 2020), and the practice was widely undertaken by surgeons cross continentally. It has been estimated that, in the 19th century, over 150,000 women underwent a procedure in which their ovaries were removed (Thiery 1998). Battey’s operation was performed not only for conditions associated with gynaecological health (such as endometriosis); it was also performed as a general treatment for other conditions that fell into the category of ‘hysteria’ or ‘nervous disorders’. This included conditions such as anorexia (or any eating related disorder), anxiety, depression, mood or personality disorders, ‘nymphomania’, fainting, chronic pain, fatigue, and epilepsy (and/or other disorders where ‘convulsing’ physical symptoms occurred).

It is worth noting that the expression of sexual desire was also known to be treated at this time by not only removing the ovaries but by performing a clitoridectomy (the surgical excision of the clitoris). This stemmed from the belief that the procedure would prevent a woman from descending into idiocy as a result of their ‘lustful’ desires (Gronemen 1994).

Whilst fluctuations in our hormones do impact wellbeing, the correlation between women's hormones as implicated by the menstrual cycle and concepts of 'insanity' have been utilised as an oppressive patriarchal mechanism. Battey drew upon such understandings to legitimate the performance of normal ovariotomy – it was not only relieving women of their 'mental maladies', but also protecting communities by ensuring that 'ailments' of this kind could not be inherited or passed on to others. These women were sterilised (regardless of whether this was the openly stated aim) for the good of society (Battey 1872, 1873, 1880, Dowbiggin 2008).

Although the removal of ovaries grew in popularity during the 19th century, it also garnered concern within the medical community. The procedure was likened to that of 'castration, with commentators noting the seemingly senselessness sacrifice being made by consultants when they chose to remove a woman's well-functioning ovaries (Thiery 1998, Studd 2006). However, it's essential to convey that, within accounts, the risk posed to women as individuals is not outlined. The high mortality rates, the impact that the procedure may have on women as people – neither of these factors are crystallised as features that are 'good to think with' (Strauss 1962). Rather, and to call upon Foucault's concept of biopolitics, it is the body and its parts – the functioning ovary – that takes centre stage and becomes both the vehicle for controlling the agent and the central concern of the clinician.

Despite the high mortality and complication rate, normal ovariotomy continued to find support from gynaecologists. By the later part of the 19th century, the overuse of ovariotomy had become starkly evident, moving even Battey to denounce the intervention. What is particularly disturbing to note is the use of the procedure within institutions as a mechanism to help 'alleviate' an abstract misogynistic concept of 'disease' (Longo 1979, Shorter 20017, Drenth 2020). Routinely performed without consent, sporadic 'lucid' moments exhibited by women in which 'consent' was given are noted by physicians as a rationale to perform the procedure (particularly among those suffering with postpartum depression). It was not until the late 1800s that ovariotomy was denounced as experimentally brutal.

Battey's death in 1895 may have marked an end to the popularity of performing normal ovariotomy as a catch-all for solving the problems associated with women exhibiting distress, yet the procedure did not mark the end to the concerning nature of clinical practice in women's health. The eugenic belief systems held by practitioners in which 'unwell women' (Cleghorn 2021) – and those predominantly from undesirable 'under' classes – were in need of surveillance due to their 'dangerous' bodies persisted (McDermott & Graham 2007, Tyler 2011).

The development of the normal ovariotomy took place against the backdrop of gendered assumptions in which a woman's 'fragile' mental state is inextricably linked to her primary purpose: to reproduce. Gynaecologic practices and their historic development are entrenched in eugenic misogynistic discourse, with practitioners routinely takin unnecessary risks with women's health. Women are stripped of personhood and reduced to bodies to be experimented upon in the name of a modernistic march to progress. In 1934, Herbert Spencer has the following passage to offer:

> *"Much courage was required in the patient in pre-anaesthetic days to enable her to submit to an operation previously thought to be impossible or uniformly fatal, and in the operator who had no previous experience to guide him. When he succeeded, he was often disbelieved, and when he failed, he was vituperated, not only by individual rivals, but also by professors and academies of medicine."* (Spencer 1934)

Something about this excerpt allows us to fully appreciate the manner in which women were presented as docile objects, required to succumb to the will of the intellectual man in order benefit modern medicine and the progression of the patriarchy. We talk of 'undergoing' or 'enduring' a process or event, such as an operation. We do not (or perhaps more aptly *should* not) 'submit to' an operation. This action of 'submitting' communicates concepts of power surrounding submitting to a *person* instead. Thus, the structure of ideas expressed in the quote fundamentally highlights the dominant relationship between doctor and patient, not the relationship between the patient and the experience of the operation. In the context of the operation, the removal of a woman's ovaries would have induced menopause if it had not already been reached naturally, yet there was little concern over this. In the 1870s and 1880s these gynaecologists saw no harm in inducing menopause at 30, and it was only at the end of the 19th century that the fledgling field of endocrinology began to make sense of the importance of hormones in the context of menopause.

‘Endocrine Perverts’ and ‘Derailed Menopausics’

As previously discussed, endocrinology was concerned with secretions from the ductless glands – those mysterious substances that were thought to drive ‘gendered’ behaviour. The menstrual cycle, the function of the ovaries, and the physiological changes associated with menopause were all hypothesised as associated with these secretions. As such and similarly, to that which we have explored in relation to testosterone, forays into learning more about easing symptoms afflicting women involved the dissection and ingestion of body parts too.

‘Organotherapy’ was a precursor for menopausal women before HRT became widely available. In 1920 at least 3 companies were known to be manufacturing ovarian extracts. It was not until 1934, following the successful isolation of oestrogen in 1929 and progesterone in 1932, that the first orally active oestrogen became available (Houck 2009). It was derived from the urine of pregnant Canadian women, but due to production concerns (namely the number of pregnant women in Canada that were able to donate to the cause) manufacturers found it to be unsustainable.

Methods of administration during the period of time in which organotherapy was popular were fairly crude. At the beginning of the 19th century, ‘fresh’ ovaries were ground up and fed to menopausal patients. This technique was first experimented with in Berlin in 1898, where a young woman who had had her ovaries removed was offered the treatment as a way to combat the debilitating vasomotor symptoms[6] she was experiencing as a result of her ovarian removal. She was fed fresh cow ovaries, to mixed reviews, with some commenting that it was likely no more effective than giving her saline solution (ibid). Over time, organotherapy fell out of fashion. This may be partly due to the fact that the most successful ovarian ‘harvest’ came from animals at the peak of their sexual

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[6] More commonly referred to as hot flushes.

maturity once again posed concerns regarding sustainability; little did they know they still had the pregnant Canadian urine shortage of 32 to endure.

At the turn of the 20th century, language surrounding menopause developed a specific tone. Judith Houck outlines how clinicians described menopause as "a senile degradation of the sexual organs, a process in which the ovaries and external genitalia 'shrink' and 'shrivel'… [and the] breasts and vulva 'degenerate'" (ibid: 41). Gynaecologist William J Robinson's description of menopause in his book *The Menopause or Change of Life* (1933) as "a period of withering, shrinking and closing up" in which the vagina, particularly in 'old maids', becomes so narrow it makes intercourse painful and sometimes impossible. Houck notes how he cheerfully goes on to explain that the "the pubis looks moth eaten," and "the breasts begin to shrink and wither, hanging down like two empty sacs." (Robinson 1933: 212)

Houck's exploration of discourse in America during this time aptly captures the ways in which menopause was not only thought about as a form of degeneration, but as a *transgression* too – a movement away from what is feminine, toward what is masculine. In tracking the development of ways to treat menopause, Houck observes that much of this practice was not just about alleviating symptoms, but about assuring and firming up the binary distinctions between men and women. She notes that "as long as middle-aged women remained sufficiently feminine, doctors encouraged them to enter public life. But as soon as women's menopausal symptoms presented behaviours that challenged normative gender roles, many physicians warned against crossing social boundaries." (Houck 2009: 41)

In the menopause...
transition without tears

Milprem promptly relieves emotional distress with lasting control of physical symptoms

Milprem®

In minutes, Milprem starts to ease anxiety and depression. It relieves insomnia, relaxes tense muscles; alleviates low back pain and tension headache. As the patient continues on Milprem, the replacement of estrogens checks hot flushes and other physical symptoms.

Easy dosage schedule: One Milprem tablet t.i.d. in 21-day courses with one-week rest periods; during the rest periods, Miltown alone can sustain the patient.

WALLACE LABORATORIES, *New Brunswick, N. J.*

Figure 3: Image of an advert for Milprem in the 1950s (Homemaker 2011)

Houck highlights how the birth of the 'New Woman' in particular gave way to increasing anxiety surrounding threats to traditional gender roles and, as such, the patriarchal regime. It is noted that the 'single' the 'sexually active' and the 'masculine' woman were thought to be the most at risk when it came to experiencing severe menopausal symptoms. This was, supposedly, because these women had not fulfilled their highest social calling: to become a mother. To remedy the risk, these women were encouraged to be mothers in other ways – a mother to society, committing themselves to charitable work and other pursuits of high moral value (Bartlett 1995). Houck continues to explore how 'masculine' women or those women that deviated from gender expectations (both in appearance and behaviour) were thought to be more vulnerable to mental health conditions too. The authors of a 1931 study claimed that women of athletic or "robust" build or those "showing conspicuous intersexual traits" were more likely to suffer from psychosis at menopause." (ibid: 46)

The preoccupation with gendered difference can be seen to pervade accounts of menopause between 1897 and 1937. Many physicians took to describing menopause as a masculinising process that rendered women not necessarily more 'male' but certainly less female. Sylvanus Stall described in 1901 how menopause left women more physically masculine. They describe how the contours of a woman's body and her distribution of hair changed. Stall goes as far as to say that, for some menopausal women, their facial hair grew so thick it resembled that of a man's beard.

Interpretations in which hormones were intimately connected to gender were thus solidifying. Hormones were able to bestow – and equally, take away – masculinity and femininity. George Richter outlines in 1917 that at menopause, “the secondary signs of femininity wither, the voice deepens, the psyche tends towards the interests of man which, in some instances, may be the cause of divorces after several decades of married life” (ibid: 50). It’s highlighted with some concern that menopausal women also show more of a predisposition towards aggression too. Remaining the ‘right’ type of woman was thus of the upmost importance. Childless women with career ambitions were of particular concern. An Illinois medical journal characterised these women as “endocrine perverts” and “derailed menopausics”, expressing that “these unstable, “mannish” indeed unnatural, women could not be trusted to create social policy” (ibid: 48). Physiology Professor William Sedgwick took this further, discussing the biological fallacy of the feminist and suffrage movement, highlighting that it was led by masculine half women – mistakes of nature (Flexner et al. 1914).

Although the majority of discourse surrounding sex and the menopausal woman focused on fears of fantasies of promiscuity, there were some physicians that hypothesised that menopausal women could turn to one another for sexual gratification. In 1934, Podolsky outlines that sexual ‘abnormality’ could be a serious danger in menopause. He argues that, in his own practice, he often ‘sees in women, bored or unhappily married, a retrogression to homosexuality at or near menopause’, advising that to guard against the aforementioned potential sapphic dangers to women would become


help keep her this way

specifically designed for estrogen replacement in the menopause...and later years

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CONJUGATED ESTROGENS (equine)

Premarin (conjugated estrogens—equine) is a naturally occurring, orally active, water-soluble estrogen presented as the complete equine estrogen complex. CAUTION: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period). *In the male:* Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy. AVAILABLE in 4 potencies for individualized treatment: *Tablets*—2.5 mg. (purple), 1.25 mg. (yellow), 0.625 mg. (red), 0.3 mg. (green); bottles of 100 and 1,000. 2.5 mg. tablets also available in 20's.

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AUG 24 1966

Figure 4: Image of a Premarin advert from the 1966 (New York State Journal of Medicine 2015).

exposed, one could sublimate their sexual desire by channelling it into creative endeavours'[7] (Houck 2009).

HR, But Not Too Much T

The menopausal landscape shifted dramatically with the development of two new oestrogenic preparations in the 1930s and 1940s. Charles Dodds – an English Biochemist – produced a synthetic hormone called diethylstilbesterol (DES) in 1938 (Abboud 2017). In tandem, Ayerest, Mckenna and Harrison (a pharmaceutical company based in Montreal) developed Premarin, a conjugated oestrogen derived from the urine of pregnant mares. Premarin became the most popular option for women experiencing menopausal symptoms as DES for many, led to nausea. Much of Premarin's success came from the direct marketing campaigns that were aimed at physicians in the 1940s and 1950s. These promoted oestrogen as a cure-all for a variety of complaints. Vasomotor symptoms, anxiety (or 'nervousness') headaches and related concerns were all seemingly alleviated by the wonders of oestrogen. A number of clinicians did however choose to combine oestrogen with tranquilizers, (meprobamate) and as Houck notes, the combination was promoted as guaranteeing a menopausal "transition without tears" (Houck 2009: 83).

Fears and concerns regarding the need to protect the endometrium were becoming more apparent in the 1960s, with physicians citing the possible development of cancer as important to consider. These concerns were addressed in the popular text 'Feminine Forever' (1966) by Robert A Wilson. Wilson was one of the first physicians to advise using a combination of progestin *and* oestrogen to treat patients, and it is this combination that we have come to refer to today as HRT. Wilson argued strongly for the use of HRT as he felt (as the title would suggest) that the use of hormones for menopausal women would ensure any troublesome gender transgression could consequently be suitably managed. Women would remain (if they followed Wilson's advice) 'feminine forever'. Wilson goes as far as to argue that the use of oral contraceptives could also prevent *against* menopause. He discusses one patient who he says 'never reached menopause' because she had used synthetic hormones throughout her

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[7] It is with regret that we must inform Podolsky his suggestion is entirely queer and indeed likely to lead to the homosexual retrogression of which he speaks.

reproductive years, leading Wilson to conclude that the use of oestrogenic contraception could, if used effectively throughout a woman's life, automatically halt menopause and its effects.

The anxiety regarding gender conformity that underscores Wilson's text is palpable. It is in keeping with clinical thinking in which femaleness and maleness needed to be distilled, teased out and appropriately understood. His work moves beyond the remit of simply trying to *understand* the body; the advice regarding how to stay feminine forever contributes to a patriarchal canon in which moral value is attached to a woman's decision regarding whether or not to treat her menopausal symptoms. Use of the term 'feminine' in Wilson's title is key. It communicates sentiment suggestive of behaviour as well as biology. The patient does not simply remain *female* forever; she remains *feminine* forever. This is important, as the associated connotations with femininity imply specific behavioural traits. Subservience and docility are all communicated in discussions of 'good women' during this period of history, (Friedan 1963, Golberg 1970) and reminding ourselves of this allows us to better appreciate the pressures placed on women to submit to particular forms of treatment for their menopause. In 1969, there were discussions in 'Reader's Digest' of mental instability and the onset of psychosis with menopause. She outlines how women were expected to be agreeable to undergoing electroshock therapy, (ECT) and discusses one particular patient who was subjected to 18 rounds of ECT during a 6-week stay at Crown Hill Mental institution (Houck 2009: 195).

Although there was a sharp fall in oestrogen prescriptions in 1975, after studies suggested a link to endometrial cancers, the adding of progestin as suggested by Wilson in 'Feminine Forever' seemingly *did* address this, and the prescription of HRT continued to increase in popularity right up until the publication of the Women's Health Initiative (WHI) Study in 2002 that found causal associations between the use of HRT and the development of breast cancer, cardiovascular disease and dementia (Manson, Chlebowski & Stefanick et al. 2014; Cagnacci & Venier 2019; Langer 2021; British Menopause Society 2022). Whilst the WHI has since widely been denounced due to its failure to control for confounding factors, it is essential that the impact the study had be recognised. It signalled a profound shift in not only the way we think about menopausal therapies, but about hormones in general. After the WHI, HRT began to be positioned as dangerous, with journalists adopting tactics that served to instil fear and cause concern among patients. It equally deterred clinicians from prescribing. Before the WHI, women were prescribed HRT as a matter of routine under the assumption that it was good for one's health, and in the early 90s, Premarin had become one of the most widely prescribed drugs in the USA, competing as a frontrunner alongside SSRIs and other anti-depressant medications (O'Dowd 2001; Singer & Wilson 2009; Kohn, Rodriguez, Hotaling & Pastuszak 2019; Bezzant 2022).

Whilst the WHI may have briefly eroded confidence in HRT, prescribing cultures can be seen to contemporarily be shifting once more, and the widespread use of HRT is returning to contemporary menopausal medicine. However, within this long and complex hormonal history, it is the narrative of expectation that is important to draw out and consider. Wilson's position that a woman should remain *feminine forever* (1933) is reflective not only of the physical but the sociocultural, too – the woman is positioned as being required to adopt the practices the physician sees as beneficial. This theme of expectation, when it comes to decision-making in the navigation of women's health, is a pertinent point. The 'feminine' docility represented in narratives of the good patient arises throughout the complex story of HRT and the treatment of menopause in the Global North. The women is thought most 'agreeable' when following the instructions of those in a position of power: the clinician, the press, or the social consensus at large.

Thinking About Bodies: Beyond the Binary

Having explored the history of the synthesis of hormones and the development of their use in the global North, we may acknowledge how gendered messaging has been inscribed upon the hormonal body. Considering the work of anthropologists allows us to better appreciate the *impact* of this in relation to the 'making of menopause'.

Dualistic models in which certain hormones belong to certain genders are inarguably seductive. As we have demonstrated in the discussion of the history of hormone hunting, the desire to apply order to the body, to establish what makes it male and what makes it female underscores much of our thinking around hormones. These endocrine actors are positioned as oozing with pink personality or blue boldness. These perceptions have undeniably informed the ways in which the medical community both describes and prescribes hormones, and how gendered perceptions echo down into social consciousness today. However, the question as to whether this is a conscious process is more complex and it is here that it is useful to turn our attention to the work of anthropologists that inform the theoretical positioning of this research and the development of key conceptual ideas.

The allure of ordering the body is demonstrated by a dominant mid-20th century theoretical model known as structuralism[8]. As opposed to thinking about the actions of individuals or groups, the structuralist perspective concerns itself with the underlying logic of social and symbolic systems. Claude Levi-Strauss (1963) argued that human culture is best understood as a manifestation of the human mind: a projection of its internal mechanisms and structures onto cultural phenomena. Through the exploration of unifying systems such as kinship, and through the observation of similarities in the construction of myths and stories, Levi-Strauss considered how systems of belonging may be formed. Drawing upon the foundations of linguistics, wherein systems of relating are informed by the idea of opposition or binaries, culture becomes observable as a series of opposites. These dualities are found, Levi-Strauss argues, across a wide range of social-scientific thought: nature-culture, society-technology, rationality-emotion and so on; yet they also can be seen to permeate conceptualisations of gender.

That which is masculine is that which is not feminine, just as that which belongs to ‘technology’ is not ‘social’. The idea that the social world and its categories can be rendered intelligible, concrete, and accurate through mediums such as ‘science’ is comforting. It represents natural, even cosmological axioms. Critical-theoretical currents have come to query such systems of opposites. ‘Post-structural’ analysis ultimately rejects the idea of categories such as masculine and feminine being fixed, instead proffering an understanding that positions them to be better understood as created through complex interactions and discourses. In the case of gender, figures like Judith Butler (1991) turned their attention away from ideas of patriarchy as an immutable fact and towards

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[8] As used by anthropologists; structuralism has wider meanings in other disciplines.

conceptions in which gender itself could be understood as produced. Recent developments have moved towards a focus on dynamic, relational, and shifting sets of relations between various actors (DeLanda 200, Latour 2005). Thus, while dualistic pairings may present overtly at times, and powerfully resonate with us as absolute, the deconstruction of oppositional thinking often reveals a more complex picture.

When we are able to observe and label natural phenomenon in a manner that supports deep-seated cultural assumptions, our understandings of the world may be sured up. It is comforting and serves a purpose – it helps us delineate what in our world belongs where. However, this desire – in which the binary is presented as a natural occurrence – is, upon exploration, revealed to require not just work but also maintenance. To move away from gender in the abstract, we may consider how biological sex is, upon reflection, less ‘absolute’ than it can be conceived to be. The biomedical processes involved in ‘sexing’ the body can arguably be seen to reveal insufficient objectivity and reflect deep-seated social norms, values, and anxieties. Anne Fausto Sterling (2000) has explored the relative concerns with ‘difference’ through her work, detailing the desire to bio-medically categorise intersex individuals. In *Sexing the Body,* Sterling asserts that individuals should not be forced to compromise their individual differences to fit a flawed societal definition of ‘normality’, or indeed to belong to a dualistic binary. In identifying variations in genitalia, Fausto Sterling hypothesizes that the need to categorise bodies into binary systems of male and female is more representative of a desire for social order than an actual biological reality, thus demonstrating how inextricably linked concepts of body and biology are to social norms and the desire to categorise.

Though binary thinking continues to come under increasing scrutiny, the foundations of our biological teachings continue to rest upon deterministic models in which the identification of innate distinctions are commonplace. Moreover, while the conflation of sex and gender may be being addressed as problematic, in practice, the bleeding between these categories is not always easy to observe. As such, there are multiple instances in which the biological, or seemingly empirical, is in actuality imbued with sociocultural context and gendered stereotypes that remain unchallenged in research, and which permeate medical spaces such as those observed over the course of this research.

Entering its 32nd year, the relevance of Emily Martin's work (1991) is still profoundly relevant in the context of this conversation. Moving beyond the generalised representation of gender and the body, Martin's research looks at the domain of scientific and biological narratives themselves. Their work explores how the process of procreation relies upon gender-normative narratives, underscoring just how fluently biology becomes imbued with gendered meaning. Outlining the use of provocative gendered language, Martin explores how romance plots have been rehashed in the telling of conception. Though contemporary understandings of fertilization recognize the process as biologically collaborative (the egg drawing in the sperm as it makes contact), depictions in medical literature, teaching material, and popular culture are outlined by Martin as chronicling conception differently (and more traditionally). Using extracts from educational textbooks, Martin highlights how both egg and sperm are anthropomorphized (the strong and courageous sperm greets the passive docile egg).

As we have explored, historically, gendered, and sexed bodies have been 'created' in environments dominated by men, in which male enterprises are "haunted by the spectre of femininity" (Oudshoorn 2005; Milam & Nye 2015: 2). The motivations to draw boundaries between bodies, races, classes, behaviours, and social origins can be seen to exemplify specific ideologies. Bodies are not only divided into binary categories, but made subject to a measurable analysis of worth, using a feminised spectrum of "more or less" masculine (ibid). To use testosterone as an example, positioning the hormone in proximity to femininity is an act that disturbs both the historic and binary order upon which sexed and gendered bodies have been conceptualised.

In this sense, anatomy and biology can be viewed as more than objective disciplines, they extend their 'usefulness' as sociocultural tools – a form of thinking and rationalising that can apply order to the disordered. Mary Douglas explored concepts of 'dirt' as matter out of place – commenting that dirt is rarely unique; rather she notes "where there is dirt there is a system" (Douglas 1966:36). The same too could be said for the body and for hormones. They exist in specified systems and can help to apply cultural order. Thus, the transgression of hormonal boundaries – the use of a hormone that doesn't belong to you, or the use of it in non-controlled ways – is concerning because it threatens the established system. Again, to use testosterone as an example, if it is found to reside in the ‘wrong’ body or is administered in the wrong way, it becomes ‘risky’. When a ‘dirty’ hormone is placed in the wrong body, it threatens to become ‘matter out of place’ (ibid). The conditions of this assertion are complex and require thoughtful consideration (such as the circumstances surrounding transgender hormone therapy[9]), but the principle remains. An order is applied, and threat to that order produces acute discomfort.

Katrina Karkazis and Rebecca Jordan Young (2018) present an analysis that speaks to this idea, introducing the concept of ‘T-Talk’ when referring to the manner in which direct claims and indirect associations can circulate around hormones but specifically, testosterone, rendering it both “material substance and multivalent cultural symbol”. In a thought-provoking analysis of the regulation of testosterone in women athletes, the authors draw attention to how T-Talk naturalises a narrative of sport as inherently masculine, while minimising the racial politics at play within these debates. T talk is presented as the forms of narrative that weave together scientific claims with cultural beliefs in order to validate and rationalise the misconception that testosterone is inherently male, rendering women with high levels of the hormone not only more masculine but also at an unfair advantage due to the knowledge that testosterone is a ‘foreign substance’ to women (Karkazis & Jordan Young 2018). Tagging testosterone as a sex hormone in these debates is also noted by the authors to infer its purpose to be purely sexual (despite the knowledge that testosterone’s function extends beyond reproductive physiology (e.g. liver function (ibid)).

The concept of hormones being assigned genders may then be explored as a mechanism that serves the collective. It helps order and organise according to preestablished structures that are complex to tease apart (Levi Strauss 1955). The action of separating hormones from these concepts, and particularly from concepts of gender, is thus palpably complex and threatens to unravel order and challenge our understandings of what ‘goes together’. In this sense, biology may be the easy win, not society and culture.

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[9] In this instance, we may argue that the transgression is diminished by the knowledge that hormone use is fundamentally restoring order. A body that feels out of place is returning to its assumed natural state. Testosterone is not changing boundaries so much as supporting them – helping ‘return’ a masculine state.

Menopause in the Multiple

It is easy to misjudge the analysis presented as an argument against biology. Yet, this is far from the intention. It does not propose that hormones lie outside the remit of biology, rather that biology is an aspect of culture, not outside of it. In this sense, hormones, and their uses in the relief of menopausal symptoms may be explored like any other ‘artefact’ or subject matter - imbued with non-objective ideals, systems and symbols. All forms of HRT will act and react upon contact with the body, but the experience will be unique to the individual and occur in parallel, with multiple factors that contribute to shaping the individual’s experience of using said hormones.

Considering menopause as a constructed category is complex. It is easy to interpret such a statement as dismissing the tangibility of the phenomenon entirely. This is not the case. It contends that menopause is made in specific ways according to specific circumstances. Annemarie Mol's *The Body Multiple: Ontology in Medical Practice* (2002) is one of the most insightful frameworks for examining this issue. *The Body Multiple* explores the complex and fluid nature of medical practice, and the ways in which bodies may be conceptualised and understood in distinct and specific ways according to the medical context they find themselves within. Challenging the notion of the body as singular or fixed, Mol presents the body as a multiple entity, one that is constructed and reconstructed continually via medical practices, interventions, and interactions. Focusing specifically on the condition atherosclerosis (a narrowing of the arteries) Mol highlights how, when it comes to treating a condition, medical knowledge and practices are not uniform but rather shaped by the experiences of a variety of actors (doctors, nurses, researchers, patients etc.). Each group is identified by Mol as carrying specific interpretations and understandings about the body that lead to the development of multiple versions or "body multiples" that coexist within medical practice.

As part of this analysis, the importance of "ontological politics" is explored, and the negotiation and contestation of what counts as ‘real’ or ‘significant’ within medical practice is considered. Mol outlines how various stakeholders engage in ontological politics by defining and redefining the body and its pathologies. In doing so, they can be seen as not only shaping medical decision-making and treatment, but definitions and perceptions of conditions themselves.

Professionals are observed by Mol to engage in a process termed *translation*, whereby a patient's experience is made sense of under a medical framework. The translation process involves aligning a patient narrative with medical terminology and knowledge – something that complexly transforms and fixes the experience within appropriate medical rhetoric.

The Body Multiple ultimately challenges the traditional narrative in which medical practice is understood as objective. Instead, it presents the ongoing care and treatment of patients as a dynamic and socially constructed process involving multiple actors. In exploring the diverse ways in which the body is conceptualized and managed, Mol questions assumptions about medical objectivity, presenting new possibilities for critically examining the ways in which medical knowledge and practice shape our understanding of the body and its processes. Mol's work is relevant in the context of this research where conceptions of menopause are positioned as constructed via an engagement on the part of multiple interconnected actors. The *translation* of symptoms into diagnosis can be seen to occur in multiple contexts and settings, and in turn, the emergence of menopause into a category specific to the patient is seen to be achieved.

Producing research that considers the *multiple* versions of menopause produced and (consequently) enacted highlights the variation at play within concepts that are 'fixed', foregrounding knowledge as performative. Ultimately, it demonstrates how "facts objects and natures have built-in normativities [that can] contribute to some worlds-in-progress but not to others" (Moser 2008: 99). Thinking critically about the body and its processes as deeply intertwined with social narratives is challenging. It requires a curiosity of thought in which we must challenge ourselves to begin unpicking the stitches that hold together the social fabric of our world. More than this, it asks us to commit the closest thing to secular blasphemy. It asks us to question the empirical – to ask to what extent science can be seen as 'doing' cultural work. We may respond that perhaps it is always doing cultural work. The inherently 'natural' is after all rarely born but rather made – sculpted from interpretation. This statement does not dismiss the existence of scientific rationale or 'fact'. Rather, it questions the objective, highlighting that, as outlined, it rarely remains value free.

In the popular 1969 text *Everything You Always Wanted to Know About Sex* (*But Were Afraid to Ask),* which was later parodied by Woody Allen in the 1972 film, Reuben writes this about the menopausal woman:

> *"As the estrogen is shut off, a woman comes as close as she can to being a man. Increased facial hair, deepened voice, obesity, and the decline of breasts and female genitalia all contribute to a masculine appearance. Coarsened features, enlargement of the clitoris and gradual baldness complete the picture. Not really a man, but no longer a functional woman, these individuals live in a world of intersex [where] sex no longer interests them… Having outlived their ovaries, they may have outlived their usefulness as human beings."* (Reuben 1969: 287)

The concept of 'threat' here is palpable. The menopausal woman is presented as 'risky' in her propensity to disrupt the boundaries of gender. Her body threatens social order – in her menopausal state hair tries to grow in the wrong places whilst falling off in others. Her body changes shape. It no longer bears the same contours it once did. Her breasts hang differently, her genitals sit at a border of a gendered parameter. She exists in the in-between.

It is here, in the context of discomfort regarding the transgression of bodily boundaries, that the concept of liminality as explored by anthropologists is useful to consider. Equally, liminality will be a thematically significant concept drawn upon throughout this thesis.

Coined by Van Gennep, liminality has been utilised upon by theorists to express how periods of ambiguity (specifically pertaining to age) can induce feelings of discomfort. Derived from the Latin for 'threshold', liminality literally considers how remaining on the 'threshold' of something is disconcerting to us, due to the fact that the 'in between' has the propensity to threaten our social and cultural order (Goffman 1959; Van Gennep 1960; Turner 1967, 1969, 1988; Thomassen 2009; Beech 2010; Howard-Grenville et al. 2011; Glass 2012).

Theorists observe how, in reaction to this concern, we often address dis-ease via the enactment of ritual practices. Doing so, the liminal period of time is ‘marked’ and this ‘marking’ encourages a person to move *through* said liminal space. The enactment of rituals allows a person to enter a socially secure space. It restores social order by returning or moving the individual into a discernible social category. In the context of age, for example, theorists have explored the ways in which teenage years are often punctuated by rituals that stress the importance of transitioning into a defined category – into manhood or womanhood. One may consider the Bar or Bat Mitzvah or the quinceañera, and how these events express a social consensus and concern with needing to move through an ill-defined in-between category (teenage years) in order to occupy a socially secure space (adulthood). Whilst we are of course able to recognise in a contemporary context that a young person entering adulthood at the age of thirteen does not meet nor reflect the parameters of what we consider to be adulthood, it demonstrates the sociocultural need to mark beginnings and ends, as well as our desire to celebrate the end of ‘transition’ and the start of continuity (Ben-Lulu 2020; Schwartz 2020; Cooper & Guzman-Carmeli 2022; Carson et al. 2021).

Furthering this discourse, we may consider how legal frameworks often assign ‘appropriate’ ages to particular contexts. For example, in the UK, the legal age of consent for sexual intercourse is 16 years of age, and until recently, it was also the age at which a person could consent to marriage. The age of consent for marriage has now been raised to 18 years, and the decision to change these parameters recognises the ways in which we collectively maintain or change social boundaries in accordance with a cultural consensus. In the instance of marriage, we are able to recognise how the social collective ‘acted’ in order to bring about transition within the legal context, and in doing so, alter the ways in which we set the legal beginnings of adulthood. This is essential to underscore as it highlights how we *are* able to enact pertinent changes related to our thought processes as a collective community.

In the traditional sense, the middle stages of rites of passage are considered the periods in which a person no longer holds their ‘pre-ritual’ status yet has not begun the transition to a state that would indicate a ‘ritual’ has been completed. During a rite's liminal stage, a person is thought to stand at the threshold of change, somewhere in between a previous structured identity and a new way of perceiving the self (which, once adopted, would complete the establishment of the ritual).

During liminal periods, social hierarchies can be temporarily dissolved. The continuation of traditional roles or ways of being can become uncertain, and future outcomes once thought of as inevitable can be thrown into disarray or evoke doubt. The dissolution of order during liminal periods creates a fluid situation that can, in tandem, encourage new conceptual ideologies and ways of being to be established. However, it can equally encourage a suring-up of structural parameters that call upon traditional concepts of social order (e.g., traditional gender-conforming familial roles).

The relevance of the concept of liminality is pertinent to consider in association with menopause, as menopause represents a period of time in which ideas of what it means to be a woman are called into question against a backdrop of biopolitical social control (Morawski 1994; Sievert 2008; Marshall 2015; Benson James 2016; de Salis et al. 2017; Salvatore & Venuleo 2017; Kroløkke & Bach 2020). The menopausal body is policed. One is asked to conform to gendered discourses and is not permitted to exist in a liminal space. Rather, the person going through menopause is asked to subscribe to defined categorical groupings. She is perimenopausal, menopausal or postmenopausal, each temporal state marked with a dotted full stop, or more accurately the biomedical prescription of hormones to restore the picture of womanhood in order to allow her to remain ‘feminine forever’.

In light of changes in medical care and technologies there is no clear script pertaining to what the menopause as an interim stage is or should be. Thus, we place markers upon it, such as average age, symptomatic experience, diagnosis of state and so on. In reality, menopause is fluid. It occurs individually and uniquely in separate bodies. Just like the Body Mass Index (BMI) and other metric thresholds, we create parameters for menopause. We ask bodies to meet these markers, so we are able to categorise them and make sense of an in-between state. We carve out and create menopause, representing the socially constructed nature of knowledge and the treatments that are prescribed on the basis of that knowledge, to appropriately restore balance to the binary.

Describing the permeation of boundaries as ‘dirty’, Douglas details our desire to eliminate and regulate these contraventions, as part of an indicative need to organise the environment to conform to a social order (Douglas 1966). With this understanding in mind, one may consider how the menopausal body's destabilising of normative bodily expectations may implicate social order. Through its susceptibility to leak, to sag, to reject… the permeability of the maternal body's boundaries is betrayed. Unlike "the mythical well-bounded… masculine body" (Kukla 2005: 3) the menopausal female body "threatens" social order (Bartky 1988; Bordo 1993; Carson 1995; Orbach 2010). As Carson puts it, through its "leakages – [she] expose[s] what should be kept in" (Carson 1995: 129). As a consequence, this "matter out of place" (Douglas 1966: 36) has been seen to generate a social anxiety expressed in a compulsion to fix, control and co-ordinate these boundaries (Kukla 2005, 2006).

Thus, interest in menopause appears relatable to larger concerns around the transgression of bodily boundaries and issues of 'pollution'. While purportedly for the good of the woman, it is arguable that the interest in surveying women's menopausal bodies may be an expression of an innate discomfort about aging bodies' liminal and mutable status. Considering the belief in correct bodily decorum as key to securing the social stability of society thus reveals a desire to maintain cohesive order through the establishment of regulation over menopausal women. Medical, scientific and public surveillance over menopausal bodies can arguably be interpreted as a 'response': a desire to fix and stabilise these bodily boundaries (Kukla 2005).

Reviewing the historic context surrounding perceptions of the biological body, hormones, and menopause in tandem with a consideration of the anthropological cannon allows us to consider the ways in which biomedical perceptions are entrenched within sociocultural and historic discourse. Such appreciation frames the ways in which menopause has, in this research been explored. The following chapters that present ethnographic accounts are informed and implicated by the history that has been considered. Both menopause as an objective concept, the body in which it is occurring and the treatments utilised to alleviate symptoms, are considered as a chapter within the history we have outlined. It is a chapter that involves and exists in conversation with the conceptual imaginings of periods past. It is not isolated, rather, it exists within.

Thus, this chapter has outlined both the context surrounding the ways in which our understandings of menopause have developed and equally, it has touched upon the key conceptual ideologies that are helpful in understanding menopause as a mediated medical phenomenon. The ‘realness’ of menopause is not contested, yet the history in which it has evolved is acknowledged. The biomedical, as our accounts outline are *not* devoid of patriarchal context which may be seen to both inform how menopause is treated and equally perceived in contemporary culture.

Ideas that communicate a simple, linear model or pathway in which use of hormones ensures the attainment of an embodied ideal version of gender, highlights how patriarchy is maintained and achieved in practise through the discourse of scientific rhetoric. After all, such an account has to an extent, been replicated here. We have discussed the history of hormones and whether intentionally or not, attached said histroy to specific genders. Testoterone becoms in the telling of it’s syntheis the property of men and oestrogen the porperty of women. Whilst every effort has been made to detach the hormone from the gender – to explore how and why these gendered imaginings and mechanisms become woven into the fabric of what is known, it is almost impossible in doing so, not to become a part of an established system that perpetuates these understandings.

CHAPTER 2

Endocrine Orchestra

The London School of Hygiene and Tropical Medicine (LSHTM) requires PhD candidates to navigate an upgrading process before permissions are provided to begin ethnographic fieldwork[10]. The upgrading process involves writing a document which communicates the who, the what, the where and the why of one's research to a selected board of assessors. After a public presentation has been undertaken, said assessors are able to ask questions before ultimately determining the future outcome of the research and strategy proposed – a yes, a no, or a "we think you might want to revisit your thinking on this one". The original intention of this research had been to undertake a multisited ethnography that 'followed' the hormone testosterone into numerous spaces and places, one of which was a private menopause clinic in which testosterone was prescribed to patients as part of their HRT treatment plan. The change in research direction, by which menopause in a holistic sense became the conceptual topic of interest, crystallised during the research process itself. Adopting a grounded theory position from the fore meant that the research direction was shaped by the ethnographic observations themselves. Thus, as concepts emerged, the research followed them. In the case of this research, it became clear that following testosterone in isolation would not prove plausible, as the hormone itself exists as part of the wider endocrine system (Fathi Najafi et al. 2016).

One of the best metaphors to call upon to exemplify this is the idea of the endocrine system being a little like an orchestra (Sengoopta 2006). We may think of the amygdala as the conductor – it keeps all of the orchestral sections in harmony. Woodwind, brass and percussion all need to be rhythmically attuned for the melody to be made distinguishable in the most appropriate manner. If a section sits in the wrong key, or the brass is missing, the music hits differently – it sits out of sorts. To call upon this metaphor in the context of the endocrine system, it became clear through the research process that you could not pull one hormone out and conceptually explore it in isolation. You could not consider it

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[10] To provide clarity, during the process in which ethnography occurs, researchers will refer to the places in which observations take place as 'fieldwork sites' (Van Maanan 2016). In tandem, they will discuss the active process of research as 'fieldwork' (ibid).

without factoring in the role of other hormones. In the same way Beethoven's 5th may be most associated with strings, without the supporting sections, without percussion or woodwind, the movement would simply not deliver to a listener the music we are moved by. Thus, in the context of menopause care, testosterone could not be adequately explored *without* thinking about the circumstances surrounding its use in their true complexity. Testosterone was a part, but it was the convalescence of multiple factors that may be understood as 'making menopause'.

In detailing the ways in which this research progressed, it is useful, and in keeping with a grounded theory approach, to explicate the process from inception. As such, the following chapter will detail the mechanisms by which this research developed and the methodological context from which this ethnography stems. It is worth noting that this chapter details a process as opposed to a product – it tells a research story as it unfolds. The means by which menopause was thought made in the context of the clinic and beyond will be revealed as a productive process – one in which conceptual imaginings were born out of a curious questioning which moved this research beyond its original remit of enquiring into the use of testosterone in isolation. Rather, it considers the interconnected context of the menopausal experience. It considers the movement in motion.

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Employing a fluid logic, the objective of this research was to explore, as explicated, how various articulations of testosterone may occur. It proposed resisting the desire to define testosterone in static terms, highlighting instead, how the hormone could be 'made' and 'remade' depending on the circumstances and interactive dynamics within which testosterone found itself situated.

Drawing inspiration from the kind of ethnography Annemarie Mol and John Law (1995) have undertaken, this approach considers how the environment and context within which a 'thing' exists can shape and reshape the way that it is characterised and understood. Often termed 'empirical ontology', such an approach positions the 'doings' of actors as essential to our understanding of a particular entity in question. It explores how the relational actions and interactions between both persons and 'thing' can bring specific expressions of said thing into being (Law 1994, 2004). When adopting an 'empirical ontological' framework exemplified by Mol and Law (although the general approach is grounded in Wittgenstein 1921), testosterone is understood as not existing materially in the same way from place to place. Rather, testosterone is 'made' depending on the interactive dynamics of the circumstances in which the hormone resides. When understood in this way, a bodybuilder using testosterone as part of their steroidal routine would be considered to experience the hormone differently to, say, a menopausal person using testosterone as part of their HRT treatment. This is not because testosterone is chemically *different* in either scenario, but because multiple competing factors contend within each environment to inform the way testosterone is perceived, understood, and experienced, thus co-constructing *that* testosterone uniquely in each setting.

Given this theoretical framework, four fieldwork sites were originally suggested as settings within which the 'making' of testosterone would be explored:

- A menopause clinic in which testosterone would be prescribed as part of a person's HRT treatment.
- A clinic in which testosterone was prescribed to treat persons diagnosed with Klinefelter syndrome or hypogonadism.[11]
- An online forum supporting those seeking treatment for low testosterone (predominantly men entering midlife and claiming to be experiencing 'andropause'). [12]
- A gym frequented by bodybuilders using testosterone (or an associated derivative) as part of their steroidal routine.

The feedback was unanimous; such an undertaking was simply too onerous for a lone PhD researcher. Indeed, the logistics of navigating four separate fieldwork sites, completing multiple ethics applications, and indeed navigating the dynamics of ethical practice when observing in online spaces was just too ambitious. Despite appreciating the rationality of this feedback from assessors, the decision to pick a single fieldwork site was ultimately disheartening. The

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[11] "Klinefelter syndrome (sometimes called Klinefelter's, KS or XXY) is where boysand men are born with an extra X chromosome" (NHS 2017).

[12] Andropause is best understood as the 'equivalent' to menopause for men. It is defined as a 'syndrome' that can cause a decrease in sexual satisfaction and desire or a decline in a feeling of well-being with low levels of testosterone considered to be the root cause of the issue. Andropause is a contested topic among clinical professionals and is often considered with a level of scepticism (Frith 2003, Nandy, Singh, Madhusoodanan, Sandhu 2008, Mayo Clinic 2022).

hope to demonstrate the temporality of testosterone, the impermanency of its character and the fluidity of its use seemed impossible to explore if *not* by comparing the way it manifested in differing contexts. In the process of reflecting upon this decision, however, it became apparent that all these factors could be explored in the same contextual environment. Whilst the use of testosterone may be administered in one setting in the hope of achieving the same outcome, it did not mean that multiplicities would not remain woven into a static space.

The decision to choose one space – to choose one fieldwork site – therefore needed to be made. Whilst all four of the originally proposed options offered something unique and interesting to examine, the thought of letting go of menopause, of not looking at the use of something so iconically 'male' in the treatment of women seemed a disservice to the field of both medical anthropology and gender studies. Not only did the use of testosterone within this environment speak of multiplicities, it also spoke of performance, and of change; both in the physical and conceptual sense. The opportunity to observe the inversion of a gendered entity, to explore how it was made sense of, administered, and conceptualised by those coming into contact with it, led as the deciding factor.

Meeting Menopause

The use of testosterone to help alleviate perimenopausal and menopausal symptoms was something discovered as opposed to known when this research initially began.

During the first year of this PhD, all of LSHTM's research students had been relocated to the Chinese Community Centre (CCC), as work was being undertaken at the Tavistock Place building where students were usually 'housed'. Whilst the consistent engagement in Thai Chi and endless games of Mahjong would become familiar, there were certain other activities that made engaging in 'rigorous' academic study a little more challenging. In the aftermath of Chinese New Year, there was a buzz in the building and loud excited conversations travelled through doors and across corridors, making quiet contemplation more challenging.

As a consequence of this, on one fateful February afternoon as procrastination peaked and the sound of paper mâché dogs being constructed could not be ignored, the search term ‘testosterone treatment’ was once again entered into Google.

As opposed to navigating straight to ‘news’ to read about relevant developments relating to testosterone use, filtering through the results from ‘all’ seemed a more fitting and arduous task to undertake that day. After navigating through multiple pages displaying images of cis men who had seemingly forgotten their shirts, a small landing page designed in pastel tones appeared. It contained some general information on treating perimenopause and menopause, under which prescribing testosterone as a means to help alleviate perimenopausal and menopausal symptoms was outlined.

Reading rapidly as multiple tabs were opened and search terms hastily entered, it became apparent that testosterone was indeed prescribed by menopause specialists as a treatment for alleviating specific perimenopausal and menopausal symptoms. Whilst PubMed seemed adamant that the use of the hormone should be specifically reserved for a condition termed ‘hypoactive sexual desire disorder’ (a descriptor so problematic an additional thesis would need to be undertaken to appropriately highlight our historic predilection for pathologising women’s libidos) the pastel page still open in a separate window communicated a different view.

Improvements to mood, concentration, energy, and libido were noted; however, terminology such as ‘in some cases’ accompanied these reports, implicating that testosterone was usually only administered following unresponsive or less-than satisfactory-responses to HRT that comprised of oestrogen and progesterone alone. At this stage of the research, the terminology and expansive references to hormones pooled out like a spider’s web – connected prismed cubes of chemical compounds that worked together yet functioned in isolation. It was confusing, yet increasingly seemed simple. Hormones were not isolated entities, they worked together, in the body and in treatment. In the case of menopause, it seemed, a careful weighted approach was required; some of one, a little of another – and in certain cases, the addition of something a little more ‘special’: testosterone.

At the point of this discovery, over 50 clinicians had been contacted regarding this research, each receiving a carefully worded and personally tailored overview of the project intentions. A variety of possible options for connecting has been proposed, along with a selection of dates and times to host a call or meet over coffee. Follow-ups had been sent, receptionists and PAs called. Out of the 50, a grand total of 0 had responded. To say the response was disheartening was an understatement. Remaining undeterred, however, one other email was drafted. Carefully entering a request for a meeting into the 'contact us' section of the pastel website, a message was sent at 5pm, with little expectation.

The little flash of light that appeared just after 10pm that evening didn't really require checking, but it seemed strange for a notification to appear that late. Unplugging the iPhone an email was opened:

Re: Enquiry from your Website

Lauren Redfern
To [redacted]

Retention Policy Staff mailbox default delete after 7 years (7 years)　Expires 19/02/2025

Wed 21/02/2018 14:40

From: [redacted]
Sent: Tuesday, February 20, 2018 10:05:39 PM
To: Lauren Redfern
Subject: Re: Enquiry from your Website

Dear Lauren

I am really interested! I prescribe testosterone very frequently in my menopause clinic to women and I am really shocked by how few women can get testosterone from their doctors and also how few healthcare professionals know about testosterone in women. I am involved with [redacted] writing some guidelines for testosterone use in women.

My diary is really crammed - how about 4.45pm next Thursday 1 March?

Best wishes

[redacted]

Dr [redacted]

Figure 5: Screenshot of email from Claire.

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At 4.45 on Thursday the 1st of March 2018, sat in the small meeting room on the top floor of the Chinese Community Centre, the phone number that had been sent across upon confirming the call was typed in. The phone rang twice before a voice rang through with authority. Immediately it was clear – Claire was driving, and Claire had forgotten we were scheduled to speak.

"Lauren! I'm on my way to pick up my daughter, tell me everything about your research".

Claire's voice was commanding, yet all at once pleasantly warm. She made you feel comfortable, she made you want to tell her "Everything about your research".

If there was a recording of that call, the comparison, vocally, would be stark. Stumbling over words and grasping for menopausal terminology, it was clear at this point in time the research proposed lacked clinical competency. Claire graciously accommodated the bumbling descriptive overview yet wasted no time. She explained the state of play of testosterone treatment in the UK as she saw it, highlighting why she felt there was a hesitation to prescribe testosterone to perimenopausal and menopausal patients. She also outlined her imminent plans to open her own menopause clinic in the autumn of that year.

> "I'm only consulting 2 days a week at the moment, but I still have so many women that are waiting to see me… we've found a building, and we are hoping to have it ready to open by October. You should come and do your research here when we open!"

At the point of discussion with Claire, the four-fieldwork site concept was still very much alive and well. The invitation to come and spend time in the clinic was also something that strengthened the decision to pursue this as a primary locale for the ethnographic research to take place.

The other front runner had been the clinic where treatment for hypogonadism would be administered. An invitation had also been extended to undertake research there, however the NHS ethics application was proving complex. It was further made difficult by the fact that patients diagnosed with Klinefelter syndrome would be considered vulnerable and thus their capacity to engage with the research with full cognisance of its implications was a point of contention, not only from a theoretical standpoint, but a personal one too. It sat heavily, and that dis-ease seemingly did not shift, it led to the decision to pursue the one fieldwork site: The Mansfield Health Menopause Clinic.

Ethical Environments

Before a full ethics application was submitted, it was important to visit the clinic and obtain a sense of the way it operated. A clear picture of who worked there, how many patients were seen each day, and other operational factors needed to be established before the full scope of what the research could look like could be finalised. Invited by Claire to observe a morning's worth of appointments (assuring her the observations would not be included in any findings presented in the thesis, as consent had not been obtained) the soon-to-be-familiar two-hour drive to Southampton was undertaken for the first time.

The clinic itself had been open for a little over two months at the time of that first visit. The clinic's staff was comprised of Claire, who was working full time at the clinic, five part-time practising consultants, two part-time receptionists that shared the role, two nurse practitioners, three admin assistants, a practice manager, and an operations manager. The team was competent and well managed. Every member of staff was friendly and genuinely seemed excited to be working at the clinic, and in so doing, contributing to improving access to care and support they deemed important.

It became clear that the goings-on of the clinic – the booking of appointments, the greeting of patients, the drawing of blood – were all important factors that contributed to the experience of care and treatment at Mansfield Health. Whilst lucky enough to observe engaging appointments that day, it was also fascinating to consider how the journey of treatment did not sit behind a locked consulting room door – it followed patients out of the room, down the stairs and into multiple environments (both physically and symbolically) in, and outside of the clinic. Claire graciously agreed that should the ethics application be accepted, and due diligence afforded to protecting anonymity with the full consent of patients, that she saw no reason why the research could not take place at the clinic – and extended an invitation to spend time in the clinic each week. Claire tasked Practice Manager Carys as the main point of contact to help 'timetable' the research. Carys helped map out the practicalities – when clinical observations could take place, when sitting in reception could occur, and so on.

When it came to submitting an ethics application, the research was identified as an ethnographic investigation, which would primarily involve 'participant observation', or, as it is more often and perhaps more appropriately referred to by anthropologists: 'hanging out' (Scheper-Hughes 2009a, 2009b; Van Maanan

2016; Cornwall 2018; Siem 2021; Hurst 2023). As opposed to other forms of qualitative research in which the exact and specific methods of 'data collection' are outlined prior to the research occurring (e.g. structured or semi structured interviews), ethnographic practices are more fluid. Participant observation does not include simply 'watching' the goings on. Rather, it includes a level of involvement: hence the word 'participant' is called upon. This is important to highlight, as within the method of participant observation, conversations and dialogue feature yet the structure is free moving. Whilst as anthropologists we may allow space and time in which a 'sit down' conversation akin to an interview may occur, care is taken to keep the interaction natural; as much as possible we attempt to capture the lived experiences of those participating in the research in a natural manner. The combination of both watching and talking allows for comparing and contrasting to occur – what did someone say and how was this actioned in their behaviour.

Since the reflexive turn in Anthropology, theorists have considered the impact their presence may have in shaping the research they are producing (Rabinow 1977; Ruby 1982; Clifford & Marcus 1986; Geertz 1990; Beher & Gordon 1996; Venkatesh 2013; Asch 2015; Singer & Baer 2018). As opposed to attempting to diminish one's presence as much as possible, anthropologists have accepted that involvement in the context of research will always have an impact and will likely implicate both the objectives and the outcomes of the research. In response to this acknowledgment, the discipline has considered how best to practice due diligence and to adequately appreciate how findings may ultimately be *made* specific in line with that individual researcher's unique involvement.

In the context of this research, the position held as a young white woman played a role that should be acknowledged. It both aided and complicated the research process in specific ways. The women who kindly shared the stories featured in the coming chapters seemed to feel connected via our shared identity as 'women', but equally in certain instances also to feel alienated due to the lack of contextual shared knowledge: they had been through menopause; I had not. Whilst in some instances this proved frustrating (a sense of 'you could never understand' was certainly communicated), it was important to hold that space with compassion and to fully appreciate that they were correct: I had not. Equally and in tandem, concern surrounding sharing their experiences was subtly communicated in other ways. The context of ageing and the vulnerability involved in expressing those feelings around an individual who was younger was at times palpable; whilst sisterhood is something we should all strive to achieve, sociocultural conceptions often present younger women as a ‘threat’, and echoes of this could be felt in the context of this ethnographic investigation. However despite this, the impact which positionality had on the research is celebrated, as it is thought that the unique markers of difference are a part of what aided in producing this thesis.

Ultimately, my research sought to allow women “the freedom to talk and ascribe [their own] meanings” (Noaks and Wincup 2006: 80). This approach developed both the line of questioning and the analysis. While this approach has been argued to “raise thorny problems of verification” (Clifford 1986: 25), I still feel it to be the most appropriate means of investigation. Anthropology can surely only ever seek to present a partial view of the reality explored (Clifford 1986; Denzin 2009; Silverman 2011). This does not refute the validity of findings, but rather gestures toward the potential fractionality that exists in *all* research. Analysis presented is therefore understood always to reflect the content that resonated most profoundly with myself - the researcher (Van Maanen 2011). The stories presented in the subsequent chapters represent the themes I as the researcher found to be most pertinent. Adopting an approach such as that which has been outlined recognises that a different researcher could have contributed knowledge which reflected different social histories within the same exploration. Thus, I adopt an understanding that identifies ethnography as functioning more as “true fiction” (Ghosh & Staankiewicz 2012) than as positivist reality – it is this position which frames the discussion.

Having outlined the methodological approach, confirming that participant observation entails so much more than voyeurism, we may return to the context of the ethics approval.

The following format for research was suggested and subsequently approved:

- ➢ Participant observation of clinical appointments with patients. A condition to this included obtaining verbal consent prior to the appointment from any patient that was to be observed, along with the assurance anonymity would be upheld.

- No discerning identifiers would be included in the writing-up of research, and the patient's identities in the research would be kept anonymous.
- Participant observations in the reception area of the clinic.
- Participant observations in the phlebotomy suite.
- Participant observations and assistance to the admin team in the administration office.
- Participant observation in common areas of the clinic including observations at relevant non-patient centred events held at Mansfield Health.

During my fieldwork practical methods such as taking notes during observations were employed, but only in instances where it did not detract from the interaction. The image of a researcher holding a notebook should visually communicate *why* the action of scribbling onto paper during a clinical consultation could be disconcerting to those that are participating in the research. Thus, notes were predominantly written at the end of the day and summarised what had been observed. These notes formed the basis of much of the analysis that was developed in subsequent chapters.

The scope of the research was verbally communicated to patients and options to participate beyond the remit of observation were also offered. As a means to streamline the explanation process to those interested in participating in the research, and to provide greater insight into the research intentions, along with an assurance of legitimacy, a website was built.

The website laurenredfernwrites.com offered participants insight into what the research was attempting to achieve, alongside options to submit queries and feedback regarding their own experiences; all whilst maintaining anonymity.

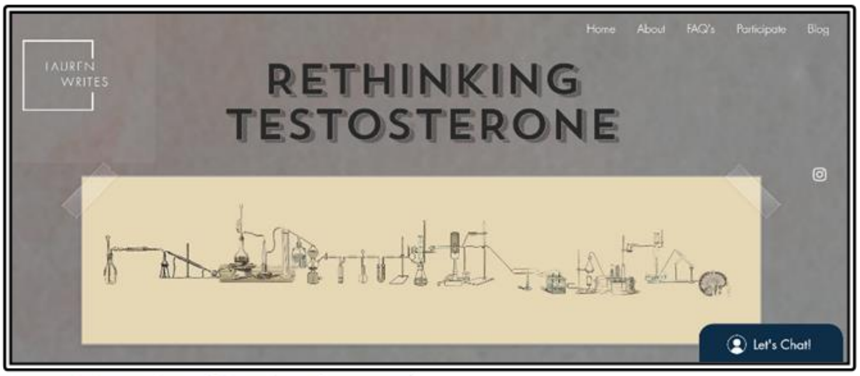


Figure 6: Screenshot of the website homepage

When selecting the ‘about’ tab, on the website, participants would be presented with two options:

1. Information about the research.
2. Information about the researcher.

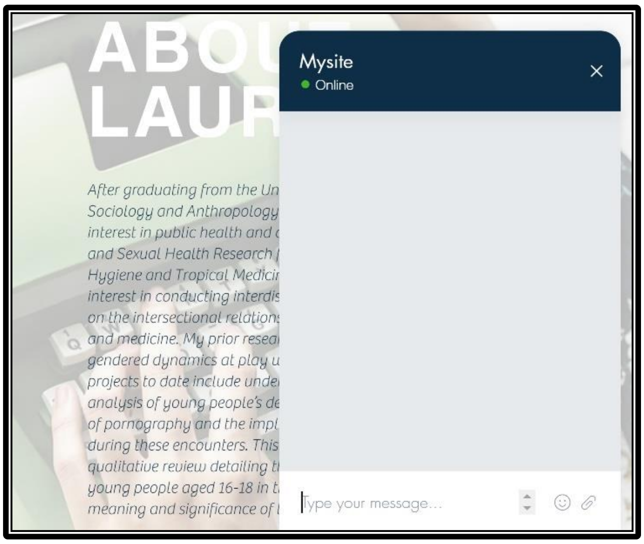
A ‘Frequently Asked Questions’ page was created that addressed questions that may be raised regarding what participation in the research would look like. Three topical points were listed, and the following descriptions were provided:

1. Anonymity: “If you decide to take part in this research all your information will remain anonymous. That means that no identifiable aspects of your life (like your name, date of birth, job, or other important characteristics) will be shared or detailed in the research.”

2. Why Participate: “Stories about health are important. They help us to understand more about people's experiences of accessing services, creating research that could provide suggestions for how care could be improved upon.”

3. What’s Involved: “Words like participation can sound quite daunting, but they shouldn't! Taking part would simply involve getting together to have a chat about your experiences. You can choose what we talk about and can also change your mind about being involved at any time.”

Under each of these subheadings a 'learn more' tab was included. When clicking on this tab, the user was directed to the LSHTM home page. This decision to include this 'link' was made as it was felt that it served as a mechanism to instil confidence in the user that the research was associated with a credible institution, well known for facilitating leading research in the public health field. The rationale for adopting the friendly and engaged writing style was two-fold. Firstly, it attempted to humanise the research process and explicate the style of anthropological engagement as somewhat informal. Further, it attempted to position the research as collaborative in nature, something designed to capture the individual unique experience of any participant without performance or bravado. Secondly, it sought to reassure by informing participants about the control that they could exercise over the process. The intention was to create an even playing field from the start: an environment where researcher and participant were active agents in the same process, one that was as devoid of researcher/researched power dynamics as possible. The intention, in employing accessible language therefore, served to create an experience of neutral weighting regarding who leads and who is led in communication. A dynamic that is validating, mutually respectful and conscious. (Finkelstien 2008)

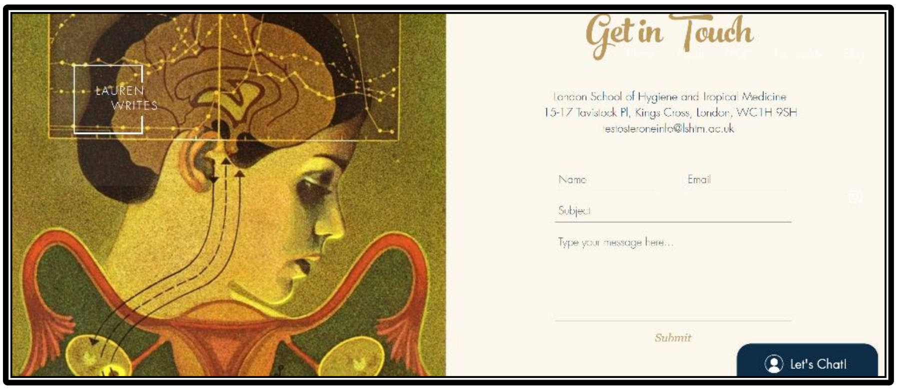


After graduating from the Un
Sociology and Anthropology
interest in public health and c
and Sexual Health Research (
Hygiene and Tropical Medicir
interest in conducting interdis
on the intersectional relation
and medicine. My prior resea
gendered dynamics at play u
projects to date include unde
analysis of young people's de
of pornography and the impl
during these encounters. This
qualitative review detailing th
young people aged 16-18 in t
meaning and significance of t

Figure 7: Screenshot of the option to send a direct message via the website.

The intention of this research had always been to strip back engagement to something vulnerable and raw. The hope in doing so was that an individual's lived experience – one that exists as closely to a core sense of 'real' – could be captured. Of course, this is understood as an endeavour that will always exist in conversation with the positionality of the researcher within the interaction. This facet of the interaction between researcher and participant is one that will be expanded upon in due course.

The opportunity to make contact was provided in a number of different ways. It was offered when at the clinic to patients if they enquired via the direction to the website built. As can be seen from the image of the homepage, a 'let's chat' option was available in every section of the website. When selecting the 'let's chat' option, a user could enter a question or make contact directly. This provided the opportunity for direct messaging to occur – meaning that, if the website was open, a message could be read and responded to immediately. It was an informal option and allowed the user to engage in (as the language suggests) chat, as opposed to formal enquiry.



Get in Touch

London School of Hygiene and Tropical Medicine
15-17 Tavistock Pl, Kings Cross, London, WC1H 9SH
testosteroneinfo@lshtm.ac.uk

Figure 8: Screenshot of the 'Get in Touch' form on the website.

Alongside this, a 'Participate' tab was created that led users to a formal 'get in touch' segment. This option allowed for an email-style enquiry to be made and indeed proved the most popular method of contact over the course of the research. It was designed so that an individual navigating the site could express interest in participation and consciously submit their contact information so discussions regarding the research could begin.

The final option for contact included a means for digital participation that incurred no follow-up and no engagement beyond the submission of an individual's thoughts.
The segment of the website titled 'your thoughts' activated an option to participate when an individual hovered over the box. Upon doing so, the option to submit feedback to the query: "how would you describe testosterone? A word? A sentence? A short paragraph? Submit your thoughts below" was offered.

YOUR THOUGHTS

How would you describe testosterone? A word? a sentence? a short paragraph? Submit bellow!

Figure 9: Screenshot of the 'my thoughts' option provided where people could submit a response the question 'how would you describe testosterone?

All contact made via the website was housed on a secure platform that required a two-step verification process. In order to log in to see any messages, a password would need to be entered, triggering a unique passcode to be sent to the registered mobile device. After entering this, access was given to the website hosting platform and all messages could be reviewed and responded to. It also contained statistics regarding the performance of the website – for example, how many times a day it was being viewed or accessed, the times of day it was being viewed most, and so on. An Instagram account was also embedded and linked on the website. The account documented the research process and offered the additional opportunity to keep up to date with relevant developments pertaining to the perimenopausal and menopausal landscape; an environment that continued to grow exponentially over the course of the research. Equally, during the period in which the research was undertaken, social media became an environment in which the 'community' associated with perimenopause and menopause become outwardly active and engaged.

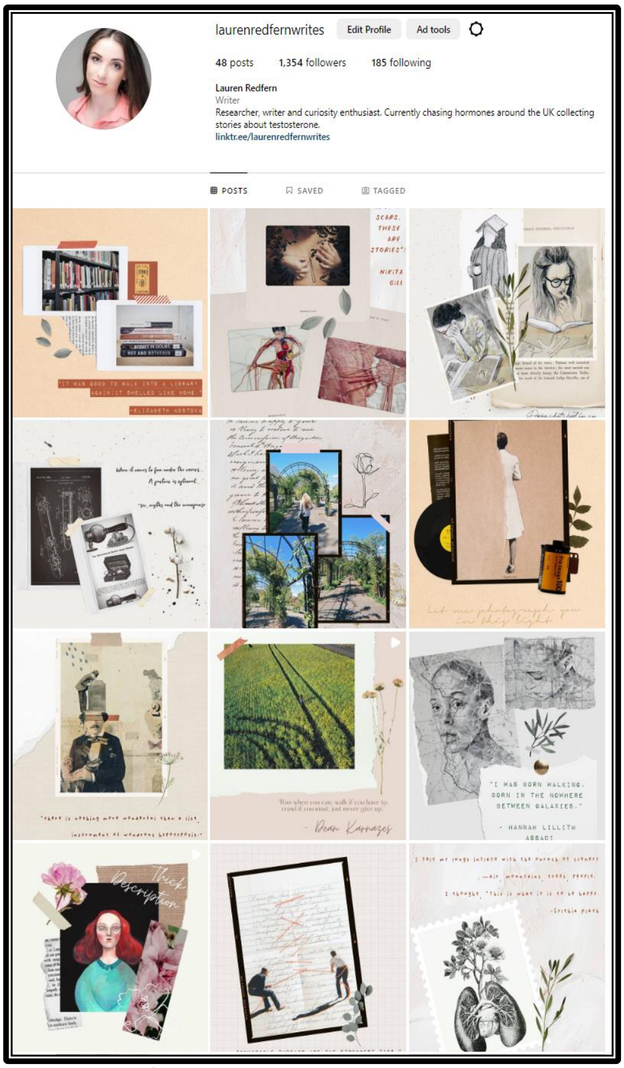

laurenredfernwrites
48 posts 1,354 followers 185 following
Lauren Redfern
Writer
Researcher, writer and curiosity enthusiast. Currently chasing hormones around the UK collecting stories about testosterone.
linktr.ee/laurenredfernwrites

Figure 10: Image of Instagram project page.

The word 'community' is used to refer to both clinicians, associated 'professionals' operating in the arena of perimenopausal and menopausal care, and patients/others impacted by perimenopause and menopause. Instagram in particular operated as a space that provided a platform for leading figures (such as Claire) to be recognised and promoted, and equally as an environment in which debate could occur. The sharing of views and experiences took place in a publicly visible manner (predominantly through commenting on posts or posting individually), and this mechanism of engagement allowed commentary regarding particular developments in menopausal care or treatment to be explored in a temporally immediate manner. A news article would break, a post would be published, and immediately thousands of comments representing different viewpoints would appear.

Multiple 'debates' would also occur in the comments section, and this was an important space to 'observe' during the research, as it allowed coinciding opinions regarding the same idea or concept to be explored in real time.

Use of social media will be explored in more depth in the later part of this thesis, but it is useful to note its presence and importance as a research 'space' in and of itself. Notable theorists have commented upon the ethical challenges that are raised in deciding to observe in online spaces. In particular, the concepts of anonymity and coercion are central. If you are observing in online or digital spaces, it has been queried as to whether you should be clear and forthcoming in your intentions when interacting with anyone. For example, should a person engage in dialogue where the ethical argument would suggest an immediate disclosure should be made – an 'I just want to let you know I am conducting research and whilst I will not use any identifiers, anything you communicate to me in this context may end up in the research I produce' would be necessary.

Fundamentally these questions are not straightforward to resolve. Digital ethnographies such as *Coming of Age in Second Life* by Tom Boellstorff (2008) opened up considerations as to the contexts in which anthropological research *can* take place, but equally, they also raised concerns surrounding appropriate ethical conduct in these environments and this may always remain a point of contention within the academic community. This largely relates to the ways in which concepts essential to the anthropological process such as positionality, disclosure and accountability (Jacobs-Huey 2002, Massoud 2022) are more difficult to navigate in digital environments. Whilst some may argue that the digital offers benefits, such as it providing a greater level of distance between researcher and researched, thus promoting increased impartiality; the flip side to this perspective would be that any sense of responsibility to the research subject also slips.

Just as we may observe behaviours such as ghosting, simmering, icing, and breadcrumbing becoming common place in the digital age (M, S. 2021), where the ability to 'disappear' without a physical confrontation has become the norm over empathic engagement; the same risk may be posed for digital researchers. There is no possibility for in-person confrontation, questioning or concern – nor any opportunity for a messy research breakup that implicates the boundaries of what will and will not be explored in a research context. For these reasons, the online space is often positioned as an ambiguous context where the ethics of accountability remain unclear. Discussions of risk and responsibility, of ethics and principle, are of particular importance when the subject matter of one's research involves observing health-related behaviours in an online space. The aforementioned Boellstorff's ethnography revealed stories of love, of fantasy and of private desire amongst a community of persons *choosing* to exist, for a great portion of their time, in a virtual reality. Whilst the desire documented may be observed as vulnerable, the persons involved in the research are, from a health-related perspective, not high risk.

Yet there have been instances in which highly vulnerable groups are ethnographically observed online and the concept of risk and responsibility sits heavily when reflecting upon the position of the researcher in such an environment. Fox, Ward and O'Rourke's ethnographic exploration into pro-anorexia and anti-recovery forums in 2005, for example, pushes the parameters of responsibility. Collecting data from the pro anorexia forum 'Annagrrl', the authors explore how the maintenance of a low body weight is complexly navigated by participants and how the actions (or lack of action) of users subscribing to the forum challenges disease models that pathologise and problematise eating disorders.

From a theoretical perspective the research is fascinating. From an ethical perspective, it is exceptionally concerning. The authors note participants disclosing suicidal ideation, the use of non-prescription medication, and engagement in self-harm practices. Using the foundations of anthropological ethics, the case is inadvertently made that it is not the place for the researcher to care for the participant. However, in the context of research such as this, where you are engaging with a highly vulnerable group of at-risk persons, should extended mechanisms for safeguarding and onward referral not be incorporated into any research proposal or design?

Of course, since 2005, other ethnographic studies into 'risky' online spaces have been undertaken with a more rigorous approach to the ethics of care, which highlights the ability to conduct research in these environments consciously (Fox 2021, Huang, Cadwell & Sasamoto 2023). Yet, for this research (and in considering the place of online behaviours in the collation of accounts) caution was exercised. Contact made online via the website was kept to a minimal level. Should participants express interest in getting involved with the research arrangements would be made to have a phone call or to meet in person, where possible. In some instances, contact was made in such a way that long accounts of an individual's experience of care was provided without request. For example, when enquiries were submitted under the 'Get in Touch' form on the website, the message portion would often include a few hundred words detailing specific struggles. In the context of the research, no contact was initiated that revealed troubling findings (such as suicidal ideation) upon receipt of an enquiry to participate. However, safeguarding mechanisms had been developed and included in the research planning to account for this.

There were instances in which, following engaged contact (informal conversations and observation), concerns regarding mental health were raised by those participating in the research. Countless persons over the course of this fieldwork expressed having experienced suicidal ideation at some point in their perimenopausal or menopausal journey. In the context of this question being posited by a clinician, observations demonstrated that the clinician **always** followed up to ensure no participant was feeling that way at the point of engagement. In instances where no clinician was present (e.g., during one-to-one meetings with those that had made contact via the website) a number of probing questions were posited to ensure that any feelings of mental distress were being managed by a clinician, and equally, were not present while participants were engaging with the research. Equally in instances where any mention of prior mental health concerns had been raised, support services were subsequently references at the end of the call. For example, "if you do start to feel worried or isolated again, you should think about reaching out to your GP or calling a service like Samaritans, I'll send some more information over in an email when we finish the call if you like".

Whilst this cautioning may seem exaggerated, and one may not consider the perimenopausal or menopausal demographic to be 'high risk' in comparison to, say, a community of persons struggling with an eating disorder, we are becoming increasingly aware of the impact symptoms of perimenopause and menopause can have over one's mental health. Indeed, during the course of this research, one patient that was on the waiting list for an appointment at the clinic did, sadly, take her own life. Her husband, upon cancelling the appointment, was adamant that he felt the decline in her mental health was strongly correlated to the onset of her perimenopausal symptoms. This serves as a desperately tragic reminder that, when operating in any health-related contexts, appropriate measures beyond the anthropological forms of engagement must also be considered to practically protect the rights of those engaging with the research.

With all of this in mind, the decision was made to use Instagram *only* as an observation method. Any contact initiated on the platform regarding the research was carefully managed. Those who expressed interest in taking part in the research were immediately directed to the website and asked to review the information and make contact 'formally' if they still wanted to participate. Information and a link to the website was also provided in a 'link tree' connected to the Instagram account.

The term 'observation' on Instagram refers to reading public posts or responses to comments. No specific information was sourced, nor were participants actively 'recruited' or approached. Any contact made regarding the research was done by the person interested in participating. The decision to observe in a digital space ultimately related to the fact that the community grew at an unprecedented and exponential rate. It seemed vital to spend time considering what it was about the social media platform that engaged perimenopausal and menopausal persons in such an involved manner.

The website took a number of months to build, but it was important that is was an established domain when fieldwork began. It ensured that those being observed in the clinic had a source of information to refer to *and* a means of contact should there be any questions regarding the observations (including the ability to retract permissions to include any observations that had occurred). The website also offered the opportunity for persons that were *not* patients of Mansfield Health to get in touch about participating. This was very important as a consistent point of contention to consider regarding the research findings included the feedback was that it only represented one perspective – that of a demographic with enough financial capital to pay to seek private treatment for their symptoms. Whilst (and as shall be expanded in the coming chapters) this assertion was challenged through observations that highlighted a much broader demographic of patient than may be assumed, it was still useful to engage persons solely seeking their treatment via an NHS General Practitioner (GP) or another affiliated clinician.

The ethics application submitted was vigorous and specific in its conditions. Mansfield Health would be the primary fieldwork site, but employing snowball sampling was also approved. This methodological tool allows for 'referrals' or non-immediate parties (e.g., a clinician or patient at Mansfield Health) to participate. They may have learned about the research from someone who took part, or independently come across it (e.g., through a google search) and wished to take part. Thus, the parameters of the research expanded beyond the remit of the clinic to include contact made in the digital domain. Additionally, observations were carried out at medical conferences where interactions between clinicians were able to be observed and the latest trends and concepts surrounding perimenopausal and menopausal health were able to be considered. Equally, in relation to interest in hormones and perceptions of them, conferences afforded the opportunity to consider how hormonal treatments were perceived and marketed by pharmaceutical companies. The EMAS conference that took place in Berlin is noted of particular importance and forms the staging for Chapter 5 of this thesis as a wide range of pharmaceutical companies were in attendance promoting a variety of hormonal products and other affiliated 'treatment' options for assisting with perimenopausal and menopausal health issues (such as vulvovaginal laser for vaginal atrophy).

The final arena of observation that this research explored was that of the press and media. Whilst all researchers will, during the course of any investigation, pay attention to coverage as it pertains to their topic of enquiry in the press, it's rare for that investigation to become a noted 'front runner' in every form of media you come across on almost a daily basis. When fieldwork began in 2018, menopause was becoming a topical talking point, conversations regarding the use of HRT were increasing, and some attention was afforded to this in the media. Now, in 2023, at the point of this thesis being submitted, menopause has rocked parliament, been the subject of Channel 4 documentaries and become a focus in every major newsroom Great Britain has to offer. Thus, it has been impossible *not* to include the conceptual imaginings of menopause in the mainstream (Bluteau 2019). In keeping with Harraway's approach, it was important to 'stay with the trouble' (Harraway 2010).

The parameters of locale in which this research took place, and the remit of engagement is summarised as follows:

- Participant observations of clinical appointments in the Mansfield Health Menopause Clinic between patient and doctor.
- Participant observations in public and private areas of the Mansfield Health Menopause Clinic (such as the reception, admin office etc.).
- Participant observations of staff completing their day-to-day activities (both clinical and non-clinical in the Mansfield Health Menopause Clinic).
- Participant observations of workshops and other relevant events organised and hosted by Mansfield Health (e.g. menopause 101, as led by a nurse practitioner).
- Participant observations at medical conferences, both in the UK and internationally.
- Informal conversations with staff members and patients of the Mansfield Health Menopause clinic about perimenopause, menopause, the use of HRT, and the use of testosterone as part of an HRT regime.
- Informal conversations with persons that made contact via the website built for the purpose of carrying out this research.
- Informal conversations with professionals working in the field of perimenopause and menopause or hormonal health more broadly. Contact was usually made and followed up after attending medical conferences.
- Observations of public engagement and commenting on social media platforms such as Instagram, where topical debate regarding perimenopause and menopause took place.

- Analysis of and commentary on coverage of perimenopause and menopause in popular culture. This included but was not limited to engagement through television, journalism, and the marketing of particular products or brands targeting perimenopausal and menopausal health.

The majority of this ethnographic research was carried out over the span of one year, during which observations at The Mansfield Health Menopause clinic took place twice a week (bar prior engagements such as holidays). When combined with attendance of conferences and other relevant events, thousands of hours of fieldwork were completed over the course of that year. Hundreds of different individuals have contributed to the findings presented in this thesis, and the observations and conversations detailed in the following chapters represent just *some* of the extensive experiences that took place.

A conservative estimate would suggest at least 130 appointments were witnessed over the course of this research. This does not include informal conversations with patients in communal spaces in Birchwood House, nor observations of blood test appointments. If these numbers were also included, a realistic figure would suggest approximately 300 women participated in this research *directly* at Birchwood House. As hundreds of letters were also proofread during field work, it is suggested that many women *indirectly* participated in the research too. At least 500 patient letters (which included rationale's for visiting Mansfield Health) were examined and proved contextually foundational to this research.

There were 45 contacts made via the website designed for this research and a further 36 contacts established through social media channels. Of these, 32 women agreed to take part in informal conversations about their menopausal experience.

17 professionals also participated in this research. The term 'professional' is used as a broad descriptor to refer to persons involved in the care of patients at Mansfield Health. Observations from the EMAS conference in Berlin are presented in Chapter 5. These descriptions include details of conversations held between a number of clinical and pharmaceutical professionals. Engagement at

the conference is central to the development of analysis in Chapter 5, however these interactions are not included in the table below. This is because the interactions were spatially and temporally relational to the context of the conference. The category ‘professional engagement’ is thus used to refer to persons that I *consistently* interacted with throughout the research process.
The table below provides a breakdown of the estimated number of consistent participants that contributed to the research presented in this thesis.

Method of Engagement	**Number of Persons**
Patient Appointments	130
General Engagement	170
Clinic Letters	500
Website Contact	18
Social Media Contact	14
Professional Engagement	17
Total number of Persons	**849**

In sharing their stories (both directly and indirectly) a total of **849** people have supported the development of the analysis undertaken in this thesis. Countless others have shaped the foundations upon which a critical exploration of the menopausal ‘space’ was able to be undertaken.

It may be noted that the anonymity of all those that participated (including the name of the clinic under observation and lead practitioner) have been anonymised and that pseudonyms are adopted for all persons that feature (patients, staff members and clinicians). However, due to the rise in notoriety of menopause in the mainstream the process of ensuring anonymity has been made more complex. It has, as such been untenable to guarantee the complete concealing of the identity of the research site and the founding clinician as it features as a central part of the research itself. Thus, while every effort has been made to maintain anonymity, it is within the realms of possibility that this may not be possible upon reading the surrounding context explored in this thesis. As a mechanism to support the protection of those taking part in the research, observations, conversations and experiences have been amalgamated in order to provide a realistic overview that reveals no one specific lived experience. This translates to mean that singular observations as detailed in chapters are in fact integrated accounts (composite narratives) informed by the hundreds of appointments witnessed (Piper & Sikes 2010; Wertz et al. 2011; Taber 2013; Biglino et al 2017; Willis 2019; McElhinney & Kennedy 2021; Creese et al. 202; Johnston et al. 2021). Whilst it is easy enough to dismiss this methodological approach and critique the findings as unreliable or lacking in rigour, given the context and circumstances as they played out, the decision to adopt such an approach was considered to be the most viable in order to protect the anonymity of those involved as much as possible while public profiles grew.

Thus, returning to our abstract, did the research hit the jackpot and bet on the right horse? 'The extent to which this is true – the ramifications for this research to elucidate the conceptualization of menopause and the role that testosterone plays – will be explored and explained.

Issues of Temporality and Inclusivity

Returning to the context of the upgrading, where four fieldwork sites were initially proposed, one can see – considering the expansive terrain that was involved in pursuing a 'singular' fieldwork site – the rationale for the recommendation to limit the number of spaces and places in which the following of testosterone would occur. Whilst the focus of the thesis may have begun as an exploration into the perceptions of testosterone by those using it as part of their HRT treatment, and by those prescribing it or coming into contact with it in a professionally capacity, direction shifted. Perimenopause and menopause as explicated at the beginning of this chapter in the broad sense became the subject of the research discourse instead.

One of the central challenges to acknowledge is the issue of temporality encountered. As perimenopause and menopause has exploded into mainstream discourse, perceptions, and understandings of it have shifted and become subject to greater scrutiny. Thus, whilst engaging from a conceptually developmental perspective, it makes 'fixing' the research in the traditional anthropological sense more complex. Whilst the nature of the research has always intended to be fluid and to 'stay with the trouble' (Haraway 2010), one element that can be observed in the context of perimenopause and menopause is how it continues to play out differently day by day on an ever-expanding and changing landscape. As the subject matter remains in perpetual motion and development, the exploration and its parameters have evolved significantly over the course of the research.

With this in mind, it is important to acknowledge that the fieldwork findings that inform large parts of the conceptual explorations of this thesis represent a phenomenon at a specific point in time – a point in time that is predominantly pre-pandemic. This is important to highlight as *centrally* important to the clinical observations. Before the pandemic, all appointments would take place at the clinic in person., post-pandemic, most patients that have an appointment at Mansfield Health will attend their consultation remotely. This has led to an extensive expansion in which Mansfield Health has managed to acquire a greater number of consulting physicians and expand its reach geographically. Equally, assertions are made throughout this thesis that highlight the importance of in-person contact and interaction as central to the experience of treatment and care. Whilst this position is legitimate, it is important to note that this is found to exist in contradiction with the current consulting structure that has largely shifted to online appointments. Thus, considerations of the analysis must appreciate the context of the research to reflect a largely pre-pandemic circumstance.

Equally, the occurrence of COVID 19 had a significant impact on the ability to have important follow-up conversations and to wrap up fieldwork in the way the research usually requires. A complete stop occurred as a result of not being able to attend the clinic in person, and clinicians and patients largely disengaged from the follow-up stages of fieldwork due to the impact the pandemic was having over every facet of their daily lives – prioritising a call to discuss their perimenopause and menopause or the prescribing of testosterone for symptoms seemed of waning importance in the midst of family members and friends being hospitalised as a consequence of a condition that was not yet understood.

As a result, a decision was made to take an interruption of studies (something that also related to the significant decline experienced in my own mental health as well). Thus, it is acknowledged that the period in which the research took place conceptually extends beyond much of the fieldwork experiences that are documented. For example, reference to the 'Davina Effect' – in which many more women began taking HRT following the airing of a documentary about the effects of perimenopause and menopause – are included, as it occurred during the writing-up stage of the research (Craig 2022; Harris 2022; Khan 2022; Donnelly 2023; Griffin 2023. The relevance of this research is thus and has been stressed understood as temporally specific. Even in a few years from now, much of the relevance of the exploration will need to be placed in contrast to developments in the care and treatment of perimenopause and menopause. For example, one temporal factor we must consider that may have led to the expansion of conversations surrounding perimenopause and menopause *is* the context of the pandemic. During COVID19 Claire was vocal in highlighting the importance of the role oestrogen had in immune response. This interest was echoed by other professionals who were seeing the impact of long COVID exponentially effecting women in perimenopause and menopause who had *not* used HRT and men *more* than women using HRT and younger cohorts. As oestrogen has a central role in immune response it was stressed that those with lower levels may be suffering more intensely with COVID and recovery from symptoms than those with higher levels of oestrogen. Thus the context from which conversations grew is multiple and evolving.

Despite all of this and the reference to the research only representing a singular point in time, the relevance is maintained as exceptionally important. It captures the understandings and experiences of those teetering on the precipice of a health-related explosion before it occurred. It provides insight into the factors that led to an uptake in treatment and equally sheds lights on what may have shifted the discourse to the mainstream in such a significant way.

It is finally essential to acknowledge the fact that accounts presented in this PhD thesis represent a subsection of a wider population of persons. Though every attempt has been made to diversify the voices represented (e.g. by allowing those not attending or seeking care through a private physician to make contact through the public website) the research is not diverse in its representation and thus cannot claim to show a representative en-masse account of the navigation of perimenopause and menopause in the UK today. Essential to note is that physicians are not the only actors within the history of medicine or indeed menopause. All too often, we find ourselves within the context of academia ‘doing’ history from a perspective that elevates the experience of the clinician. This tendency can render the patient as subject to a clinical gaze as opposed to an active and contributing part of the medical process. In recognising the menopausal woman as an agent rather than a participating pawn, this thesis considers women's choices in tandem with the acknowledgment of the social pressures that may implicate her decisions. For example, if a woman decides to use HRT, her rationale (as will be expanded upon) may be manifold. She may in doing so hope to relieve her vasomotor symptoms or to protect against future adverse health outcomes; the decision itself may appear the same, but her motivations ultimately will differ. In writing about agency therefore, there are multiple considerations that we need to remain aware of. In the context of "choice" we must remind ourselves that a woman is not a passive participant, rather she is an active agent.

To return to the beginning of this chapter it is reiterated that containing testosterone in a singular space proved implausible. As has been stressed, the body and the hormones within it (and being administered to it) are fluid. They increase and decrease. They can be injected, swallowed, absorbed, or stuck on. Even when administered via a prescription *in* the clinic, they travel to homes, workplaces, dates, and social events. They are constantly on the move. Thus, the original intention, the want to 'follow' testosterone to different spaces and places *was* delivered, but it could not be done without thinking about menopause in the wider context. The decision to consider the experience and perception of menopause beyond the remit of the clinic has proved important in relation to this, as it allowed comparisons to be drawn regarding whether different 'versions' of hormones and their use could occur in different ways in separate spaces and places, even in circumstances where they were being administered for the same reason (perimenopausal and menopausal symptoms). Ultimately, was menopause the same in every space and place, or – as alluded to at the beginning of this chapter – was it made in relation to the contexts and circumstances it found itself within. Fundamentally, hormones became a mechanism by which to trace a complex and expansive network of actors (both material and symbolic). In this sense, hormones, (and testosterone in particular) were of central importance, but were not, by the end of this research process, considered more important than the person that was prescribed them. Unlike traditional STS accounts (Appadurai 1986; Latour 1999, 2000; Law & Mol 1995, 2001; Singleton 2005), hormones are not foregrounded as central in each ethnographic experience, but rather, a mechanism by which to trace the universality or disjuncture of said experiences as they relate to navigating perimenopausal and menopausal care in the UK. This includes both practical and symbolic understandings of care (e.g. the physical attending of appointments and the internal navigation of concepts relating to invisibility, aging etc.).

Thus, in concluding this discussion it is stressed once more that the move to consider perimenopause and menopause in holistic terms was a natural occurrence, as, in following testosterone it became implausible *not* to consider the associations with other hormones, and with other factors involved in the making of perimenopause and menopause. We needed to listen to the movement as intended – with all the sections of the endocrine orchestra.

CHAPTER 3

The Clinic

"The concept of space for which I want to argue is one that holds that space is open and dynamic. That is ... 'space' cannot be a closed system: it is not stasis, it is not defined negatively as an absence of temporality, it is not the classic 'slice through time'. Indeed, the closed-system/slice-through-time imagination of space denies the possibility of a real temporality - for there is no mechanism for moving from one slice to the next. Rather the spatiality that I envisage [is] open…constantly in the process of being made ..."

(Massey 1999: 264)

The following chapter considers the ways in which the physical space of the clinic formed an essential part of patient care at Mansfield Health. Conceiving of the construction of the building, the furnishings within it, and the positioning of both clinical and lifestyle objects in the space as critical, this chapter contends that it is the 'non-clinical' spatial configuration that helps to 'make' menopause unique in the context of Mansfield Health. Use of the space is outlined as implicating a patient's experience of their menopause journey, with the clinic layout positioned as critically important in the navigation of patient care. In particular, the clinic is explored as 'spatially split', with choices (whether subconscious or conscious) made that speak to how to 'do' menopausal care properly in the context of the clinic. The fusion of material objects that are both clinical and non-clinical in the environment is examined as important in reframing conceptions of the individual's 'need' for treatment, with space ultimately understood as a factor informing how menopause was managed by clinicians.

We begin with a 'tour' of Birchwood House (the clinic), which attempts to provide a tactile overview of the environment, how it is laid out, and the supposed function of the space in providing a form of patient care. Analysis is peppered throughout, but a more comprehensive engagement with the theme of space in the context of the clinic is undertaken as the chapter moves toward a discussion of how space is critical in the navigation of menopausal treatment at Mansfield Health.

Birchwood House

Set back from the main road, Mansfield Health Menopause Clinic is detached from the adjacent businesses to the left and right. The property's architectural style is striking. Departing from the half-timbred Jacobean buildings in the near vicinity, Birchwood House is a large, white, two-story Georgian-style townhouse with neat, wide panelled windows and a pillared entrance. The columns surrounding the entrance were painted a deep blue grey. The choice of colour modernised the architecture and drew attention toward the front door.

Figure 11: Personal photo taken of the outside of the clinic.

Prior to Birchwood House's conversion into a 'menopause and wellbeing centre' in 2018, the property acted as a registry office for the local council; a backdrop for couples to say 'I do'. In front of Birchwood House was an accessible ramp flanked by a curved stainless-steel rail. Enclosed by the railing was a small planting bed with green shrubbery and a neat white sign. In tidy pastel lettering, the name of the clinic was spelled out. On warmer days, the building's facility manager, Alison, could be found replanting and tending to the small bed of greenery. The little collection of plants was observed over the coming months to serve as a postage-stamp-sized public garden for the local community. The small bench in front of the building was used by passers-by. Patients departing from appointments took a seat to make phone calls or send messages. Accompanying partners who had chosen not to venture into the clinic could also be found frequenting the bench too. Birchwood house, thus, is woven into the fabric of the community.

From the foot of the steps, the wide front door and large brushed silver handle were just visible. The handle did not turn; the door must be pushed open.

Weighty, this action required effort. Multiple miscalculations regarding the appropriate force would be made over the coming year.

Figure 12: Personal picture of the entrance hall in the clinic.

Entering the clinic, a water cooler was visible. It was positioned underneath the curvature of an ornate sweeping staircase. The stairs are an important feature of the clinic; they punctuate the space. In the centre of the hallway leading into the clinic’s reception and directly in front of the staircase was a table. Items on the table were changed regularly. Books were displayed, as well as fanned-out glossy information leaflets. Reed diffusers and candles were also interchangeably included in the table display. Positioned in the centre of the table was a colourful floral arrangement. Like the rotating items on the table, the flowers remained a clinic constant, with the display varying in vibrancy.

Directly opposite this table lies a door leading to what was, when this research began, an administrative office. Since this time, the space was converted to accommodate a Dual X-Ray Absorptiometry (DEXA) scanner. A DEXA scanner allows clinicians to check a patient’s bone density, determining if they may display signs of either osteopenia or osteoporosis. A lack of oestrogen is known to often contribute to a loss of bone density as we age, and requests in the clinic for scans became popular as patients learned more about their future health risks – it allowed clinicians to check whether a patient’s aches and pains were simply related to fatigue or muscle soreness, or whether they might indicate something more serious – a decline in their bone health.

Beyond the table and at the foot of the stairs was an arched entrance way leading to the clinic’s bathroom facilities. These were bright, clean and open. Perfumed diffusers and room sprays were positioned neatly in each cubicle. Sometimes sachets of vaginal moisturiser and lubricants were placed in glass bowls on the cisterns. These bowls were usually empty by the end of the day. Soaps and hand creams of the same fragrance were placed at perfect angles by each curved handwashing basin, along with plush disposable handtowels. The handtowels were positioned in exact piles by the sinks, with steel bins for their disposal after use.

To the left of the bathrooms lies a short corridor leading to the nurse's office and a consultation room where bloods were taken. The office was small and difficult to move around in comfortably. Fitting more than one person inside took concerted effort, and when nipping in to drop off cups of tea or have a quick chat, the size of the space became notable in comparison with other parts of Birchwood House.

The consultation room where blood samples were taken was the least 'inviting' part of the clinic. The fire exit for the building was at the back end of the room and even when the heating was switched on, a draft could be felt running through the space. This may perhaps also be due to the fact that this room was adjacent to the clinic's 'studio', the two rooms separated by the use of dividing doors which could be opened to maximise the space if needed.

The primary function of the 'studio' was to offer a space to practice yoga; however, during the research it also accommodated events (such as a book launch, workshops, conferences, and staff training). The room was open, bright, and spacious. It was equipped with underfloor heating, ensuring maximum comfort during any active classes. Yoga sessions would take place outside of clinic hours and were run by a variety of chosen instructors for small groups of attendees. While this research was undertaken, a number of 'weekend workshops' were also hosted, in which participants were able to purchase tickets to attend a full weekend of scheduled yoga classes and other 'wellness seminars'.

Figure 13: Personal picture of the yoga studio space in the clinic.

The studio was described as an important space by Claire – an environment where she would frequently spend time improving her own yoga practice and taking one-to-one lessons from her chosen instructor. Early on in the research

Figure 14: Personal picture of the reception area at the clinic.

process, the benefits of activity – and in particular, yoga – were highlighted by Claire. She outlined how the introduction of HRT and testosterone had enabled her to feel stronger and more capable in her yoga practice and that she had noticed improvements in her strength and flexibility. Additionally, she explained that adopting a holistic approach to treating menopausal patients – one in which factors such as diet and exercise are discussed routinely – proved important. As such, for Claire, the decision to dedicate a space to practising yoga was not just desirable; it was essential. Yoga was referenced as a transformative self-care practice in Claire's own menopausal journey to wellness, and something she wanted to share with her patients. In tandem, it is worth noting that Claire lived exceptionally well: she followed a plant-based diet, didn't consume caffeine, and limited her alcohol consumption to special occasions.

The decision to 'make space' for a yoga studio seemingly extended beyond the simple rationale that it provided a convenient space for Claire to utilise at work. The studio acted as a transformative environment. It opened up Birchwood House, allowing the space to exist outside the remit of traditional clinical practice. It incorporated 'bodily action' – something patients could implement themselves outside of clinical intervention. It provided a form of care that was not a gel, a patch, or a cream, but a sequence of movements – it offered embodied care.

Equally, the studio spatially highlighted the multiplicities of care available to patients at Mansfield Health. It serves as an architectural example of 'additional' interventions to consider for healing the body. The term 'additional' is preferred here, as it was explicitly noted by *all* clinicians at the clinic, that exercise and diet were not sole interventions to treat perimenopause or menopause, rather, they were complimentary lifestyle changes to adopt. HRT remained *the* treatment suggested.

The reception area of the clinic was the final large space on the ground floor of the building. Found to the left of the archway leading to the nurse's consultation room, the door to the room was always left open. The reception desk was positioned so that anyone entering the clinic could see another person. It was the space one naturally gravitated to, the space you instinctively know to walk towards.

The furnishings were soft velvet and suede. Hints of purple and grey ran throughout. These colours worked together to ensure that the space felt inviting but also communicated a sense of decadence. Flowers featured, regularly alternating in colour and arrangement. Adjacent to the vase of rotating flowers was a wooden block calendar and a variety of information leaflets. Occasionally when checking in, patients picked these up and flipped through them while waiting for their consultation, nervously pulling at pages without concentrating on the text. Leaflets were also collected when payment was made for appointments. Collection of them at this time was more purposeful – anxiety and concern having been eased following a consultation, patients know what they want to read, and what they want to take home with them. All payments at the clinic were taken via the Heydoc system – a software (as it would become apparent) that was used by most major private clinics operating in the UK at that time. Heydoc had the capacity to hold credit cards on file when a patient booked an appointment, and additional payment methods could also be added at any time. Thus, when a patient was paying for an appointment, the receptionist might simply ask, “shall I charge the card we have on file that ends in…”, as opposed to having to negotiate a card machine. Invoices were printed discreetly on lettered paper and placed along with any prescriptions in glossy bags bearing the clinic’s logo. The transaction was seamless; the space remained calm. This is important to note as a patient appointment was at the time of fieldwork £295. Patients equally needed to pay for blood tests, and a private prescription fee should they wish to have their HRT dispensed on the day. Finally, there was the additional cost of the HRT itself. This was usually around £30 - £40 for each preparation (Oestrogel, Utrogestan etc.), but should a patient be prescribed testosterone in addition, the preparation prescribed (AndroFeme) was at the time of observations £85 per tube. Thus, the decision to keep the financial element of the interaction somewhat ‘removed’ meant that any anxiety regarding expenditure was minimised.

In the back-left corner of the waiting room was a coffee machine. Cups and a variety of herbal teas were displayed neatly above the machine. The reception staff always offered to make tea or coffee for patients attending the clinic, but the positioning of the machine also provided the option for patients to make their own drinks as and when they chose. There were a number of small tables on which cups and phones could be placed, but these tables were usually occupied by a variety of magazines and other reading materials. One-handed shuffling of magazines while holding small white coffee cups could often be observed as patients looked to clear a space for them. Most of the magazines were dedicated to menopausal wellbeing. Liz Earle's smiling face was a constant feature, with her book (2018) placed in prime position on the central coffee table. Other reading material focused on gut health and diet.

Figure 15: Personal picture of the product cabinet in the reception area of the clinic.

The room also contained two large display cabinets that held products available for patients to purchase. Early on in the research, these cabinets were relatively sparse. They held supplements and some books. During the course of the research however, their content noticeably expanded. While observing in the administrative office, the subject of these cabinets became a pertinent topic of conversation.

The facilities manager, Alison, would discuss with Claire potential items that could be sold, sourcing the relevant information and details of the products for her approval. Content was assessed not only by aesthetic appeal but by relevance. Claire was clear on this matter. A product needed to support the identity of Mansfield Health; if it did not, it did not make the cabinet. Claire would occasionally have an idea that a particular product could feature, but then change her mind. This decision was far from flippant. Both she and Alison could be heard discussing with administrative staff not only whether they *liked* the products, but whether they would use them or find them useful.

Just like the overall aesthetic of the clinic, everything in the cabinet had its place and was purposefully selected with reason. Never was this more apparent than when considering supplement choices. When observing appointments with Claire and her patients, discussion of supplements were frank. She outlined what might have been beneficial for them and in what dosage supplements should be given, along with the realistic cost a patient might be expected to pay. When discussing this with her outside of appointments, she noted the importance of talking about this with patients because she found they often paid large amounts of money for supplements that they not only did not need, but often bought due to supposed concentration of the supplement. For example, she highlighted the international unit (IU) content of vitamins actually *needed* was often lower than that which patients were purchasing. While some were mistakenly going the other way and not purchasing supplements with a sufficient concentration, the majority of patients were found to be paying extra for an IU content than was unnecessary. Consequently, the clinic itself sold a number of supplements branded under their own name – a mix of different supplements specifically tailored for those experiencing perimenopausal and menopausal symptoms. Specific items such as vitamin D supplements, however, were sold individually. This was in part due to the fact that patients were usually in a deficit and required a stronger supplement. Adjacent to the cabinet dedicated to supplements were vaginal moisturisers and lubricants – products that may be broadly grouped under the term 'lifestyle'. On the top shelves were books, all selected due to their relevance to menopause. Along with reads such as *Me and My Menopausal Vagina* (Lewis 2018) were recipe books exploring how to experiment with spices, grains and seeds, self-help guides on increasing one's inner sense of peace, general wellness, and lifestyle – as outlined in Marie Kondo's *Spark Joy* (2011).

Figure 16: Personal picture of books displayed in the cabinet in the reception area of the clinic.

Most of the books had hard covers. Picking them up, their weight was noticeable. Unlike so many of the leaflets and marketing material seen in medical practices, their covers were welcomingly *non*-glossy; rather they were rich, papery and colourful. Below the books were products that could be referred to as ‘self-care’ items. This included a variety of hand creams, lip balms and moisturisers. Next to them were hand-made sleeping masks, each a different vibrant botanical print.

The shelf below held a collection of candles with samples neatly arranged in front of the products. The testers were contained under glass bell jars that needed to be lifted in order to experience the candles’ scent. On the bottom shelf of the cabinet were room sprays and rollerball oils produced by the same company as the candles. Each candle, room spray and roller ball had been tested and selected by staff members. On one particular day, the small roller balls could be found being passed around the administrative office, applied to pressure points, and periodically sniffed before reported on to Karen. From this feedback, decisions were collectively made regarding the scents that proved most appealing. Questions such as ‘which are the most relaxing?’ were asked, and it was interesting to observe how – when patients discussed the benefits of these sprays and roller balls with staff – they were consequently able to comment on their own experience and note the products that they found most appealing. The roller balls in particular were favourites with staff; they described how they could be carried around and applied throughout the day if one was feeling the need to be comforted or reassured.

The display cabinets not only held products, but also functioned as a means to provide ‘activity’ for those waiting for appointments. Patients could be observed perusing the shelves, picking up books and reading the back covers, sniffing candles, and starting conversations over particular items. The cabinets offered staff a means by which they were able to engage with patients or those accompanying patients to appointments. “Have you read that…?” “It’s really good isn’t it…” “I know! Doesn’t that candle smell amazing”. These conversations were energetic circuit breakers. Patients entering the clinic could often be seen to present as visibly nervous, fidgeting with their hands, eyes darting around the room – but the reception space served to ease discomfort; it was aesthetically anything but intimidating.

The combination of all of these factors served to create an environment that could be emotionally versatile. Passing the doorway to the reception, loud laughter could often be heard, along with patients swapping stories among one another. Sometimes, tearful hugs could be seen being exchanged between patient and receptionist, as well as the unburdening of anxiety and concern following an appointment. The reception space was so much more than a booking system. It was, part of how the clinic 'made' menopause.

Spatially, the cabinets in reception aided in the transformation of the waiting environment. Whilst many clinical waiting rooms may provide magazines for patients to peruse, the selected reading material *here* was specific. They were curated. From book to leaflet, every literary offering spoke of menopause and menopausal health. They showcased empowering narratives of self-discovery and independence. The smiling faces staring up from the front of glossy magazines were not 'irrelevant'; they were reminders of possibilities, opportunities, a signifier that *this* could be the first day of your new life. Moreover, whilst providing patients with an opportunity to shop may not seem highly relevant, it acted in a manner akin to the reading material. It allowed patients to foreground themselves within their story of health, independence, and self-care. As would become clear in the interactions observed between patients and clinicians, many of those visiting the clinic struggled to find any time for themselves beyond their drive to and from work. They were responsible for partners, children, ailing parents, multiple pets, gardens, preparing dinner, purchasing groceries, and the sorting, washing, drying and folding of copious amounts of laundry. For many patients moving in and out of this space, their lives had become dictated, to a great extent, by responsibility – by duty.

This sense of 'doing what was expected' filtered through from home life, to work and eventually, to the body. The very fact that so many patients were embarrassed to admit to their GPs that they were going to see a private consultant was complex, but at the heart of the concern arguably lay a fear of judgment surrounding their decision to prioritise themselves over others: to allow themselves time to think, reflect, speak, and simply 'be' in their own body. The opportunity to look at candles, to smell essential oils, to pick up or stroke a silk eye mask was of the highest tactile importance. It re-grounded patients into their bodies, it allowed them a few moments in which they were able to think about their bodily experience – what felt good and right and important. Outside of family, of work and of duty, there was Birchwood House.

Whilst of course for some, the opportunity to shop was not a novelty, for many it was. Clips of conversation caught in the reception space carried a cadence of guilt, of concern in taking time to absorb their surroundings. When observing women who purchased items, many bought not only for themselves but for their friends. This communicated a familiar narrative: 'I must give back in order to feel OK taking for myself'. This sense of suppressing need, desire or want, has largely been explored by feminist researchers in the context of appetite and the expectation placed on women to suppress their 'hunger' (both materially and symbolically) (Bordo 1993; Thompson 1994; Lupton 1996; Randall 1997; Reichl 1998). Women are not permitted to 'want', and this was evident in the often-palpable reticence to purchase in the clinic. Additionally, it carried not only the weight of patriarchal guilt and shame surrounding what it meant to be a well-behaved woman, it equally carried concern regarding what it meant to be a good citizen. The bordering beyond the clinical shall be explored in due course as an active part of the treatment process, however it equally can be found to raise concerns for patients. Many narratively explored their feelings of shame and anxiety that accompanied seeking care privately. As such, the purchasing of items *beyond* the appointment – the decision to invest in candles or books intensified this. There was a level of guilt surrounding contexts of caring for the self.

Despite this, sitting in the reception, it was hard not to be struck by the ways in which the material offerings of the environment were reminiscent of a really good gift shop. The clinic somehow made it hard *not* to purchase because it was so streamlined into the context of care. It presented opportunities to acquire a relic of one's time spent at Mansfield Health: something that could be carried to remind a patient of something important – something special. Perhaps they functioned as a talisman to keep these women close to the narrative of self and of body.

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The second floor of Birchwood House was comprised primarily of the clinic's consultation rooms. These could be accessed via a large sweeping staircase. The staircase seemingly served as a means to divide the clinic into distinguishable parts: a liminal space between the bottom level and the top. The bottom, an environment in which acts of ‘self-care’ could take place (such as shopping for supplements or attending a yoga class) and the top level: a space in which a ‘fixing’ of the body could occur (through the diagnosing of perimenopause or menopause).


Figure 17: Personal picture of the stairway at the clinic.

Of course, while there was cross over (e.g., the addition of the DEXA scanner and the phlebotomy room) it could be argued that the *type* of care carried out at the bottom level of the building was more aligned with concepts of ‘self-care’.

The clinic visit routine took the following format: a patient would visit the top level of the building to find out what was ‘wrong’ in their body, before returning to the ground level to put into action the advice given (e.g., having their bloods drawn, their prescription filled, their bones scanned, and their supplements purchased). The space therefore is able to be observed as spatially hierarchical in relation to clinical expertise, with nursing being housed on the ground floor and clinicians on the top floor. This reading world infer that hierarchy may be read as a division in status, with greater clinical expertise represented via the occupation of spaces ‘higher up’ in the building. However, such an interpretation doesn’t hold up in practice. To use the arrival of the DEXA scanner as an example, the addition of the machine required a relocation of administrative staff to the top level of the building. Thus, should an analysis be undertaken in which hierarchy is inferred to relate to space and levels in the building, where would this leave the administrative team?

After observing the use and the division of space in the clinic for some time, the building layout appeared reflective of something more in line with a patient’s menopausal journey rather than a division of clinical hierarchy. Whilst, of course, each visiting ‘body’ is unique, similarities in the clinic’s spatial ‘staging’ can be observed and go something like this:

The patient arrives at Mansfield Health and immediately makes their way into to the waiting room. They speak to the reception staff. As soon as a patient arrives, the receptionist will alert the patient's consulting clinician that said patient has arrived via a function on the Heydoc operating system. Whilst the patient waits, they will be able to peruse magazines, complete (if they have not already done so prior to the appointment) the Greene Climacteric Scale Score (GCS) assessment, which discerns their menopausal symptoms[13], have a tea or coffee and make small talk with the receptionist. The patient is greeted in the doorway of the reception room by their consultant, who will motion for them to follow them out of reception and up the stairs to the consultation room on the first floor. The consultation takes place behind a closed door and usually ranges from 45 minutes to an hour. If necessary or relevant, a physical exam may be carried out, but this is not common. After the appointment has ended, the patient will be directed back to reception, however, not accompanied by the clinician. Descending down the staircase, they will re-enter the reception area and wait to be called in for blood work by the nursing staff. After blood is collected in small tubes, the patient will re-enter the reception area to complete their 'purchase'. This may simply consist in paying for their appointment and blood work but can also include the purchasing of any supplementary material, such as books, supplements, or candles. If a private prescription fee has been paid – meaning that patients are able to take their HRT with them on the day of the appointment – this will be dispensed and handed to them before leaving the clinic.

The pattern in which a patient travels through the clinic enacts physically, treatment in practice. As they move through space, the body is 'restored'. They enter and exit each room – each part of the clinic – at an appropriate point and at the relevant time that is in keeping with their journey toward balance and better health. The emotional responses of patients also reflect this sense of journey too. Commonly, when new patients could be seen arriving in the space,

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[13] The *Greene Climacteric Scale Score* was used to evaluate the severity of symptoms and act as a baseline against which to measure improvements in future appointments. In follow-up consultations, clinicians tended to hold the new completed survey next to the computer monitor that displayed the old, completed survey, as a means to visually depict the improvement that could be seen. It was visually quite clever as – by the way ticks were arranged – one was able to see a dramatic shift from one side of the paper to the other, and as such, clearly draw attention to improvement and change (Spencer 2021).

they would tend to remain relatively quiet, some quite nervous before their appointment. However, both in the nursing space and in reception after an appointment, patients would often be ‘overcome’ with emotion. Some would cry, apologising and explaining that they weren’t sure why they were crying. Usually, patients also explained how nice it was to feel heard (be that by a clinician or other relevant staff members at the clinic). Moreover, the emotional state that could be observed in patients before and after appointments was stark. Women described feeling lighter, calmer, and reassured now that they were equipped with a plan to follow.

It is important to note that to arrive at this state was not automatic. Patients needed to be cared for in a particular manner and in a particular way throughout their navigation of the space. The consultation (which will be expanded upon in the following chapter) is just one part of that process. Navigation through the clinic’s spaces at the right temporal speed and in the right spatial way was equally considered just as necessary.

Clinical Consulting

Consultation rooms were occupied by different practitioners throughout the working week, with most rooms remaining ‘unassigned’ and rotating. Clinic directors Claire and Rachel, however, had assigned spaces, and elements of their ‘personalities’ were communicated in the interior environment. Turning left at the top of the stairs led you towards Claire’s consultation room. As founder, lead practitioner and ‘face’ of the clinic, Claire spent a considerable amount of her time in Birchwood House. Her consulting room reflected this. The room was spatially divided to accommodate different needs. A room of two halves, it communicated both the clinical and non-clinical. When entering the room, the first thing that was noticeable was the inviting-looking seating. A myriad of different coloured leathers and velvets were displayed, with chairs positioned slightly askew

Figure 18: Personal picture of the doorway to Claire's consulting room.

around a glass coffee table. Akin to the entrance hall, this table often bore a floral arrangement or well-chosen pieces of relevant literature. Large windows would direct warm sunlight onto this seating area, catching on the colours of the fabric. The wall directly behind this seating area included large cupboards for storage, and displayed a few books and photographs. On one particular visit Claire took out a picture from between some books that her daughter had drawn in school. It depicted a woman. A line had been drawn down the middle of the woman's face and body. One half of the woman can be seen smiling, with a vibrant palette adopted; the other half shows the woman's mouth turned and sketched out in grey tones. In the picture, the smiling side of the woman is accompanied by brightly coloured flora and fauna, and the sun shines in the background. On the opposing side, clouds ominously sit above her head. Claire explains that the school had asked for students to draw a picture as part of a Mother's Day project. The picture showed, as Claire explained, her daughter's depiction of what Claire's work was about: the effects of HRT.


Figure 19: Personal picture of Claire's consulting room.

Adjacent to the seating area is Claire's consultation space. A small sink had been built into the wall and served to separate the spaces. A sleek mahogany-topped desk supported by curved steel legs sat around a metre away from one of the large twin windows in the room. Two chairs were always made available. One, positioned at an angle towards the desk, another resting against the wall. The chair against the wall was able to quickly become utilisable by a friend or partner who may be attending the appointment with the patient. Behind the desk was a small steel-drawered cabinet containing information leaflets and sample products. The cabinet had been made accessible so that in a quick turning motion, Claire could select the pieces of information relevant to the patient and retrieve HRT samples in order to demonstrate the application process.

The desk had been positioned flush to the wall where framed certifications of Claire's medical qualifications hung. They were positioned in harmonious symmetry, their neat, ornate lettering catching the light. As observations continued in the clinic, these certifications were discussed. Like everything in Claire's life, her academic achievements represented so much more than a proverbial hoop. They were her call to arms, a representation of her insatiable interest in everything and her want to develop, and to grow. It became apparent that her training and expertise was more expansive than first assumed; Claire held an immunology degree alongside her other certifications, and this (as has been explicated in the previous chapter) became important in the context of COVID 19 when the relationship between hormone levels and immune response began to garner attention.

The back left portion of Claire's consulting room was sectioned off by a curtain rail, hung to shield an exam table and a set of scales. An abstract painting had been hung beside the exam table and there was a light fixture fastened to the wall for ease of use during vaginal or cervical exams. Beside the light fixture there was a small table where exam tools may be placed. On the bottom of this table were neatly folded towels placed snugly in a wicker basket. They seemed somehow reminiscent of the towel displays one may see at a spa or hotel. Behind the head of the exam table was a dark wooden chair featuring a brightly coloured cushion. Next to the chair was a display cabinet in which supplements offered by the clinic had been carefully piled on top of each other in a prismed display. These cabinets were a feature in most of the consulting room spaces, however it was only the supplements that were displayed on these shelves. Testosterone, oestrogen, and progesterone remained in locked cupboards out of sight.

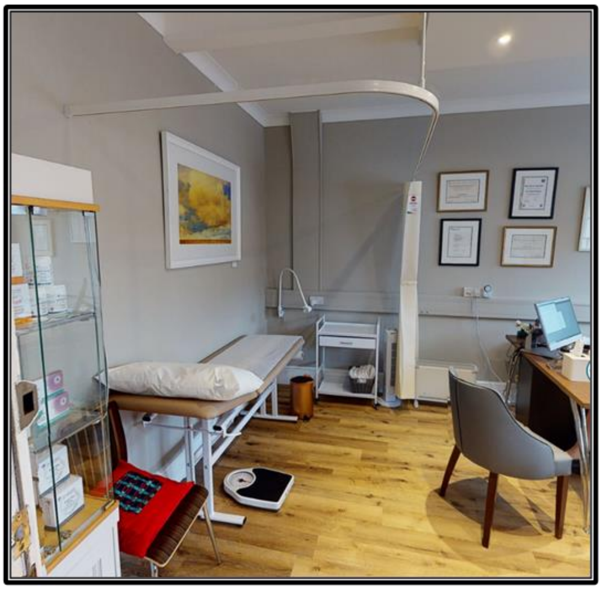

Figure 20: Personal picture of the examination table in Claire's consulting room.

One of the most salient elements of Claire's consulting space was the manner in which it 'physically' worked. The division of the large space into separate sections enabled the reservation of particular 'bits' of the room for particular actions. When entering and leaving, when sitting, when speaking to her over her desk, when observing her wash her hands prior to a consultation, the manner in which the consulting space itself functions represented more than a clinical space. The lines of separation drawn down the hardwood floor were symbolic. They helped to create a sectioning of experience. The space, though open plan, draws clear and important lines in the architectural sand. The room spoke of that holy trinity – mind, body, and soul. When patients enter the room, they followed Claire toward her desk, where the consultation occurred. The interaction was in many ways cognitive. It was talking and discussing. Surveys were consulted and symptoms listed. The computer was utilised to record important information. All the while, watching over clinician and patient were the certificates of credibility – the qualifications. Beyond the desk there was the back of the room, where patients could be examined and weighed – a purely physical interaction. This was the body. Then there was the collection of comfortable seating, a place that patients did not tend to frequent – though they may have seen it if they followed Claire on Instagram or other social platforms. Here was where she recorded her podcasts, and where she spoke about the issues and concerns that extended beyond the clinical. This was the space in which matters of the heart were shared candidly. This was the space for the soul.

Considering the curation of clinical spaces as a form of care, it is interesting to observe the ways in which the consulting rooms were in some ways also made to remain non-clinical. The cabinets displaying supplements all packaged in soothing colours with appealing illustrative designs were noticeable. The cabinets – those from which the absence of hormones felt conspicuous – were not to be shared with the clinical. They were there, perhaps akin to the reception space, to remind women of their own power: their ability to choose how they would like to continue in caring for themselves. Near the examination table, towels were kept on hand. The display of these was, once again, interesting. Small, neatly rolled up white and fluffy towels resting in wicker baskets, ready for women to remove and use as necessary. Looking at the careful arrangement of these towels makes one think about all the experiences encountered by those that have had to have their cervix examined. You undress behind a curtain and are asked to cover yourself with thin tissue that provides no privacy. The tissue is pulled from a roll, and one cannot help but consider the number of bottom halves that have been hidden from view under the same roll of tissue. Though a small distinction, it is an important one. As opposed to feeling part of a cattle production line – one person in and another out – the neat and undisturbed pile of towels allows for patients in this environment to feel cared for – to know that the arrangement of these towels has been organised in preparation of *their* visit.

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Figure 21: Personal picture of a consulting room in the clinic.

Leaving Claire's office and turning left leads toward additional consultation rooms, the clinic manager's office, and a bathroom featuring a free-standing shower. This bathroom space was frequented only by staff and physicians. In the corridor, space had been utilised well. Indents in the wall had been converted into 'snug' seating, with velvet cushions scattered on wooden bench tops. The clinical consulting rooms were smaller than Claire's, but nonetheless remained a comfortable size. Bar Rachel's consulting room, which featured a few beautiful wooden antique pieces reminiscent of an apothecary, the consulting rooms contained few personal touches. This made them accessible spaces, easily occupiable by any clinician. Though framed family portraits did not appear in the consultation rooms, this did not make them unappealing to spend time in. Like most of Birchwood House, large windows were a feature in many of the assigned consulting spaces. Their tall frames allowed bright sunlight to bounce off cream walls and helped to make the space calm and inviting. Artwork featuring vivid splashes of colour hung on the walls and pops of personality emanated from the glossy fronts of information leaflets that featured smiling faces. Moreover, thematic consistency was clearly visible across all of the consultation spaces. Each room featured the same desk and grey leather chairs. The weighing scales, telephones, stethoscopes, blood-pressure readers, computers, pads of paper and pens – they were all the same. The glass display cabinets featured the same supplements and, of course, the samples of hormones brought out as testers to show patients were also uniform. Whilst this design may sound structured, care had been afforded to provide subtle variety between the displays in each room. For example, the prismed ordering of supplements differed in each display cabinet, information leaflets were arranged in different ways and furniture was placed in contrasting arrangements. In this sense, though consultation rooms may have in essence been uniform, each had been uniquely tweaked to remain individual. The overall effect of this spatial arrangement was interesting. As opposed to feeling you were in a strange or unfamiliar space, you experienced entering a consultation room as a continuation of the familiar Birchwood House 'home'. The clinic carried the thread of itself through from the moment you entered to the minute you left – each carefully placed cushion a choral refrain of the wellbeing mantra.

The final part of Birchwood House in need of depiction is the administrative office. As mentioned, during the process of this research being undertaken, the administrative team were moved from the ground floor to the upper floor of the clinic. Prior to the conversion of the space into an office, it had functioned as a meeting room space with brightly scattered cushions adorning window boxing. To reach the now administrative office, you must turn right at the top of the staircase and proceed along the landing corridor. Passing through a door you will enter a short corridor where coats and umbrellas are hung. To the right is a small kitchen, which served as the proverbial 'water cooler' hang-out spot where gossip could be shared over the brewing of tea and dunking of biscuits (although clinicians rarely partook in ritual dunking). Behind the little kitchen was the administrative office. This was a space that, during the research, became a 'home base', and the environment in which so much of this research's learning took place. Systems were put in place spatially in order to keep on top of the ever-increasing demand from patients. A large whiteboard was hung on one wall with impressive shorthand understood perfectly by the bodies milling around the office. Like an athlete recapping the 'play' they have been asked to perform, the whiteboard contained all the

Figure 22: Personal picture of the administrative office before it was converted.

information needed and was a non-verbal exchange batted back and forth between staff members.

Which consultation letters needed writing up for which days and for which practitioners. Which clinicians needed appointments to be changed or cancelled due to conflicts. Which administrative tasks required clinical approval, and which could simply be executed without supervision. The space was busy but remained at all times visually appealing. The window seats were still scattered with cushions, and once again flowers stood on a central table. Unlike other parts of the clinic, the administrative staff left a stamp on the space. Simple features like a staff member's notebook or chosen water bottle communicated a little of who they were within the space. Pads of paper laying on desks showed carefully doodled imaginative sketches.


Figure 23: Personal picture of the board in the administrative office.

And of course, there were the mugs. Though Birchwood House stores its own neat selection of white porcelain Ikea cups, staff members chose to bring in their own cups from which to drink tea and coffee. There are mugs with cartoon dogs on, mugs from clinical conferences, mugs with charity logos branded across them and mugs with family snapshots. Over the course of the research, it would be important to remember not only how a person took their tea (for example Tracy liked a black English breakfast, the teabag dunked exactly twice with no final squeeze) but also which mug was their mug. Over time, remembering this, along with who liked 'skinny milk' became an important indicator of familiarity. Little reminders of wellbeing also featured in the office, but in a different way. At the end of each day, mail would need to be sorted and put through the franking machine. On one particularly fateful day, the silly researcher entered the wrong code to this machine and accidentally franked over twenty 2nd-class letters as

1st-class packages. This required a quick team effort in which stamps on letters were scalpeled off and set aside to be used for packages at a later date.

The aforementioned may not seem of significance in the context of spatial configuration, however it is argued that it is the very contrary of this judgement that obtains. The administrative office, where staff interacted, and where cups were brought from home and the biscuits were shared, made up a significant part of the Mansfield Health aesthetic. It was the backstage area. It was the space where the performance could be ‘made’ before it was executed. The very fact that it was so starkly opposed to the rest of the neatly manicured spatial configuration of the clinic rendered it unique and important to consider. Under mounting pressure from patients, practitioners and the public at large, the ways in which the administrative team made Birchwood House their home enabled the practices of care that played out in the clinical context.

Complete with a Cupboard

Observations in the clinic had been taking place for a few months before one final part of the space was discovered. Immersed in conversation with Elaine (one of the practising nurses) over a query from a patient regarding their prescription, our walking debate had, without warning, drifted into a part of the clinic not yet seen: the ‘drugs’ cupboard. Use of the term ‘drugs’ here is arguably complex phraseology. There are many who may contest entirely the reference to HRT as a drug at all. However, for the purposes of this description, the term ‘drugs cupboard’ is called upon not in relation to the *contents* of the cupboard, but the clinical security adopted by the staff when entering this space.

Following Elaine, full attention had not been paid to where we were actually going. Looking up as she stopped short, keys in hand, there was a sudden realisation that this space we were about to enter had not been seen before. Located close to the clinic entrance, it was a small room, the door to which was easy to miss. It could simply have been a coat closet or other storage space. Elaine fiddled with keys, and we moved inside. Piled high on larder-like shelving were multiple different forms of HRT. Patches, gels, pills and creams stared down from all angles; their piles surprisingly haphazard when contrasted with the prismed displays in glass cabinets. As Elaine selected boxes and peered over her glasses to double check dates, nodding absentmindedly and counting under her breath, a 360-degree turn could be made to fully take in the space. All HRT was kept on shelves, names pointed outward, so it was easy to read and select. Leaflets and other marketing materials were also noticeable. Boxes were stacked and the angled corners of explanatory materials could be seen peeping out of boxes that had been hurriedly torn open. Tracy had selected the HRT she needed and was now moving toward the door. As she ushered me out and closed the door, the habitual lock check was noticeable. After keys had been turned, the handle was shaken in that distinct way, to ensure that the keys had performed their duty correctly.

Thinking about this experience, a few salient factors are worth noting. The first is that it was some time into the research before this space was discovered. While it was explained to the clinic staff members that this PhD was an exploration of the materiality of hormones – the physical compounds that are rubbed into the bodies of those entering the clinic – until this point, hormones had only been seen leaving in paper bags or represented in dummy forms as clinicians demonstrated the application technique. In this sense, their appearance here was fascinating. It was striking how ridiculous it seemed that until this point, consideration had not been paid as to *where* the hormones were being kept in the clinic. Seeing this space was almost reminiscent of witnessing a magician explaining a magic trick, showing you the secret door where they may switch out items in a trick. Suddenly the illusive hormones were not ‘in the ether’; they were material, solid and real. Somehow this realisation changed the perception of the journey hormones made to the body. It added in a piece of the puzzle, another dimension to the journey from box to body. Until seeing the drugs cupboard, it was the absence of hormones in the clinic that *was* their presence.

Equally notable was the level of disarray within the cupboard space itself. Whilst the room was not ‘messy’, it contrasted starkly with other parts of the clinic, where every single item – from pad and paper to curated cushion – had a home that was maintained and cared for. The cupboard had a clear structure; items were placed on shelves, boxes were piled, but the *care* afforded to their placement was distinctly different. They told a story of the clinical process that occurred ‘backstage’, away from the eyes of patients. It highlighted the pace and extreme turnaround often demanded from the nursing team and administrative staff. It showed (just as the administrative office had) the haste with which staff needed to work. Prescriptions needed to be filled and leaflets needed to be restacked.

The presentation of the cupboard also communicated something authentic about hormones. It showed flexibility, movement, and disarray. It was hurried and in parts unkempt – as if it involved systems that were not absolute or stringent, but rather flexible and permeable, subject to influence from outside factors. Unlike the public parts of the clinic that were tidied each day, hoovered, mopped, and dusted, the cupboard of hormones remained quietly untouched. This ‘maintenance of space’ resonated something akin to the maintenance of the body. The outside or surface of the body in a spatial sense here may be seen as the public parts of the clinic, cleaned up and made presentable each day. The inside parts of the body, or the private spaces in the clinic (such as this cupboard or the administrative office) were left in slight disarray, just like the nature of hormones, slightly unpredictable and unique, accessed purposefully and often in haste.

Finally, there is the emergence of the theme of ‘value’. This space needed to remain locked to outside persons, communicating two possible readings. The first is that the content of this space is of monetary value and thus in need of secure storage. The second is that the content found inside is in some respects dangerous and in need of specific care. The action of ‘locking a door’ not only communicates that the content is private and precious, but that it should only be accessed by particular persons – that it needs protection. In this sense, hormones are arguably communicated as both high value and potentially dangerous substances, highlighting that they must be audited, and accessed only by certain individuals. In the case of the clinic, though clinicians may issue prescriptions, it is the nursing team that are the endocrine gatekeepers. We may think about our literature discussion and the echoes of the history in which the ‘magical’ symbology of hormones is communicated time and time again.

Fundamentally, the action of entering this space from a research perspective was pertinent. After months of observing in the clinic, relationships had been formed, but this interaction felt different and more important. It communicated a level of trust. In entering the space where hormones were kept, one was able to become a part of the act – part of the team of magicians that brought forth the magic, or at least a witness to the show.

It is at this point useful to reiterate the 'journey' that patients may be seen to take at Mansfield Health. They enter the clinic in need to support, their menopause is yet to be 'fixed'. In navigating the space, their menopause is, in part, made. From entering the reception area, to journeying up to the clinical consulting rooms, menopause is 'put together'. Symptoms are collected on the way and a tangibility to an experience is affirmed. All elements of the clinical environment contribute to meaning that through the process of spatial navigation patients are able to leave Mansfield Health 'transformed'.

Conscious with Concern

Having explicated the ways in which Mansfield Health was spatially configured, a few points are worth returning to. First is the ways in which everything within the clinic was chosen, but this *choosing* expressed more than a story about the object. It expressed everything about the identity of Mansfield Health. To use the DEXA scanner as an example, the decision to convert the space and acquire a scanner was made because of the volume of referrals that needed to be actioned by clinicians. Without a DEXA scanner at the clinic, patients needed to be referred to an external service or team in order to book DEXA scans – an inconvenient and time-consuming process for the administrative team. The addition of the DEXA scanner to the clinic made sense on multiple levels. It was convenient for the patient. They would be able to book their scan to coincide with other appointments (such as routine follow-ups), reducing the number of visits to the clinic. Moreover, its addition meant that yet another important aspect of a patient's care could suddenly be made accessible within the same clinical space, streamlining the treatment processes further. Finally, (although this was not overtly positioned as a rationale) DEXA scanning generated revenue for the clinic. Whilst the DEXA scanner's upfront cost was significant, the decision to invest in a DEXA scanner was a pragmatic one. Not only did it offer a return on investment, but it also communicated something specific about Mansfield Health. After returning from the EMAS conference in Berlin (the context of which will be explored in Chapter 5) it became clear that when it came to menopause, it was not just hormonal treatments that could be marketed, but also a number of other 'corrective' technologies. Representatives at the conference could be seen to be promoting various versions of the same vulvovaginal laser equipment, designed to be administered in order to assist with symptoms associated with Genitourinary Syndrome of Menopause (GSM). Symptoms of GSM are broad but commonly include: vulval and vaginal dryness, vaginal discomfort (usually a burning sensation), vaginal discharge, itching or irritation of the vulva, painful urination, a sense of urgency with urination, more frequent urination, recurrent urinary tract infections (UTI), urinary incontinence (that can be mild to moderate), bleeding after intercourse, discomfort or pain with intercourse, vaginal dryness that impacts sexual activity, shortening and tightening of the vaginal canal, and thinning, drying or inflammation of the vaginal walls (sometimes referred to as vaginal atrophy).

GSM is just one category of symptoms connected to perimenopause and menopause – there are plenty of others for us to cover. Explicating the number of symptoms associated with just *one* broad term such as GSM, however, allows us to demonstrate the 'market' for menopause is expansive and expanding. Speaking with the clinic manager Cerys after the conference, the question as to whether Mansfield Health would ever consider using or implementing laser therapy[14] was broached. She noted that the supporting evidence for the use of laser was not conclusive – an accurate deduction. Laser treatment needs to be consistent, as, after 12 months any 'changes' that have occurred reverse if treatment is not maintained. More importantly, however, Cerys highlighted how offering such treatment communicated a very specific message about the clinic. The technology that featured in the clinic not only needed to serve a purpose, it also needed to communicate an *appropriate* message. The space, the equipment, the technology was full of socio-political meaning. The addition of the DEXA scanner was not just about financial gain or a reduction in duties for the administrative team. It was a decision about how space and the use of it could communicate a message about the essentiality of particular kinds of care (Mol 2008; Mol, Moser & Pols 2010; Pols 2014; Winance 2010; Baker & Beagan 2014). The placement of different elements within the clinic ultimately elevated the importance of particular conditions or parts of the body. In the case of the DEXA scanner, its presence and affordance of space served to draw attention to the need to 'recognise' the skeleton and its association with menopause – our bones exist as part of the anatomy of endocrinology. More than this, however,

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[14] An intervention that involves inserting a laser device into the vagina to stimulate new blood flow and encourage the development of tissue growth in the vagina. Laser treatment will be explored in greater detail in chapter 5 but it is important to note that it's efficacy is widely disputed (as is in the opinion of this researcher, it's ethics)

they exist as a *legitimate* part of the treatment, as opposed to other forms of care, such as vulvovaginal laser.

As has been communicated throughout this chapter, it is not the space itself that renders Mansfield Health unique – it is the *use* of space. Every item is chosen carefully, every context curated in order to create a specific menopausal experience. Whilst items such as flowers may seem of little importance, there is much to note in regard to their symbolic value. They represent growth, new life, beauty, and care. They contrast the archaic narratives we have presented in chapter one that surround what is 'known' about menopause and reframe the experience. It doesn't appear as it so often does, as a series of symptoms in need of intervention; it is cared for and considered with kindness. Moreover, the curation of the space as outlined allows those frequenting it to experience their body, their health and the decisions made about their menopause as a unique individual – they are able to leave the clinic having felt that meaningful interactions occurred in which they were made the subject of the enquiry. That ability, however – to feel special, to feel recognised and to feel supported – *is* accommodated through the configuration of the space itself.

To return to Massey, it is important to highlight that "'space' cannot be a closed system." (Massey 1999: 264) and that in the case of the clinic, it was in a constant state of flux, acting and reacting in tandem with the bodies (both material and symbolic) that entered and exited the environment. This is important to stress as the making of space that occurred could also, on occasions, cause casualties that represent much of what matters in the making of menopause.

To end with our ethnographic vignette and to explore this further, a story depicting a weekend workshop taking place at the clinic is provided. The workshop was hosted and delivered by Hellen, a visiting nurse practitioner. The workshop was titled an 'introduction to menopause'. For a fee, it provided a space for women to come and learn about menopause, ask questions, and meet other women who may want to connect around their menopausal experience. Meeting Hellen in the administrative office on the first floor (this was prior to its conversion) she seemed flustered preparing for the delivery of her opening talk. Hellen bids a short hello, and, after casting her gaze up and down she slowly enquires "where do you work". Replying to her with as much buoyancy as can be mustered that early in the morning, I explain the research I am undertaking and that I have been told it would be OK for me to sit in on the workshop as long as everyone is happy for me to be there. Hellen nods and, trying to be helpful, I ask if she would like me to wait downstairs and direct some of the attendees arriving to where they need to go. This suggestion is well received, so I set off along the landing and down the large sweeping staircase.

People arrive and I direct them upstairs. Toward the back of a newly arrived gaggle of women, a lady hangs back. I come to learn her name is Alison. I ask Alison if she is here for the menopause workshop, and she replies that she is. Alison is using a wheelchair, however, and, in my few visits to the clinic I have not noticed a lift. Whilst there is a ramp to reach the clinic, there is no means of getting to the first floor or the consultation rooms. I ask her to wait a moment and track Hellen down, who, at that moment is busy in the kitchen making swirled arrangements of herbal teas. I tell Hellen that one of the women due to attend is downstairs and needs access to a lift. Hellen freezes mid-tea-flourish and immediately directs a barrage of questions in my general vicinity. The clearest of these appears more of a statement than a question. “I wasn’t told there would be anybody attending with extra needs!”. Adopting a calm approach, I suggest that, as neither of us are frequent attendees to the building, we should look for possible ‘hidden lifts’. In retrospect, this was probably an entirely unhelpful endeavour, but it seems to centre Hellen, so we set off opening doors and peering inside cupboards. With little success, Hellen rushes past me on the stairs. Hellen’s ‘concern’ in this moment is palpable. She dashes about checking behind doors, seemingly hoping a lift may reveal itself to her if she concentrates hard enough. With no luck, she bounds forward to greet Alison with a shrill exclamation that she was “sorry but didn’t know anybody would require a lift”.

Hellen says she will call her supervisor to double check whether anyone had told them that *they* had additional needs. Left alone with Alison, she chats to me with a kind of poise that feels very fragile. She explains that her husband had dropped her off and that she will have to call him to ask him to collect her again. She jovially remarks that she thought as they had wheelchair ramps outside the building, they would be equipped to meet her ‘needs’ and she didn’t think to ask. Hellen reappears at my shoulder; she tells Alison that she’s sorry and that they will of course reimburse her for her ticket. I look at Hellen and suggest that she could perhaps give Alison a flyer or card with her details, that way she could let her know of other workshops taking place in accessible spaces. She nods and passes a piece of paper to Alison before jogging back up the stairs to the other women awaiting her, and ready to enjoy the workshop.

There is a strained silence. I ask Alison if perhaps I could, with the assistance of others, help her to get upstairs. This feels like the wrong thing to say, but so concerned by the lack of presented options I feel I should offer her something. Alison gives me a weak smile and says not to worry. I tell her I will wait with her until her husband arrives. She tries calling him, both on his mobile and on the landline. She leaves two messages on each line explaining what happened. The fragile cheer remains in her voice as she carefully thinks about which coffee shop she could wait in for him. I think to myself that she must be considering which are accessible to get to and from the clinic. As she hangs up, I tell her that I would be more than happy to wait with her until she is able to reach her husband. She explains that won't be necessary. I tell her that I will contact the owner of the clinic to explain what has happened. Alison insists that it is fine, but as we talk, the initial solidity of this judgement seems to falter. I feel it lurking below the surface. It's not quite rage and not quite sadness – it's perhaps a bit of both or something else entirely.

There is no denying that remaining impartial in this instance proved painful. We chat a bit. She asks about me and what I do. I explain that I am a researcher and that I am looking at different people's experiences of using testosterone and other forms of hormonal treatments for their menopause. Alison seems interested. She explains that she wanted to attend the workshop today to learn more about HRT. As a woman with a spinal injury, Alison explains that while HRT appeals to her, she is not sure if she would be at risk of blood clotting as a result. She says that overall, she feels most disappointed that she is not able to attend to get more information about the questions she has. We talk about the different people that often appear absent in research and she tells me that if menopausal women are unrepresented generally, then women with spinal injuries going through menopause are probably non-existent in research. She says she thinks this is a shame because they probably have similar concerns to her. She asks if I would like to talk to her more as part of my research and I say I would. I give her the details of the research website and tell her I hope that she gets in touch.

Relaying what happened to both Claire and Cerys, they contact Alison to offer her a free of charge consultation at Mansfield Health. She obliges and the appointment takes place in the phlebotomy suite on the ground floor. Alison’s wheelchair manages to just about fit in the small room. Claire explains that they don’t get many patients in wheelchairs, so they haven’t yet seen the need to put a consultation room downstairs or install a lift.[15]

This interaction is of the utmost importance and is chosen as the ending point to this chapter, as it brings to the fore an aspect of the spatial arrangement of Mansfield Health that is crucial to acknowledge. The setting of the property, its design, while undoubtably beautiful, functions in a way that excludes a particular portion of the population. It renders menopause once again a place of privilege that extends beyond a financial context.

Whilst private medical care is known to ‘happen’ in exclusive spaces, we do not routinely consider how, as such, private medicine has the ability to communicate through its architectural and interior configuration, markers of wealth. The realities of what this looks like in practice are not just disheartening; they are heart-breaking and even at times repugnant. The precise yet lazy way these spaces are able to draw careful circles around patients that belong – and so exclude those that don’t – leaves curious women at the bottom of staircases, underinformed, for profoundly avoidable reasons.

Thus, while countless conversations with the staff that worked at this clinic were had regarding the importance of inclusivity, and in many respects a lot of what they had to say was actioned in their work, the ‘essence’ of the brand (and yes, it is a brand) of menopausal health is one of exclusion. The clinic *feels* welcoming, but it feels welcoming to a certain demographic, not just pertaining to wealth, but to gender too. It is a space built for white, well-educated, able bodied, cis female heteronormative women. I fit perfectly into that carefully drawn circle of privilege that this space intends. Whilst my positionality as queer unfolded after the majority of this fieldwork took place, the other mentioned categories remain and I am left to consider how it might feel for others. I am left to consider how this space *feels* to those on the margins of traditional femininity.

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15 Whilst the specific regulations are not known it is thought unlawful for clinical spaces to not be made accessible in the UK in 2023.

We must wonder whether it welcomes everyone in the same way. Perhaps the question is best posed as a rhetorical one. The demographic of patient that attends Mansfield Health may not be, as was consistently communicated by staff, ‘super rich’. Yet, they are able to navigate the space. Through a form of privilege, they find themselves belonging. These environments, for others, remain unapologetically ‘cordoned off’. A red rope hung across the entrance requiring a notional nod for it to be unclipped. For some, unclipping this rope may occur easily, via various forms of capital (Bordeau 1986) or through connections from friends and family. For many, however, the space remains both physically and metaphorically disabling.

Over the course of this research, I was able to engage in a number of insightful dialogues with many women about their experiences of menopausal spaces. Of the stories collected, there were clear thematic consistencies regarding the ways in which ‘exclusion’ operated. Akin to bell hooks (1981) artful examination of the ways in which traditional feminism only speaks to the experiences of white bourgeois women, universal experiences of menopause were identified in these conversations as ultimately only reflecting a particular experience of menopause – a white middle-class experience. In one interesting conversation a woman expressed her frustration that as a woman of colour, she felt her Afro-Caribbean heritage was simply not accounted for in any of the literature providing advice and support on changes to the hair and scalp (a common perimenopausal and menopausal symptom). She noted that descriptions of intervention simply assumed readers would be white. As a result of her experience this participant had opted to start a support group for women of colour. Discussing her reasoning, she highlighted how for many women in the group, they needed the opportunity to connect with others. Using food as another example, she discussed how many of the health and lifestyle modifications suggested by clinicians would assume a particular way of eating that was unfamiliar to the women attending her group. Within this, she outlined how for many women, the preparation of meals for family meant the needs of others required consideration. Thus, it was not realistic to simply add in fermented foods to a repertoire of meals.

It is easy to present the ‘cis-terhood’ of Mansfield Health in the way it is intended - warm and affirming in all its pastel glory. At its core however, the environment operates in an exclusionary manner and the parameters of that exclusion are upon examination far reaching. Fundamentally, for Mansfield Health to sustain its model of ‘care’ for certain groups of women, to remain aspirational, it must incite forms of exclusion fir others. This is supported and subtly executed through the arrangement of the space.

The example of the support group is useful to consider as it highlights how these women had to create a separate environment to feel safe, and to have their identity understood and appreciated within conversations about *their* menopausal experience. Of course, it is important to acknowledge that there is a commercial value to spaces such as Mansfield Health remaining exclusionary to particular groups. The clinic is, by design, built to provide a ‘luxury’ experience. Throughout this chapter I have referenced the attention to detail – the leaflets, the flowers, the artful display cabinets filled with candles and supplements. The extensive ‘work’ undertaken to maintain the space highlights the ways in which parameters of access are made through spatial configuration.

What does it mean when we make our spaces and places of health accessible to only specific groups? How are people on the margins – standing on tip toes and craning their necks to see over the top of that rope – made to exist when they enter these places of care, and a defiant echo of privilege reverberates with the message “you don’t belong here”. Thus, the ways in which the clinic provided care through its spatial configuration was both clear, but undeniably complex. While the menopause of the many was made, the menopause of the few - the other - was left on the margins.

CHAPTER 4

The Ritual of the Appointment

I am no less certain now that hormones are any more than a fiction, but I also don't think it matters – the processes through which we bring them into being. The talking, the weighing, the measuring, the drawing of blood, the tears spilled into tissues; it is all a part. A part of the performance involved in how this clinic does menopause. (Fieldwork Notes: January 2020)

Based on observations from the consulting rooms of Birchwood House, the following chapter explores the interactive dynamics displayed between patients and physicians during clinical appointments. Paying particular attention to concepts of care, rituals of practice, and the materiality of medicine, this chapter highlights the ways in which perimenopause and menopause is 'made' tangible via the enactment of symbolic and material medical practices. Emphasis is placed upon the term 'co-construction' or 'co-constructed', as it indicates how perimenopause and menopause is not a fixed state but rather a co-constructed category. It explores how perimenopause and menopause become diagnostically static via the interactive and participatory practices that require active 'work' from both patient and clinician (Strong 2018).

The chapter highlights how notions of progression, growth, and return are thematically significant. Broadly, the concept of 'transformation' is offered as a descriptive motif, under which the aforementioned themes coalesce and connect. The occurrence of 'transformation' or 'transformative' growth is examined as an experience unique to the individual but possessed of certain key markers. Foundationally, it is observed to require a commitment to self-improvement *or* a return to a 'core-self' from the patient. The achievement of 'transformation' is observed to be made attainable via a variety of different factors, but predominantly is understood to be measured via displays of emotional constancy and physical stability from the patient. These displays are observed as determinable by the clinician through external measurement strategies, and are effected through the administration of hormonal therapies.

Consideration is afforded to *how* a thematic emphasis on ‘transformation’ within clinical consultations may impact the manner in which perimenopausal and menopausal treatment is conceived of and experienced.

Attention is also paid to the importance of care practices, highlighting how certain forms of engagement are particularly important in constructing patient experience. Consideration is afforded to the ways in which a ‘lack’ of care in contexts beyond the clinic (e.g., during an NHS appointment with a patient’s GP) may be pertinent in, and inform *why,* patients seek support from a private healthcare provider. This engages with ideas of ‘trust’ and ‘relatability’, citing them as thematically significant in shaping concepts of care.

Finally, a feminist reading is adopted in the analysis of ethnographic observations in order to appropriately consider the patriarchal dimensions at play within clinical interactions at Mansfield Health. This is seen as centrally significant in enabling the concept of *transformation* as a marker of success in clinical interactions to be adequately explored.

It is important to note that within this chapter, one particular clinical interaction is described in detail. The rationale for focusing on one patient’s account as opposed to documenting multiple appointment observations is twofold. Firstly, in doing so, the intricacies of this particular patient’s experience can be richly captured, providing the opportunity to micro analyse the nuances of the interaction and its subtleties. It provides the opportunity for what Geertz terms *Thick Description* (Geertz 1973), in which we are not simply describing physical behaviours, but also the accompanying context as interpreted by the clinician and the patient. Secondly, and to return to Chapter 2, composite narratives have been employed throughout this thesis. Thus, whilst this story may explicate the experience of one particular patient, the ‘making’ of the interaction and the surrounding contextual information has been informed by the countless appointments which were observed during the period in which fieldwork occurred.

Despite this rationale, it is equally recognised that presenting a singular analysis means a level of variation is omitted in this chapter, on the part of the patients, clinicians and other relevant professionals who took part in this research.

Constructing Carol

During the time in which fieldwork was taking place there were few opportunities to observe initial and follow-up appointments with the same patient. This was predominantly due to scheduling conflicts. To be able to observe the same clinician consulting with the same patient months apart was logistically too complicated to plan for in advance.

Though initial appointments and follow-ups were regularly witnessed in isolation, the opportunity to sit in with the *same* patient through their treatment journey was significant. As, observing both first contact and subsequent returns to the clinic allowed the temporality of ‘change’ to settle. It allowed for the experiential occurrence of a patient’s ‘transformation’ to be witnessed – intimately. Carol was one such patient.

Kate was the consulting clinician overseeing Carol’s first appointment at Birchwood House. Although Kate only spends one day a week at the clinic, she has the type of personable energy one does not easily forget. She exudes positivity, and her speech is punctuated by a melodic Scottish lilt, which, paired with her proclivity for humour – whose tone she is able to skilfully alter to suit both the patient and the moment – make her difficult to dislike. Kate is, in no uncertain terms, entirely charming.

Carol’s appointment is the final observation of the day. She is a new patient, and her notes, quickly recapped by Kate prior to the start of the appointment, reveal she has been experiencing symptoms that are causing a significant impact on her quality of life. Entering the room with some reticence, Carol appears nervous. She glances around at the various cabinets displaying leaflets and other paraphernalia, sitting lightly when directed to do so by Kate. Beginning Carol’s consultation by asking her name, Kate follows up Carol’s response with a quick quip of ‘glad to see we’ve got the right lady then’. The joke secures a chuckle from Carol, and her demeanour relaxes.

Kate asks Carol to describe her reasons for visiting the clinic. The question is genuine and sincere; she is asking Carol to frame her rationale for making an appointment in her own words. She is asking her to speak freely about what informed her decision to make the appointment. Carol explains that she is worried about her emotional state. She highlights that a few weekends ago she "got drunk at a family gathering and insulted a number of friends and family members". She continues, explaining that she rang to apologise to the relevant persons immediately the next day, before deciding to make an appointment at the clinic. Carol makes a point to stress the following: that she is not only pursuing support for herself, but for her friends and family. She explains that she doesn't like or recognise the person she has become, and feels something needs to be done to address the changes she sees in herself following what she believes is a consequence of the onset of perimenopause.

During this time, and as Carol speaks, Kate listens. She does not interrupt. Kate actively engages with the conversation. She nods, keeps eye contact, and where appropriate, smiles and laughs. When Carol gets overwhelmed, tissues are gently pushed across the desk without explanation. When Carol has finished, Kate asks her to describe any other symptoms she has noticed. Carol mentions a few physiological changes but mostly focuses on changes that she's noticed to her mental health and in her cognitive functioning. Nodding, Kate calls upon something calls upon the GCS questionnaire to help Carol engage with thinking about the symptoms she may be experiencing. The GCS questionnaire as mentioned prior, is a measurement tool that helps clinicians to assess perimenopausal and menopausal symptoms. The questionnaire uses a series of scale-based queries relating to symptoms in order to generate a score. These scores are added up and used to diagnose perimenopause and menopause as well as monitor improvement and progress following the initiation of treatment.[16]

Carol's GCS score demonstrates to Kate that she is indeed struggling with perimenopause. Ticks are scattered over the page and her score is described by Kate as "fairly high". Kate enquires as to whether Carol has ever heard of HRT – both what it is and what it does. Carol explains that she knows about HRT – she has previously been prescribed patches by her GP but has been reluctant to try them because she doesn't want to be seen as 'giving in'. Carol has brought

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[16] The GCS is just *one* method of assessment used in the Global North to diagnose perimenopause and menopause. The assessment tool that was first created and utilised by Dr Greene in 1998. It's should therefore be recognised that (in relation to the history of menopause) the GCS is a relatively recent developed form of assessment and not one that has been subject to rigorous review.

these patches to the appointment. She pulls out the low-dose oestrogen patches (75 mcg) from her handbag and places them on the table, forming a separation between herself and Kate. The patches remain in place for the duration of the consultation – an unwitting third party invited to join the appointment. Kate asks Carol to explain a little more about why she feels she may not want to pursue HRT as a treatment option. She draws upon Carol's own words and narrative, specifically highlighting the concern Carol has raised about "putting things into her body that don't need to be there". She gives space to Carol, allowing her to talk about her beliefs and commitment to (where possible) heal the body naturally. As Carol talks, she plays absentmindedly with the large, weighted beads strung around her neck. When she raises her arms to use her hands to communicate, bangles fall up and down from her wrists to her forearms.

Kate listens, her expression neutral. She continues to nod, make eye contact, and engage with Carol as she expresses herself. Once Carol has finished speaking, Kate addresses her concerns one by one, before spending some time discussing certain 'myths' associated with HRT. Kate explains what HRT is, and how it works. In particular, she emphasises the concept of 'replacement'. Kate explains that the purpose of HRT is to reintroduce hormones to the body that are being lost as a consequence of the onset of perimenopause. She explains that all of the hormones used and prescribed by Mansfield Health are 'body identical', meaning they replicate the molecular structure of those produced naturally in our own bodies. Kate explains that, as a consequence, they are often more easily tolerated in comparison to a synthetic hormonal treatment such as the contraceptive pill. Kate finishes her explanation of HRT by highlighting that the hormones prescribed are derived from natural sources – specifically yams. Following Kate's clarification (and in particular, her mention of yams) Carol appears to relax.

Kate continues the consultation, engaging with Carol about her medical history, her eating patterns, her alcohol consumption, and her 'lifestyle' choices. Kate delivers the questions lightly and taps responses quickly into the computer as Carol speaks. Following questions about her health and her family history, Kate takes Carol's blood pressure and asks to weigh her. After completing all of the relevant physical checks, Kate opens up a discussion that focuses on the benefits of HRT. She explains why our hormones are essential not only to our perceived sense of wellbeing, but in maintaining good overall physical health as we age.

She expands, detailing the importance of our hormones in preserving our bone density, our cardiovascular health, and our cognitive function. Kate also highlights the role they have in maintaining our libido and sex drive.

Kate asks Carol about sex – whether she is having sex, how often she is having sex, and ultimately, if she is enjoying having sex. Carol takes a pause, before explaining that although she is indeed still having sex, she rarely enjoys herself. She highlights how she particularly struggles with the penetrative component of sexual intercourse, outlining that regardless of her discomfort, she has continued to have regular sex with her husband because she feels 'it's only fair'. Carol continues, describing that she doesn't like to talk to him about the physical difficulties she is experiencing when they have sex, as she doesn't want to upset him, or, in her words, "make him feel guilty". Kate explains that the discomfort Carol is experiencing during intercourse is very normal during the perimenopause and menopause, and that her vaginal symptoms could vastly improve should Carol consider using a vaginal oestrogen alongside her HRT. Kate asks Carol if she would be comfortable with her examining her vulva and vagina, and Carol agrees. Leaving the room and sitting outside, muffled laughs are audible.

Re-entering the room as directed by both Carol and Kate, Kate proceeds to explain that Carol's in indeed struggling with GSM symptoms and her vagina in particular is showing some signs of irritation. Kate explains that blood vessels can as a consequence of muscular changes sit closer to the vaginal wall and that this can increase the risk of vaginal tearing, bleeding, and overall discomfort during penetrative intercourse. Kate continues to outline why vaginal pessaries[17] could help to alleviate some of this discomfort, highlighting how the quick absorption of oestrogen locally can have a beneficial effect on treating vulvovaginal symptoms. When asked if she would like to consider the use of pessaries, Carol seems (albeit a little embarrassed by the conversation) open to the idea of trying vaginal oestrogen. Kate's encouraging demeanour increasingly invites Carol to open up further. Carol expresses her concerns that it was the birth of her 10.5-pound baby that could have led to these issues she is experiencing now sexually, but that before this time she had never felt

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[17] Pessaries are a method of delivering localised oestrogen to the vulva and vagina. They are placed inside the vagina.

comfortable exploring treatment or seeking support. Kate listens but takes care not to comment, merely reiterating when there are breaks in the conversation, how she understands. Kate tells Carol that she sees such vaginal symptoms as a consequence of hormonal depletion on a daily basis, and that there is nothing wrong with her. She reassures Carol that what she is going through (albeit distressing) is normal and likely to improve significantly with treatment.

Kate asks Carol whether she has tried using lubrication or vaginal moisturisers for her symptoms. Carol shakes her head. In the silence, I take the opportunity to mention that there are sample sachets of both moisturisers and lubricants in the toilet's downstairs. Kate smiles broadly and asks if I would mind fetching Carol some "freebies". Upon returning, Carol smiles and mouths a '*t h a n k y o u!'* as she places the sachets in her handbag. Kate is in full flow, explaining the plan of action they have agreed upon. It has been confirmed that Carol will start with patches at a higher dose than her GP prescribed and have her Mirena coil replaced to ensure that the progesterone component of her HRT is included in her treatment. The removal and replacement of Carol's coil would, Kate explains, also help them to ascertain where in the perimenopause Carol currently is, as, though the active progesterone had run out, her coil had remained in situ and would likely be affecting her bleeding patterns.

Carol leaves her appointment clutching a form for blood tests and a collection of shiny leaflets displaying smiling women framed in pastel shades. The oestrogen patches previously prescribed by her GP remain forgotten on the table.

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Three months later, on another rainy Thursday afternoon, Carol is back at Birchwood House.

A slight fatigue is hanging in the room. The consultations Kate has made that day have all been complex, and the unsuspecting tissue box that had been mostly full before lunch is now running low, showing signs of exhaustion itself. A little jolt of excitement in seeing Carol re-enter the room is therefore welcome. The visual memory of Carol at her last appointment falls into focus: her long flowing tunic dress and chunky beads. Her outfit is similar today, but this time neutral tones have been swapped for solid black. The blocks and shapes of her outline are similar, but she presents differently in some way. Carol's presentation is noted by Kate, who compliments not just Carol's clothing but her general shift in demeanour too.

It's hard *not* to notice – Carol is lighter and more buoyant. Whether the result of HRT, changes in lifestyle, shifts in her relationships, or a combination of all of these factors, Carol is brighter – less troubled and keen to chat. Carol doesn't 'spill over' as observed patients tend to when discussing their progress. She does not 'gush' about her newfound zest for life or the miracle of HRT. Rather, she takes note – she connects with the shift, sits with it, pays attention to it.
Kate queries her improvement and Carol explains that she thinks she has seen a significant improvement in symptoms both physically and emotionally. Carol outlines how she is using her HRT as prescribed and explains that she has also incorporated vaginal oestrogen into this routine as suggested, along with a vaginal moisturiser. Carol notes that while she feels noticeably better in herself, she still sees room for improvement. She says she hasn't yet felt she has 'returned' to a more 'her' version of herself.

Kate checks Carol's newly completed GCS score. She holds the paper copy Carol has brought with her today next to the scanned copy that has been opened and displayed on the computer monitor. Little ticks that were previously dotted over the page are now neatly lined in boxes. The two questionnaires contrast visually – disorder is replaced with order. Kate uses this visual prompt to confirm Carol's own assessment that there has been improvement in her symptoms, but nods in agreement that there is still opportunity for further reduction. A few bothersome ticks still lie outside of the margins of symmetry. Kate asks a few more questions about Carol's health and wellbeing – her nutritional routine, her exercise regimen, her overall health. She takes Carol's stats once more and performs the clinical component of the appointment before communicating the course of action she thinks it would be best to adopt in order to get Carol feeling more like 'herself' again.

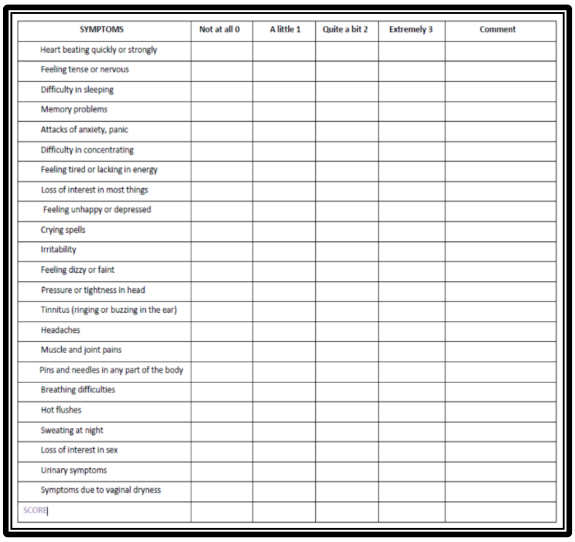
Carol is going to continue with HRT, but up her dose of oestrogen a little. Kate continues by broaching the topic of testosterone. She asks how Carol's libido has been since their last appointment. There is a discussion about Carol's relationship with sex, where she explains that she is unsure whether her anxiety she is still experiencing regarding having sex is stemming from a ‘body reaction’ to the possibility or expectation of pain during intercourse, or simply that her libido and desire is low. Kate listens patiently, allowing space for Carol to talk through how she is feeling. When the conversation reaches what feels like a natural conclusion, Kate suggests that it may be beneficial for Carol to introduce testosterone to her HRT routine. Kate pulls out a little white tube of AndroFeme. It bears a pink prismatic depiction of the chemical compound testosterone. She hands it to Carol to examine. Carol turns the tube over in her hands for a short time before handing it back to Kate. In turn, Kate explains how it should be used and the way it should be applied. Kate takes time to explain the reasons why Mansfield Health prescribes a testosterone preparation designed with women’s biological makeup in mind, outlining why dosage is important in protecting against symptoms such as unwanted hair growth or voice deepening. The rationale is delivered with brevity and humour, the conversation moving quickly from beards to blood tests.

Kate explains to Carol that, whilst measuring hormone levels is an important component for assessing the success of HRT, once levels have stabilised to a point where the patient is feeling satisfied, consistent blood monitoring is not required. This, she outlines, is not the case for testosterone. Kate stresses that in the case of testosterone, levels need to be monitored at least every 6 months – and for the entire time that a patient is using the hormone. Once a management plan has been established, Kate raises the topic of how anxious Carol had appeared during their first appointment when it came to thinking about starting HRT. She reminds Carol how apprehensive she was to begin treatment – how she has kept the patches prescribed by her GP on her bedside table for months, choosing not to use them. She reminds Carol of her narrative about ‘not giving in’ and asks her how she is feeling now – whether she feels differently. Kate’s tone is slightly theatrical. She doesn’t speak in a condescending manner to Carol, but there is a nudge towards a request for acknowledgment. There is an appreciation that perhaps Carol has seen the ‘error in her ways’ – that her fears were indeed unfounded, that she has – to draw upon spiritual metaphor – seen the light.

Carol matches Kate’s energy: they engage jovially about her previous hesitation. Kate closes the line of questioning by asking Carol if she would feel able to talk about her positive experience to her “HRT naysayer friends” having had a positive experience herself. Carol confirms that she has already spoken with a number of her friends about her positive experience using HRT. A further joke is made about crystal healing and homeopathic remedies. Carol takes it in her stride.

Booking another appointment that will take place in three months' time, Carol leaves the consulting room with a blood test request form. After departing, Kate's demeanour matches Carol's buoyancy. She expresses her pleasure at seeing patients like Carol – seeing someone displaying active shifts in their demeanour after beginning treatment. Kate explains that patients like Carol are why she enjoys consulting in the menopausal field; that there are few areas of medicine where you get to witness 'transformation' in the same way – where you get to see effective results and change, each and every time.

Fixing the Fluid



SYMPTOMS	Not at all 0	A little 1	Quite a bit 2	Extremely 3	Comment
Heart beating quickly or strongly					
Feeling tense or nervous					
Difficulty in sleeping					
Memory problems					
Attacks of anxiety, panic					
Difficulty in concentrating					
Feeling tired or lacking in energy					
Loss of interest in most things					
Feeling unhappy or depressed					
Crying spells					
Irritability					
Feeling dizzy or faint					
Pressure or tightness in head					
Tinnitus (ringing or buzzing in the ear)					
Headaches					
Muscle and joint pains					
Pins and needles in any part of the body					
Breathing difficulties					
Hot flushes					
Sweating at night					
Loss of interest in sex					
Urinary symptoms					
Symptoms due to vaginal dryness					
SCORE					

Figure 24: Image of the GCS questionnaire

Carol is just one patient. Yet, the interactions and relational dynamics described in the context of her appointment were observed on countless occasions. Whilst each individual patient was considered unique - their circumstances distinct, there was a choreography followed in every appointment. This 'ritual of the appointment' helped to create the circumstances in which perimenopause and menopause was not only constructed as a diagnostic category but also positioned as individual and specific for each patient. Menopause was made multiple – wide-reaching in its diagnostic horizons, yet specific to the individual.

One of the first things that can be observed from the interaction described between Kate and Carol are the ways in which certain 'paraphernalia' is called upon to shape the consultation. One such item is the GCS questionnaire. To provide further context, the GCS was utilised in each and every appointment as a mechanism to help evaluate a patient's symptoms, and ultimately, to diagnose their perimenopause and menopause. As demonstrated, the GCS utilises a series of scale-based questions in which particular symptoms are afforded a score. For example, the question of "feeling tense or nervous" could be scored as: "not at all" generating a score of 0; "a little" generating a score of 1; "quite a bit" generating a score 2; and "extremely" generating a score of 3.

Alongside the strictly demarcated categories that these scores signify, the process also included an option for comments. Should "feeling tense or nervous" be the main reason for a patient's visit, a comment could be included to add detail, such as "frequent dizzy spells make driving to work nearly impossible". This allowed for the interplay between symptoms to be discussed. For example, if the patient expressed "feeling unhappy or depressed", the clinician might probe as to whether other symptoms could be related to this. Could the lack of independence and autonomy as a result of not being able to drive be connected to a deterioration in that patient's mental state? Thus, when afforded space to discuss their lived experiences in detail in appointments as prompted by the GCS, patients often expressed how no one symptom seemingly existed in isolation. They existed in conversation – they spoke to one another.

Ultimately, the GCS functioned as a material means to create symptoms out of the diverse experiences that individual patients presented with. Once the process has been completed, the GCS was able to be utilised to draw potential causative links between symptoms, making certain concerns more apparent than others. What begins as a list of symptoms is able to become a web, and with it, there naturally arises in the patient's mind the idea of a centre. The GCS thus pulls in symptoms from the periphery around this centre and makes it possible to assemble them under that core heading: menopause.

The function of a score being calculated is important to acknowledge as it calls upon forms of psychological conditioning related to achievement. In the context of the GCS, the higher the score, the more severe the presentation of perimenopausal or menopausal symptoms. A high number is set out by the clinician as problematic, something that needs addressing, and this assertion is conveyed in such phrases as “Oh, you’re a 25, we need to do something about that”.

However, assigning a score also provides the patient with affirmation, in the form of an acknowledgment that the lived experiences they are navigating are not made up or exaggerated – they are tangible, they are given a number and a plan of action is put into place. Something can be done – the patient has a score to reduce, and is given work they can engage in to achieve that goal. The way the questionnaire is designed also bears relevance. A variety of options for responses are provided. A patient will unlikely answer in a uniform manner to all questions, even if they are presenting with a number of symptoms. Thus, the result of the design means the completed questionnaire looks disarrayed. In the case of Carol, in her initial appointment when symptoms were multiple, ticks are scattered over the page. Upon her return weeks later, these had resolved into neat rows of ordered check marks that could held up next to the original GCS. She is presented with her ‘result’. She has been appropriately balanced and ‘checked’ into alignment. The manner in which the GCS features as an important tool by which the appointment is structured also reveals the questionnaire to encourage conversation. Firstly, it helps to establish a hierarchical context in which the approval of the clinician is sought out by the patient. For Carol, there is a desire to be deemed compliant – to actively engage in the context of her own care. In ‘doing the work’, Carol is affirmed by Kate. Her score diminishes and her ticks horizontally comply. The newly completed GCS is encouraging; it shows that Carol has completed the homework, she has been a good patient.

Secondly, and existing in correlation with themes of hierarchy, is the role of gender. As symptoms are explored and discussed, there are further queries regarding lifestyle. How much alcohol do you drink? Do you exercise? Is your BMI in the normal range. Every ‘transgression’ is explored by Kate, every possible point of precarity policed. Women’s body are not permitted freedom to expand, or age, or spill over. Their bodies are not provided with space to exist in ‘fluid’ terms, or for hormones to decline. Rather, they are affirmed most when sealed at the edges and brought back into balance – when ticks are aligned and, decline halted. In the context of policing women’s bodies this is an important acknowledgement to draw attention to. The project of ‘physical configuration’ – of bounding the female body into something balanced and stable – is well documented (Jaggar & Bordo 1992; Prince & Silva-Wayne 2004; Rothblum et al., 2009; Longhurst & Johnston 2014; Phipps 2014; Lupton 1997, 2012, 2018). Physical configuration is associated with standards of behaviour: the compliant, stable body is positioned as an achievement, a marker of social compliance. A woman who is appropriately managed in a physical way is safer for society, since the achievement of physical configuration both demands and demonstrates character markers that hold social value as defined by the patriarchy – restraint, industriousness, and consistency.

Whilst the consequence of menopause has historically (as outlined) been associated with an erasure of women from the fabric of society (a decreasing value related to the process of aging), the menopausal body *itself* has been less subject to scrutiny – in many ways left alone to 'change' whether valued by society or not. The *menopausal turn* (Jermyn 2023) has arguably reclaimed the menopausal body as the 'seat' by which conversations of emancipation may occur. A woman's body under menopausal care is positioned in this new era as empowered. It is a body that refuses to accept the constraints placed upon it by society, and through the use of hormones, one that denies a process of 'decline', and as such, reclaims its position and value within society. The context of this narrative draws upon the same rhetoric of second-wave feminism, in which a woman's right to control her reproductive choices correlated with concepts of liberation from patriarchal constraints (Nelson 2003; Munch 2006; Gilmore 2008; Kline 2010; Fahs 2015). However, in the context of conversations of menopause, the line of argument in which intervention on the body leads to social liberation doesn't quite ring true in the same fashion. The bass line is there, but the melody doesn't catch. Something feels discordant.

A possible rationale for this is the fact that any hormonal intervention is difficult to detach from narratives in which women's aging bodies are presented as less valuable. Whilst debilitating symptoms of perimenopause and menopause are not discounted nor dismissed, the rationale for exploring treatment is positioned as important to consider. In doing so, intervention on the body via the use of HRT is arguably revealed to exist in conversation with contending concepts of patriarchal constraint. The emphasis is placed on getting back to who you were, or even in some instances, a better version of oneself, which implies that the other version – the aging version – is simply not acceptable. To consider Carol in the context of her first appointment, she highlights to Kate that her reasons for calling the clinic is due to the fact that she "got drunk at a family gathering and insulted a number of friends and family members."[18] Carol explains she is therefore not just attending her appointment for herself, but for her family too. Thus, in pursuing treatment, Carol showcases herself to be a good wife, mother, and friend. She intervenes in the uncontrolled and places parameters on her behaviour in order to 'protect' others.

Equally, in pressing Carol to discuss her symptoms, it is revealed that she struggles with vaginal penetration but continues to engage in this form of sexual activity because she doesn't want to disappoint her husband (a common narrative thread that ran through many of the appointments observed). Carol's pursuit of treatment, therefore, whilst offering the opportunity to provide relief from physical pain and increase her own sexual pleasure, aligns more closely with her partner's needs than her own. She doesn't want to cause issues, nor fail to comply with heteronormative standards of sexual intercourse. As opposed to discussing alternative ways Carol could have sex that do not involve penetration, Kate suggests hormonal intervention. This is not necessarily problematic, and indeed may well be what Carol was wishing to explore in the first instance, yet it is still proves revealing. It still positions Carol's partner as primary and her subsequent treatment (both the desire to pursue it and the enactment of it) as benefiting others as opposed to simply herself.

In considering the function of the GCS questionnaire therefore, we are able to observe that it serves not only as a mechanism to 'make menopause', but a means to open up the parameters of discussion that surround it. Whilst a patient may conceive of their symptoms prior to discussing them with a clinician; before the boxes are checked and a score calculated, menopause as a diagnosable category or entity does not truly exist. Rather, it is shaped via the interactions within the appointment – via the discursive practices that take place in which symptoms are collected and discussed to form a diagnosable state.

In this sense, as a tool, the GCS proves imperative to the work of clinicians at Mansfield Health as it removes doubt, obviates questions, and provides clarity. What was once unstable, perhaps even chaotic, now makes sense. These disparate experiences are collected and conceived of. They exist as something

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[18] Carol is our hero.

singular. As opposed to a burgeoning array of contending concerns, symptoms now converge under a neat heading – the woman is menopausal.

However, the GCS does not just assist in the making of menopause, it helps to rectify what is disconcerting. Women's bodies in physical menopause destabilising to the patriarchy due to their fluid and inconsistent state. The GCS offers reassurance. It assists to stabilise what is unpredictable, and as such, a threat to society. It regulates and codifies the unbalanced, continuing the cultural phenomenon of pathologizing women's bodies and rectifying their rebellion. Equally, once symptoms are collected and assigned their status – menopausal – this cannot be undone. The diagnosis is given, and the fluid (and as such dangerous) temporal state is fixed.

Menopause and the Material

During a clinical appointment both patient and practitioner take on roles. They each play a part which helps to establish the interaction as medical (Strong 2018). To support the construction of this, the use of 'props' is necessary in order to help set the scene (Atkinson & Anthony 1995; Janzen 2001; Briggs 2011; Patterson & Francia Kinchington, 2019; Veinot & Pierce 2019). The GCS is just one of these props. As has been outlined, the questionnaire was called upon as a discursive tool – a means to facilitate conversation that helped to collect symptoms, thus 'fixing' and stabilising something fluid. It is an essential mechanism in the process of making menopause. Other mechanisms assisted in this process, ensuring that the interaction was not simply discursive but made 'real' through the medically material. It is worth noting that the construction of the medical occurred in a specific way at Birchwood House – it walked a line that was balanced, taking care to not 'over medicalise'. Much of what has been specified in the prior chapter considers the ways in which the space at Manfield Health functioned to achieve this end. The consulting rooms helped to build an environment that was welcoming; one that contained the essential equipment to encourage women to acknowledge their experience as medical, yet without producing the feeling of an oppressively over clinical process.

We may recall, that during Carol's initial appointment, following a disclosure on the part of Carol as to what brought her to the appointment, a family history is taken, as well as a relevant medical information. After this, her blood pressure it measured, and she is walked over to the set of scales so she may be weighed. These actions were not uniformly performed. In some instances, patients would be asked, and a response would be acknowledged. However, the questions were always posed, and attention always drawn to the surrounding items – the set of scales in the corner of the room and the blood pressure cuff neatly placed on the desk. Statistics would be tapped into the Heydoc system, alongside units of alcohol consumed and the number of hours biked or hiked per week. The collection of these statistics formed the first part of the process in which menopause was made medical. In associating menopause with other health issues (namely heart health), menopause is acknowledged as something that may impact the body as a whole, something that needs to be 'considered' before treatment can be administered. It communicates due diligence on the part of the doctor. Kate is doing their job correctly, checking what needs to be checked before HRT can make its debut. The computer screen is angled away from the patient – they cannot see the things that are being typed about them or the accompanying notes that sit with these figures. Just like the GCS, this collecting of statistics functions as a means to encourage 'work' on behalf of the patient: their weight is positioned as something that could be reduced, along with their consumption of alcohol, intake of caffeine, and predilection for sugar. The body is made a site of construction, something that can be aided and assisted to be more 'balanced'.

After these checks have been performed, Clinicians were able to introduce the topic of HRT. In close proximity to the desk, dummy tubes and boxes of patches were kept and sometimes displayed throughout an appointment. These were utilised by clinicians to help patients understand what the administration of HRT would look like. Demonstrations added a tangibility to the clinical interaction. Whilst the decision of what type of HRT patients wanted to use was clear for some, others needed guidance with making this choice. In Carol's case, since her GP had already prescribed her patches for the oestrogen component of her HRT, Kate simply suggested increasing the dosage in patch form. It was agreed without discussion. Others, however, wanted to know why one might choose a certain method over another – for example, why a patch over a gel? The clinicians used these dummy examples to help demonstrate the rationale. They allowed patients to examine patches, hold them in their hands, explore the size and the feel. They were able to explain that they sometimes left a sticky residue after being removed (imagine the little bit of glue you have left over from a plaster), but equally highlighted that they wouldn't need to be changed as regularly, meaning they were useful for those who may be forgetful or lead a busy lifestyle where patches could be forgotten[19]. For the gel, patients were able to squeeze out some of the sample and feel the way it sat on the skin – they commented on the texture, whether it was sticky, how they could apply it and so on. In the case of the gel, clinicians were able to demonstrate how and where it could be applied. Just like an aeroplane's cabin crew motioning to the emergency exits, clinicians dummy rubbed circles on their upper arms or thighs to demonstrate how the pumps of gel could be applied. Like a strange sort of choreographed dance, the ritualistic application of HRT was performed, and patients returned home to repeat the same dance in their bathrooms and bedrooms daily.

The choice to model a 'dummy application' came from one clinician's experience in particular. Asking Jane after an appointment why they didn't simply rub the gel on when demonstrating, she explained that there was one particular week where she had accidentally swapped an actual tube of Oestrogel for a dummy. Needless to say, at the week's end, and after dozens of applications, Jane experienced extreme breast tenderness and it was only when another clinician asked whether this mistake could have been made that she realised she had been applying multiple doses of HRT to her arms every day that week.

The final tangible touch to the appointments came in the form of information. Patients were provided with leaflets and other reading materials they could take away with them. Early on in this research process I had visited a sexual health clinic at St Mary's in London to speak to a urologist that was consulting there for the day. Sitting in a waiting room, I examined the leaflets displayed in a wire plastic wall fixture. As opposed to offering 'new' leaflets, the 'master copy' had been placed on the photocopier to produce a number that could be hastily folded – a saving on expenditures it has assumed. Sadly the leaflets had been haphazardly placed, meaning the pages were askew and the colours (supposedly bright and inviting on the original) were dull and had bled together. The leaflets were depressing and uninviting. Sat on a hard plastic chair that was an

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[19] Seemingly a great option for an ADHD neurodivergent such as myself!

unappealing shade of brown, I remember the fluorescent lights throughout the hospital building were jarring and that I kept expecting for them to flicker and extinguish. The vinal flooring was a strange combination of colour's that fell somewhere on a yellow spectrum. The floor was clean but noticeably worn with lots of scuff marks visible near the bottoms of the chair legs. The leaflets stood out *because* of that black and white skewed text and the way 'Gonorrhoea' meekly peeped through the wire wall frame. Posters that were displayed on walls were equally worn. The corners were torn, and some had noticeably required a great number of 're-sticking' attempts in order to secure them back to their magnolia host.

As such and perhaps as a consequence of this experience, it always struck me as important to consider the relevance and 'work' the glossy leaflet in the context of Birchwood House had. Whilst some leaflets (specifically the information on testosterone) were produced externally, a number of the information pamphlets were created by Claire herself and featured abstract designs, along with the Mansfield Health logo in the top corner. They belonged to the clinic, and they performed a task. They provided the patient with real reference material to legitimate what the clinician was saying. They offered the opportunity to go away and consider what had been said – read more and continue to perform their role of 'good patient'. Perhaps most importantly however, they positioned the patient as important. These leaflets were well produced and inviting; they made the person attending an appointment feel important and cared for. Their menopause, just like them, was an individual experience – each leaflet had been selected and handed to the individual, communicating active listening and care on the part of the clinician.

In the case of Kate, this was extended a step further: not only was she dispensing leaflets, but sachets of lubricants and moisturisers, too. The tester brand that the clinic used was called YES. The branding for YES is specific – neutral, white, and unassuming. It communicates its message simply and without hesitation. It's not gaudy, nor colourful, but instead clean and crisp. Thus, handing the sachets to Carol, they look well placed amongst the

Figure 25: Image of 'Yes' products sold in the clinic. (Yes 2023)

leaflets, coloured in pastel tones against a neutral background. In the context of the clinical interaction at Mansfield Health, therefore, what is relevant is not just how material aids make menopause medical, but also the ways in which they create a specific menopausal experience. The aids are used in the right way, presented at the right time and in the right context, and help both confirm and affirm the patient experience as tangible. Patient stories are provided space, before material props feature as a means to confirm and affirm experiences. Patients leave the appointments with 'reminders' not just of the work that has taken place to construct their diagnosis, but as a memory of the experience – the ways in which they were heard and validated. The leaflets, the sachets and the patient letter outlining their appointment that will arrive through their letterbox just days later, all part of the performed work to help construct the individuals' experience as unique. The work that the clinician went to, not just to see the patient, but to select the leaflets, to take out the testers, to fetch the samples; it confirms to a patient they are cared for and could trust the context of care. Equally, the concept of *The Gift*, as described by Mauss (1925), in which we not only give gifts, but feel certain pressures to reciprocate plays out in this context. The clinician plays their part – they do the work and provide the 'gift' (that being care, in the form of both HRT and compassionate engagement) and as such, the patient must reciprocate. They must use the gel; they must reduce their wine (and in turn their waistline) and they must transform upon their return to give back what has been received.

Tackling Transformation

At the beginning of Carol's appointment, her rationale for visiting the clinic is outlined and followed with a discussion as to how she no longer feels like herself – no longer feels like the women she once was. The theme of return is thus presented almost immediately by Carol. Over the course of the appointment, it is equally confirmed as something that must be addressed; Carol must return to who she once was. The theme of a return to self was by far the most common and unifying concept that could be observed in patient narratives during the time spent at Birchwood House. Women felt they had lost themselves, lost their identity, lost their sense of purpose, and wanted to reclaim it. In so many appointments, the same story was told over and over again – the patient wanted to feel like the person they used to be. Most essential within this story was the concept of a static self, a self that may be lost, but equally, a self that could be reclaimed and returned to. Through the power of medicine, the power of HRT, these women were able to return to a core ‘true’ version of themselves.

The narrative of transformation was called upon by clinicians. Countless iterations of the phrase ‘let’s get you back to feeling like yourself again’ could be heard in response to women’s requests for support. Thus, the positioning of one’s identity as permanent as opposed to permeable was enforced and reinforced through the cadence of the consultation between patient and practitioner. Whilst this analysis may read as dismissive, perhaps even condescending, it is not the intention. In discussing the promise of a static self, the cultural relevance of transformation and return are revealed, as are the ways in which these concepts feature in the patient’s pursuit of identity. In pursuing a core self, the materiality of existence is affirmed. We no longer live our lives untethered, or in a constant state of impermanence; we commit to the idea of truth, and stability, fixing our experiences and regaining a sense of control. We become more than blood and flesh and water; we become a balanced self. Thus, the clinician is offered the ultimate opportunity, in the context of these appointments, to facilitate something of high sociocultural value. They are not just balancing hormones; they are offering a reconnection to a self perhaps considered lost.

Of course, in the context of hormones, this is somewhat ironic, as hormones can in no certain terms be measured or truly balanced. To use blood tests as an example, whilst they can provide a general read on hormone levels (meaning that an overall response to treatment can be measured e.g., moving from low levels of oestrogen to levels within the normal range), there is no certain means by which an exact number can be affirmed. Hormones are simply not static; they change throughout the day. They peak and trough. They exist in conversation with bodies holistically and relate to other factors such as nutritional intake, overall health, levels of fatigue and so on. Hormones by their very nature, and as this thesis has explored, are not able to truly be fixed; they are conceptually and materially fluid. Thus, in this sense, the fixing of the self through the use of hormones is paradoxical.

Nevertheless, a sort of fairytale narrative, seductive to women everywhere, seemingly played out in the consulting rooms of Birchwood House. Women would bear stories to a pseudo fairy godmother who would provide instructions as to how to use something 'magic potion' that offered the promise of making everything OK again. Of course, like any good story, conditions to using the potion were always provided. It must be taken at the right time and in the right way. It must be administered just as the fairy godmother instructs, or disastrous consequences might ensue. For our patients at the clinic, this involved eating the right foods, exercising in the right way, and adjusting their lifestyle too. The hormones prescribed thus perform cultural work – they offer the opportunity to obtain a sense of self; to return to what once was, or equally, to progress to a better version of who you ever were. They are managed and administered by gatekeepers (clinicians) that are responsible for performing a subtle balancing act. The clinicians review and tinker, they assist in the construction of a context in which the patient is cared for as special and unique. We can observe that whilst treatment for every patient is essentially the same, the work performed by the clinician communicates difference. The clinician selects the patches or gel depending on what is *right* for the individual. They take out the leaflets that correspond most to the narrative that has been communicated and treatment is positioned as bespoke and relative to a patient's circumstance. Just like the unique sense of self the patient is returning to; the administering of hormones is performed in a manner that *feels* specific to them. Hormones are prescribed. A material 'thing' is offered, and the effect of transition becomes tangible. The patient is physically shifting and becoming through use of the hormones.

Returning to the concept of a story, to a fairytale ending, it's important to remember that there are always instances in which a magic potion does not work in the way it was perhaps first expected to. Our protagonist may have administered everything correctly. They may have followed instructions to the letter but still have had no success. In these contexts, the character usually returns to the fairy godmother, who rarely fails to help her find a solution – there is always something else our heroine can try. In the context of the appointment, the final flourish is testosterone. Something that always felt somewhat puzzling was the fact that testosterone was only offered at the second appointment. If it was beneficial to most patients, which clinicians at Mansfield Health affirmed was their experience, why not offer testosterone initially and alongside oestrogen and progesterone?

The first thing to note in relation to this is that currently, testosterone is not licenced for relief of menopausal symptoms, beyond prescribing it to perimenopausal or menopausal women struggling with low libido. Even in instances where low libido is discussed, affirming the root cause of the issue is tricky. Often, the experiences women spoke of were complexly associated with psychosomatic factors too; factors that testosterone could do nothing to intervene upon. We may think about Carol's experience. In her follow-up appointment she mentions still struggling with sex but being unsure whether this was partly also related to a pre-emptive concern that she would come to experience pain because sex had previously been so uncomfortable.

On the 2nd of March 2023, the BMS issued a new position statement on testosterone, stating that: "Testosterone is not the third component of HRT and promoting misinformation is creating unrealistic expectations for women, some of whom have challenging social circumstances" (Mariette-JB 2023). This position statement came out of what the BMS termed "current controversy surrounding testosterone treatment [that] is causing confusion amongst women and healthcare professionals alike". They affirm that "British Menopause Society guidance follows NICE NG23 which recommends that testosterone is used for low libido after other options have been exhausted."

In a recent exchange with an NHS clinician who runs a monthly menopause clinic, they explained that before they even enter the building on the day of this clinic, they know exactly what women will be asking them to prescribe – testosterone. Whilst they candidly expressed their own reservations in these conversations, saying 'who am I to assume it doesn't work', in the same exchange they followed this with some frustration. They discussed one patient they had seen that month who asked for testosterone to help improve her sex life but that it was revealed upon probing, they no longer slept in the same bed with their partner. With gentle humour, the clinician noted in our exchange that it was going to take more than testosterone to rectify *that* distance.

This exchange and the BMS statement are both referenced because they represent the realities of perimenopausal and menopausal care in the UK. In the context of the clinic, it was common for women to be prescribed testosterone. Whilst licenced prescribing (as the BMS indicates) highlights that its use should be reserved for low libido, clinicians practising at Mansfield Health routinely discussed the benefits they saw testosterone to have on other symptoms too. Women often communicated feeling a number of their more debilitating experiences were in fact most improved upon the addition of testosterone. The 'truth' of this is not the concern of the analysis, rather the observation that, for many, access to a clinician or a 'fairy godmother' is difficult to come by. For the clinic, having the ability to add testosterone affirmed to women that clinicians are not satisfied with 'OK' or 'good enough'. They want to ensure patients feel the best that they can – the most complete and happy versions of themselves. Equally, it provides a mechanism by which the clinic is able to meet needs that haven't been fulfilled. In the context of a follow-up appointment, there is more they can do – there is the final addition. Whilst the BMS may be clear that testosterone is not the third component of HRT, it is true that we prefer things to come in threes – the father, the son, and the holy spirit… the oestrogen, the progesterone and the testosterone. Together they affirm, together they bring back what once was – they don't simply deliver us from evil; they redeem us.

Picking Private

Whilst (as explored elsewhere in this thesis) being able to obtain testosterone may prove more complex for women pursuing care via the NHS, it was not and is not impossible. As the clinician notes, they receive an increasing number of requests from women asking for testosterone to be added to their HRT regime. Equally, and a referenced the BMS published a position statement on the matter, communicating that even though they find the process challenging, women are still seeking out this hard-to-come-by hormone. Thus, if it *is* possible to obtain treatment without spending a great deal of money on a private consultation, why would a patient choose otherwise? What motivated Carol to seek out care from a clinician at Mansfield Health? As we see from her initial consultation, Carol has already been to see her GP, she has already obtained patches and her Mirena coil is in situ, providing the progesterone component of her HRT. Why then, given this circumstance, would Carol feel compelled to speak to another clinical professional? Why should she feel motivated to seek care from Mansfield Health?

Arguably, and like so many other women that participated in this research, Carol's experience and her 'treatment' entails so much more than simply prescribing hormones. Carol is not looking for *just* a physical intervention – she has already received that; her GP has already prescribed her patches for her symptoms. Rather, Carol is seemingly seeking recognition, a validation of her experience as tangible. She doesn't want to feel dismissed or disregarded; she wants to be acknowledged. In speaking about her interactions with her GP, Carol discusses how she felt undermined; not only clinically, but in other arenas of her life too – a sentiment echoed by many women. Culturally, this is significant to acknowledge as, not only are women routinely positioned as 'other' in the context of medicine, but the menopausal woman, the aging woman, is uniformly stripped of agency and often made to feel invisible in both clinical and non-clinical spaces.

Thus, for Carol, and for so many of the other women that participated in this research, what they gained from their experience at Mansfield Health was not simply a prescription for HRT they engaged in a consultation that felt personable and wasn't rushed. (Freeman 2010, Glantz, Örmon and Sandström, 2019, Ihlebæk, 2021). In the UK, arguably you would struggle to find a person who has not, at some point in their life, felt rushed during an appointment with an NHS practitioner. The experience is familiar. Entering a consultation room, the individual feels there is a need, perhaps even a pressure to communicate your reason for attending at double speed. When considering the context of a menopausal patient, we must recognise that symptoms are far reaching and complexly interconnected. Moreover, for many, one of the most debilitating symptoms experienced is 'brain fog'. Thus, in the context of an NHS setting, where a patient has 8 minutes to communicate their needs, the pressure and stress is overwhelming, particularly if you are struggling with memory. Not only did women confirm this experience, but they also demonstrated it at Mansfield Health. On countless occasions, women could be seen rushing into the consultation rooms with pieces of paper – notes listing symptoms that they did not want to forget to mention. The patient was prepared and was communicating a lived experience in which their needs had previously not been met.

However, it is important to emphasise that in the context of Mansfield Health, it was not just additional 'time' that these patients received, it was a particular kind of time that accommodated for a particular type of empathic interaction to occur. The limited resources and period of time in which a general practitioner currently has to interact with those presenting with perimenopausal and menopausal symptoms simply does not facilitate *these* interactions to occur – it does not facilitate the co-creation of intimacy. To reiterate, it's not simply about giving more time to GPs, rather there needs to be a fundamental shift in systemic service provision and mindset to allow for women to be heard, for practitioners and service providers to readdress the value of a person's symptomatic presentation. To realise it not as a one-off consultation, but as an ongoing practice of care, a building of a relationship, a making of a home, a place of comfort and safety during a period in which everything else remains in flux.

The current model for treating those experiencing perimenopausal and menopausal symptoms in the NHS in the UK does not serve women. In the case of Carol, she had already been prescribed HRT but wasn't using it. Why is that? In the simplest analytical terms, it is contended that she didn't feel safe to do so, because the space for her to engage with her practitioner didn't allow for her most intimate concerns to be addressed or to be eased. It is of paramount importance that we recognise that women may not present to their primary care practitioner with a list of all of the symptoms they are experiencing, nor are they necessarily likely to volunteer all of that information readily. In Carol's case, her concerns regarding intimacy were not brought up by her, but revealed upon enquiry, revealed when trust between patient and clinician had facilitated a sense of safety to share the most intimate parts of herself. She leaves her initial appointment having not only covered all of her symptoms, but having undergone a physical exam which confirms she is suffering with GSM symptoms that are likely the root cause of her pain. This is the first instance in which Carol has felt comfortable to discuss this with a practitioner. She's visited her GP previously and it has never been addressed. The difference is not just in time, but in the mindset and ritual of care with which the clinician carries out the consultation. As opposed to 8 minutes, Carol has the best part of an hour, and in that hour, she is encouraged and facilitated to express her view of herself and how that relates to her symptoms and to her goals. She is able to ease into the conversation, to make sense of the complexities of the body and self so that she can then act with greater confidence. Carol is guided through the process by means of the elements that make up the ritual of the appointment – material supports, identity goals, and checklists of symptoms – and it is through this ritual that she feels both safe and cared for.

Care as a form of Treatment

The presentation of a narrative trope in which women are Disney characters and the practitioner a fairy godmother may feel trite, perhaps even reductive of the realities of what these women experience. It is important for any reader to understand that the positioning of this narrative is not to contend that perimenopausal or menopausal symptoms are not real. Equally, in discussing how they are collected via the GCS, it is not argued that this action 'makes up menopause'. Rather, it is posited as a device that helps to makes sense of a disparate experience that can be complex to navigate. In 'fixing' menopause, we provide a sense of control over what may seem unbounded. Moreover, the role of a fairy godmother exists to provide care, to provide support, and to help us return to a life we want, or a future we envision.

What unfolds in the clinical interaction between Carol and Kate is the building of a relationship in which understanding is facilitated. There is empathy, there is active listening, there is the sharing of experiences, there is humour, there is understanding, there is probing. Fundamentally and most importantly, there is the co-creation of intimacy. This, in and of itself facilitates an environment in which the patient is no longer 'the patient', rather, they are the person. They no longer feel blamed or a burden, they no longer feel responsible for what is occurring in their body. They are no longer problematic – a woman with too much time on her hands. They are instead reimagined in the role they intended to play; they are themselves. Perhaps more fitting and appropriately worded, they are the subject of care.

In the case of Carol, we may consider her concern that the reason she may be experiencing discomfort when having sex is because of the birth of her child, and in particular, the fact that she has never spoken these words into existence. She has felt them. She has claimed for herself her body's experience. Her consultation allows her to air that anxiety. Kate does not dismiss it. She does not discount it, she simply acknowledges the experience, provides reassurance, and moves the consultation forward. She is provided with care. That care is a form of treatment. The consultation model observed requires a partnership and a collaboration for Carol's full range of symptoms to be made visible – the dynamics of the consultation is the mechanism by which care can occur and treatment can be facilitated. It is a gentle interaction that encourages the symptoms to emerge and be taken seriously in due course. In observing the consultation and considering the response from Carol, we are able to acknowledge that the current provision of care via an NHS GP pathway inadvertently excludes women the opportunity to speak freely without time-pressured sensitivities, and it is *this* model that doesn't make sense when it comes to treating women presenting with multiple perimenopausal and menopausal symptoms.

This analysis is not intended to serve as a critique of GPs, who struggle with limited or time-sensitive consultation models, but rather as an opportunity to think about appropriate frameworks for facilitating menopausal treatment in which women may be offered the care that they desperately need - something that is seemingly made possible via time-rich consultations. Fundamentally, time with a practitioner should not be a luxury, as opposed to a right. From observations, it is clear that we have to underscore the word care and realise that this is a part of the treatment process that exists alongside and compliments the use of HRT.

Patriarchal Practice

There is a balance to be struck in undertaking an analysis in which women's experiences of pursuing care and treatment for their perimenopausal and menopausal symptoms are placed in proximity to the patriarchy. If undertaken without appropriate reflection, such a discussion threatens to strip the participant of agency, recreating a problematic context in which the analysis achieves little more than recreating the conditions it is attempting to critique. Would the women who took part in this research consider themselves to be a subject of patriarchal oppression? Arguably, a resounding 'no' would echo from them all. Thus, in considering this line of argument, such an acknowledgment must be made: an acknowledgement that, for these women, their desire to seek treatment largely stemmed from experiencing debilitating symptoms that they wanted to address as opposed to feeling like they had to, due to societal pressure. Nevertheless, echoes of patriarchal conditioning, in which women's bodies are positioned as a site of labour that requires work can be heard.

In particular, the focus and interest in ideas of transformation or change feeds into a cultural understanding that women need to constantly be conceived of as stable *or* improving upon themselves. Moreover, this is an improvement that is specific and rarely celebrated if identified as self-serving. In the context of these women's lives, many were experiencing newfound pressures – and equally, losses. Children were leaving home, yet caregiving for the child was replaced with caring for ailing parents (both their own and often a partner's too). There were accounts of feeling increasingly invisible in society – a sense of a diminishing cultural capital in which youth and beauty are associated with a woman's worth. Thus, the pursuit of treatment was often complexly associated with all of these things – with needing more energy to meet mounting responsibilities, but equally, to reclaim a sense of value within an ageist culture.

In contrast to these rationales, there was a more common trope – the kind that Carol presented – pursuing treatment for the good of others and seeking care in a specific and non-threatening manner so as not to upset the patriarchal status quo. It is interesting to consider, if these women had presented their reasons for seeking treatment differently – presenting solely as wanting more sex, more money, and more power, and doing so unapologetically – would that have been OK too?

Increasingly, we are seeing women embracing this narrative, a sort of midlife middle finger stuck up at the idea of losing their position of authority. Menopause campaigns and marketing utilise these themes and concepts of empowerment, and in doing so, they position the person powerfully. The patient is a woman in control, and menopause is something they take in their stride – it does not slow them down. Yet at the core, at the heart of these women's narratives, that assurance and sense of deserving reclamation was fragile to observe. There were contending and competing complexities to consider. One example is instances in which a person decides *not* to pursue treatment. In the case of Carol, in her follow-up appointment, Kate makes a note that Carol had once felt ambivalent, if not apprehensive about pursuing HRT treatment. Kate follows up this sentiment by asking her what she would now say to her naysayer friends about HRT. Pressure is placed on Carol to affirm she made the *right* decision about her care.

We can see how treating one’s menopause is never truly private, but rather part of a public politics complexly associated with concepts of choice and representation. Not using HRT becomes a statement – a lack of interest in wanting to stand behind a cause in which women support one another through their use of HRT. Equally, it communicates a position about oneself. If you do not want to use HRT, you communicate that you do not want to do all you can to take care of yourself in the ways you should, by reducing your future risk of breaks, fractures, or heart disease. In choosing not to use HRT, you choose not to be a good citizen and reduce your future burden on the NHS, but equally and perhaps more problematically, you choose not to be a good woman. You choose to decline without concern and reject the pursuit of self-improvement. You persist in instability and burden the rest of society with your imbalance.

Equally, however, the same could be said about the choice of using HRT. For example, in the context of high-risk patients, such as those diagnosed previously with breast cancer, use of HRT was positioned narratively in wider society as selfish. It placed not only yourself, but others at risk, should you suffer as a consequence of this decision. For women seeking treatment through their NHS GP, HRT was often still, regardless of evidence to the contrary, discussed as something that should only be used for the shortest amount of time it was needed. To ask to continue using it, to be prescribed it beyond the period in which your GP felt it was appropriate was considered crass. It communicated an ‘appetite’ for improvement, a desire, a want, a ‘greed’ that we know women should never display openly. Indeed, many women ended up booking appointments at Mansfield Health for this reason – to avoid feeling embarrassed at having to ask their GP to continue their treatment, when it was clear that the GP felt such a decision was unnecessary. Thus, for women navigating menopause, no decision was arguably the right decision. As in so many other instances, these women’s bodies can be seen as the site at which sociopolitical conversations around appropriate needs and wants play out.

Return on Investment

Much of this chapter could be read as a criticism of the practices as they occurred at Mansfield Health, or equally, a dismissal of menopause itself as a medical phenomenon. This is important to counter. The tangibility of these women’s experiences was visceral, debilitating and life altering. It is not argued that they did not require support, nor that they should not have felt validated in seeking it. Rather, it is contended that the manner in which menopause is made medical is temporally, culturally, and contextually specific.

This analysis has argued that menopause is made through interactive practices in which a construction must occur. Work has been outlined as needing to be undertaken by both parties in order to fuse together symptoms into concrete ‘things’. This is supported through a material enactment of other medical rituals – the rubbing on of hormones, the taking of blood, the weighing of the patient, the reading of blood pressure and more. Though the category is constructed and put together through collaborative work that involves both clinician and the patient, it is also observed as far from being devoid of influence; in fact, it is found to be both overtly and subtly shaped by it. There is a want, perhaps even a need to return (or create) a version of a core and stable self. This chapter has contended that whilst this idea is seductive, the concept of a static self lies at odds with the realities of both hormonal changes and the body itself. A diagnosis is not concrete but rather malleable, adapting and responding to a variety of factors such as developments in new and emerging research, the temporal rhythms of the everyday and the overarching narratives impacting our worldviews.

In the case of the patients observed at Mansfield Health, responses to treatment were complexly associated with competing factors. Many changed their lifestyles, their eating habits, stopped drinking, or took up mindfulness. Thus, could you ever really say that it was the HRT that worked? As long as the patient felt better – isn’t that what mattered?

One of the things observed in Carol’s follow-up appointment by Kate is that working as a clinician in menopausal medicine is rewarding, as you are nearly always able to see a ‘return on investment’. You are able to see progress from your patients and it really feels like you are making a difference. Kate observes there are not many areas of medicine where you get to make a difference like that, seeing such change every day. So perhaps our narrative trope is a revealing metaphor. Perhaps the fairy godmother really does give our heroine her happy ending.

After all:

> *The greatest power seems to lie far from the material reality of treatment, but rather, in the symbolic. Not to sound painfully – too stereotypically – like a girl; it seemingly lies in the talking. In the speaking of menopause. In speaking, it seems menopause is made real. We grasp at the once sand-like substance that slips through fingers – confused by a body that is in flux and turn to a professional that tries to oust it into apparition. Through talking we make sense – we make immaterial material. We make fact out of fiction. We find a touchstone for the magic.* (Fieldwork Notes January 2020)

CHAPTER 5

The Conference

The last two chapters have focussed on the everyday happenings that occurred at Mansfield Health. In this chapter we move beyond and outside of the clinic and present observations taken from the European Menopause and Andropause Society (EMAS) conference.

Underpinning the following observations it the understanding that categories such as sex and gender are important structural forces that serve a vital function in maintaining social order (e.g. Epstein 2009). As such, the idea that certain hormones belong to particular bodies is thought to reflect a craving for ordered physiology, and the desire for our bodily forms to communicate particular sentiments. The transgression of ‘body boundaries’ (such as bodies that contradict gendered norms, or hormones in the ‘wrong’ bodies) is observed as threatening our social order precisely due to their ability to upset normative ideologies – a powerful disruptive capability that makes following the use of hormones not only intriguing but vitally important in querying latent assumptions. Explorations within this chapter query how testosterone is involved in ‘making’ bodies and selves, simply through its presence and absence. Fundamentally, it highlights how testosterone’s location at the intersection of scientific, commerical and moral-normative discourses communicates paticular narratives on masculinities and patriarchal power.

This is furthered by considering the interplay between patriarchal power and gendered concepts in which womnen’s bodies are persistently positioned as in need ‘fixing’. In outlining the ways pharmaceutical (pharma) campaigns exploit traditional perceptions of ‘appropriate’ femininininity and the deminine form, this chapter asks us to consider the ways in which menopause is not only ‘made’ but arguably ‘mandated’ through paticular patriarchal processes. In tandem, it asks a reader to consider the literature discussed in Chapter 1 and how far we may be seen to have moved when it comes to managing menopause.

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The EMAS conference is taking place at a large convention centre about a 25-minute train ride from Berlin’s city centre. The building is concrete and grey and has the type of depressing energy that makes you think of small airports, waiting rooms, or the dentist. The team responsible for directing attendees seem to overcompensate for this by waving cheerful bright red signs, directing oncoming foot traffic toward the conference entrance.

After registering in the foyer, attendees are asked to print a name tag and collect a plastic lanyard displaying their professional credentials. These include titles such as Clinical Practitioner, Service Manager, Researcher, etc., and serve not just to provide context about the participants’ roles, but also – it became apparent – as a means of streamlining networking activities. Upon exiting the registration room, staff are on hand to direct the increasing throng of bodies down a long corridor leading to the Main Hall of the conference centre. Dotted along this corridor are double doors leading to adjacent conference rooms, all of which were utilised over the coming days for presentations and sponsored lunchtime symposiums. Outside the doors to these spaces are oversized plinths displaying the names of rooms, such as Helsinki 1 and Helsinki 2, printed in inoffensively slim, uniform black lettering.

The main hall, or as it is termed at the conference, the ‘EMAS Arena’ is an impressively large rectangular room with high ceilings. Each wall is adorned with pharmaceutical stands that vary in style. There is a complimentary juice bar built into one of these stands, and a coffee ‘hangout’ spot in another. At the back of the room there is a stage area with ample seating. The raised platform is outlined by artificial light and a speaker is already in full swing, with a few early risers in attendance. Audience members are multitasking between taking notes, sipping coffee, and checking their phones. In front of this stage area are research posters displayed on blue synthetic space dividers. Adjacent to this is a small collection of relevant literature that can be purchased. Though the programme

Figure 26: Image of Mylan advertising displayed at the EMAS conference. (Mylan 2019)

has specified a 7:30am start, at 8.30 am the room is still barely occupied bar the perfectly presented pharmaceutical (pharma) crews manning each stand and the small audience taking in the first few scheduled lectures.

The range and diversity represented on these stands is the first interesting thing to observe. Some are small and unimposing, whilst others present in a grander manner in both scale and in design. Pharma brands with more impressive stands occupy premier positions; Mylan Women's Healthcare, for example, sits directly in the eyeline of anyone entering the main hall. Mylan utilise a sleek, neutral, and minimal palette, and their main advertising image features a black and white photograph of a group of women standing together. The image is accented by pink text that reads *My Way.* Their marketing materials are white and glossy, and their staff are striking and charismatic, greeting attendees as they enter the space. It is difficult not to notice that the majority of stand representatives (reps) are dynamic, young, and conventionally attractive. There is a spread of genders but the majority of professionals manning the brands appear to be women. Throughout the conference, attendees are offered pre-prepared marketing bags from the pharma stands which varied in size and content. Some contained information (a pen, or a key ring) whilst others (such as Mylan) supply travel-sized samples of their products, perfectly proportioned for the carry-on suitcases many conference attendees travelled to Berlin with.

The pharma reps employ a number of tactics when engaging with conference attendees. Lanyards provide a scoping mechanism that allows reps to make decisions regarding the level of engagement to afford to any one particular enquiry. It provides a snippet of context to help determine the likely return on investment from a conversation, assisting reps to make informed decisions about how much time to spend with the individuals browsing their stand. Each stand is unique. Whilst products are essentially uniform, with the same chemical compound or piece of equipment appearing across multiple stands, the *brands* are not uniform. They are distinct. In this sense, there is not one version of HRT, or one piece of equipment circulating at the conference, but multiple forms, distributed and showcased individually by each pharma team. Stands are grouped thematically by type of product. On the back right wall are stands showcasing vulvovaginal laser technology. These stands are placed in close proximity, divided by some seating where conference attendees can drink coffee or check emails. Whilst the proximity of similar technologies may seem counterintuitive (showcasing the same product just metres apart), the marketing of these technologies is distinct and thematically contrasting. Upon first glance, it is not obvious to the untrained eye that each stand is marketing the same equipment or technology. One of the stands is for the laser company Asclepion Laser Technologies, who are advertising their product, *Juliet*. The stand includes a large vertical banner that displays an image of a face pressing fingers to lips. To the right of the face is a secondary photograph of a pair of crossed legs with palms positioned across the genital area. The images are set against a neutral backdrop. Lettering in the foreground reads *Juliet*: *the feminine laser* in a shade of rosy, pink. The text is surrounded by symbols resembling petals. In the leaflet provided by the stand, *Juliet* is advertised as suitable for the treatment of "unwanted urine loss, vaginal dryness, pain during intercourse and loss of vaginal tone". Opening up the leaflet, the description is developed further, explaining that "The Juliet laser treatment is suitable for women who… are going through the menopause; have just given birth; underwent cancer therapy and/or surgery; want to fight or prevent pelvic floor diseases [and] want to

Figure 27: Image of Juliet Laser advertising displayed at the EMAS conference.

improve the quality of their sexual life". The leaflet also contains an 'at a glance' section where readers are assured that the treatment is "hormone free; fast safe painless; takes less than 15 minutes; without anaesthesia downtime or side effects; immediate results."

On the whole, laser treatment seemingly divides professional opinion. Looking at the conference schedule, there are a number of talks scheduled to take place addressing the benefits and rationale for seeking out this form of care. In a conversation with a representative of Juliet, they explain that their laser treatment can help to improve gynaecological health by stimulating collagen and elastin production. They explain that the treatment is only minimally invasive, and that the laser uses light energy designed to stimulate existing tissue into producing new collagen. The handpiece is of particular interest; the Juliet rep explains how it is easy to insert inside the vagina and intuitive when it comes to handling. Directions to their website are provided where it is explained that Juliet's STERI-SPOT handpiece:

> *"features a patented MicroSpot optic with a squared spot of 9 x 9 mm, consisting of 169 MicroSpots. This optic allows the selective treatment of only "fractions" of the tissue in the form of a grid, made possible by splitting the laser beam into several hundred partial rays… [which] triggers skin renewal and collagen formation with rapid wound healing, which is supported by the untreated skin and therefore involves a very low risk of side effects."*
> (Asclepion 2022)

Nearly adjacent to *Juliet* is NovaClinical, where reps are promoting both their specialised Vaginal Dynamic Radiofrequency (VDR) device *Eva* and their 4Plus device designed to deliver treatment for the face and body. The main marketing image promoting the Eva device features someone sitting with one knee hugged into their chest. The head is tilted to the side and the gaze is focused

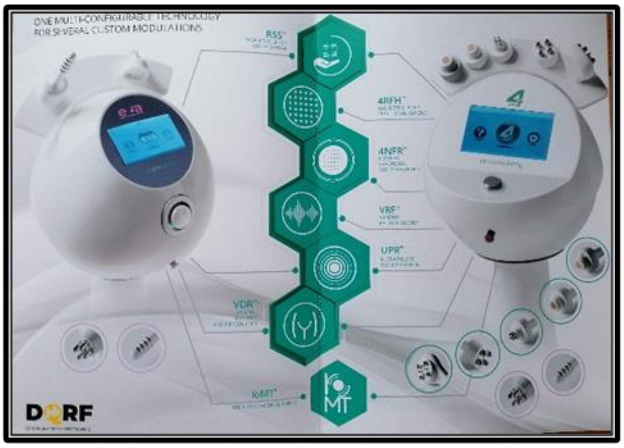

Figure 28: Image of NovaClinical promotional material given to EMAS conference attendees (Novavision 2023).

on the camera, smiling. To the right is the title "eva" in pink and purple lettering. Underneath is written "Safe effective non-ablative solution for the most common vulvovaginal pathologies". The positioning of the poster allows the image to act as a backdrop as opposed to centre stage. When passing or approaching the stand it is the *Eva* device itself that is noticeable, along with the Novaclinical desk space. Both the device and the desk space are white. Novaclinical employs a blue-and-grey colour scheme for their company lettering. The reps take advantage of conference attendees' interest and encourage onlookers to approach the stand and engage with the Eva device. Happy for attendees to hold and examine the product, reps explain the non-invasive benefits of the treatment and keep laptops on hand to present footage of the device being used. This footage includes explanations (in subtitled Italian) of how the technology was first created, with cutaway shots of laboratories. This is followed by content in which the device is shown being used in practice.

There are close-up images of the device being inserted into a vagina, and information about the mechanisms by which the individual receiving treatment may indicate discomfort. As opposed to needing to provide verbal feedback, *Eva* is equipped with a handheld button to press if any physical discomfort is incurred. For the footage of *Eva* being used, Novaclinical have chosen young white models. All of the vulvas that feature in the film are clean shaven with even skin tone and no signs of muscle wastage. Marketing material provided by Novaclinical contains a copy of the promotional film, and information on both the *4plus* and *Eva* devices. The material incorporates images of the devices, concise information on their uses and some abstract interlaid images of a dancer wearing a black leotard, spooling yellow fabric into the air.

Promotional materials also incorporate graphics to indicate the technology being drawn upon in delivering the treatment. In the case of the *4plus*, Novaclinical ensure to take time to explain the multiple application heads and detail the effects that each attachment is designed to produce. One of the images featuring the same dancer in a black leotard utilises arrows as a means of demonstrating which part of the body will ‘benefit’ from the treatment and how each variation of the attachment will help to improve muscle tone and overall bodily rejuvenation.

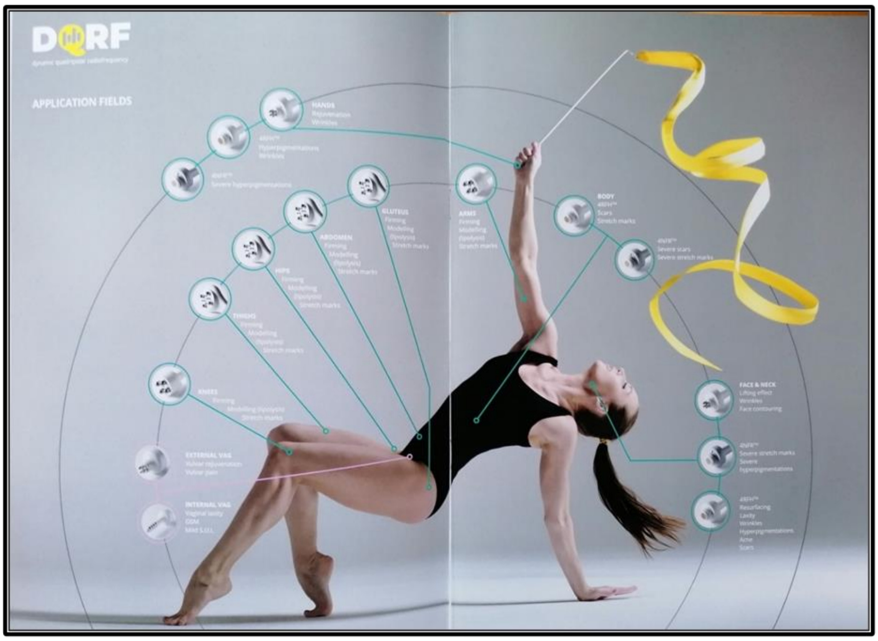

Figure 29: Image of promotional material from NovaClinical given to EMAS conference attendees (ibid).

As the model’s body reclines, their head is positioned to ensure the neck is visible. Arms are extended, legs are tensed, and the body is balanced on tiptoes. Areas listed that are accented by arrows in the image include: the vagina, with the intended benefits to include improving vaginal laxity (or more commonly termed vaginal ‘looseness’); the vulva, citing potential improvements to vulval pain and an overall ‘rejuvenation’; the body, or to be specific the knees, hips, abdomen, gluteus, and arms, which are noted to see improvements in firming, modelling (or lipolysis) and stretch marks; the hands, including improvements to wrinkles and overall rejuvenation; the face and neck, including face-contouring reduction of wrinkles and an overall lifting effect; the improvement of severe scars and stretch marks. The image also includes reference to the use of 4RFH for hyperpigmentation, wrinkles, resurfacing, laxity, acne and scars. 4NFR is also noted as being employed for severe hyperpigmentation and severe stretch marks.

Figure 30: Personal picture of Bioidentical HRT stand at the EMAS conference.

Towards the back of the arena are stands for bioidentical hormones. In contrast to the positioning of Mylan and Theramex, whose stands are spatially overbearing, these stands are smaller and more crowded with products placed on stepped display stands. Alongside HRT lozenges, gels, creams, syringes, and bottles of pills are displays of skincare products and supplements. Green colour schemes with images of flora and fauna feature, and their emphasis on the concept of the 'natural'. Representatives explain to those that take interest in the stand the benefits of bioidentical hormones or 'compounded hormones', discussing with attendees how the individual needs of every patient are met via the personalised prescription of compounded hormones. It is emphasised that the prescribing of products should be specific and tailored to each individual patient. In this sense, as opposed to promoting a particular product or brand, the stand advertises ts *approach*: 'mixing' in order to create a tailored treatment suitable for each patient. As such, treatment is not confined to the parameters of hormonal intervention only, supplements and dermatological interventions including laser therapy, microdermabrasion, and facial injections are also advertised.

Figure 31: Personal picture of Bioidentical HRT taken at the EMAS conference.

In the coming days, a spatial segregation is established and stands 'repping' bioidentical interventions are given a 'wide berth' by many of the clinical attendees. Speaking to physicians, the reasoning for this is described in part as an ethical statement. Though attendees acknowledge and explain that the presence of pharma itself at the conference is problematic, the attendance of companies promoting compounded treatments such as this is seemingly ‘worse’. In a number of conversations, the difference between bioidentical and body identical hormones are noted as confusing to those without clinical knowledge or expertise. The promotion of such treatments at the conference is therefore deemed fundamentally unethical by many. Topical concerns include the fact that bioidentical hormones are often not regulated in the same manner as body identical HRT, and that, as mistrust already surrounds the use of HRT (predominantly related to assumed risk factors drawing upon findings from the WHI) there should be an active promotion of safe and effective treatment options within conference spaces. Expanding upon this, one clinician explains that while the term ‘bioidentical hormone’ in theory means that these hormones contain the same molecular structure as hormones found in the body, the source in which the compounding occurs is not always clear. They explain that in the context of pharmaceutical production, where and how a substance is prepared is of the upmost importance. If you don’t know how spaces are regulated (as is often the case in the instance of bioidentical HRT preparation) you can never truly know what procedures are in place to ensure treatments are being ‘created’ appropriately. Underscoring this is something quite simple – a lack of trust in both clinical competency and the overall safety standards involved in regulating this form of HRT production.

Returning to the topic of ethics, another attendee emphasises that there is no requirement for compounded bioidentical HRT to subject itself to quality control, as it is often distributed in supplement form. As such, the enforced standards of practice they explain are not prioritised. As heads nod in agreement, they continue explaining that many private clinics both in the UK and beyond are charging large sums of money, promoting the treatments as custom and individual. This is particularly the case, they note, in the USA, where compounded HRT regulations are less clear and insurance provision poses another complex issue for women to navigate. These clinics offer an option if you don’t have insurance, but the efficacy of the treatment remains a point of contention. In addition to this criticism, the group of clinicians explains that the manner in which the compounds are mixed is not necessarily as sterile as one would imagine. They explain that there may be additives, bacteria or residual debris from other drugs mixed in the same pharmacy where the compounds are prepared. They continue to note that, as such, there is a lack of scientific safety and rigour displayed in the preparation of certain formulas.

The effectiveness of testing existing hormone levels is also outlined. As the basis of the marketing of compounded bioidentical HRT relies on the concept that individualised treatments may be delivered to patients, testing is important in determining what a person's body may need. One clinician explains that, in order to determine what a patient requires, saliva tests are usually carried out – at great cost. They expand, noting that the accuracy of such testing is not supported by good evidence and that as such, there is no guarantee that the results will be accurate. They explain that, as hormone levels are constantly changing in the body, precise readings are not truly possible to obtain and that "in any case, blood tests may be preferred for measuring the levels of these hormones accurately". Debate shifts to consider how although personalised treatments may be seductive, some of the hormones in these preparations are not yet approved for use in 'women' (such as pregnenolone and dehydroepiandrosterone (DHEA)). It is explained that the progesterone element of the preparation is often supplied in a cream as opposed to an oral preparation. As progesterone is known to be poorly absorbed by the body if delivered in a gel or cream, there are concerns raised regarding the level of endometrial protection that one could expect from this treatment. Coupling this with the inconsistent levels of oestrogen and oestradiol in compounded treatments, other health risks are flagged by the clinicians, including the possibility of developing endometrial cancer or deep vein thrombosis (DVT).

Agitation is palpable, with conversation considering why compounded HRT does not carry safety warnings explaining these possible risks or effects to patients. Not providing such information is noted by one attendee, however, as an important strategy in the marketing. They explain that in not doing so, it is possible that patients may believe compounded HRT to be associated with *less* risk than regulated preparations. They continue, explaining that "whilst *we* know that forms of body identical HRT are available through the NHS, there is still a clear knowledge gap that is not helped by GPs' unwillingness to prescribe". Safety is thus weighed against access and marketing; one attendee asks if patients would be (from the presentation and branding) aware that bioidentical compounds often contain synthetic ingredients, including synthetic progestogens. This is followed with a query as to whether there is knowledge that the majority of body identical HRT prescribed by GPs via the NHS is derived from yams (the vegetable) and thus essentially natural. The history of mistrust surrounding HRT and connections to horses' urine is also raised.

Of course, what is interesting in the context of this *specific* conversation is what exactly these clinicians mean by 'natural'. One may observe that in many ways horse urine is as natural as a yam. Returning to Mary Douglas and concepts of 'matter out of place' (1966), we can see this logic at play once again. Urine seemingly is less palatable to the physicians due to the fact it represents a form of excretion as opposed to a brightly coloured vegetable. The yam can be found in the 'natural' landscape, nurtured by the earth, and it remains untouched by concepts of pollution. Thus, the concerns with safety may well conceptually carry notions of this discomfort surrounding putting the 'right' kind of natural into the body. By extension, it is argued that there may be at play a 'clean' kind of natural, and a 'dirty' kind of natural, and that it is this division which is crucially important in the context of both making menopause and making medicine more broadly.

One stand to escape the watchful eye of clinicians and ethical debates is the stand promoting supplements. Omni Biotic, positioned in close proximity to the bioidentical stands, is frequented by multiple attendees. Though seemingly specialising in multiple forms of supplements, their marketing and imagery employs 'the medical', utilising illustration and images of bacteria. Omni Biotic markets itself as experts in balancing gut health. They state that "The gut is the engine of our life. It not only provides fuel by digesting food, but also influences many other processes within the body. An imbalanced gut also has an influence on the entire body".

Figure 32: Personal picture of the juice bar at the EMAS conference.

The importance of good gut health, balanced nutrition and overall wellness is promoted further, as previously mentioned, by the conference's provision of a juice bar for attendees – drawing a queue that remains in situ throughout the coming days. Interestingly, the juice bar is sponsored by the pharmaceutical company Shionogi, who are promoting a medication called *Senshio,* a treatment for "moderate to severe symptomatic vulvar and vaginal atrophy[20] (VVA)". Senshio is described as suitable for "post-menopausal women who are not candidates for local vaginal oestrogen therapy." The branding of *Senshio* sits behind the juice bar, which is manned throughout the conference by young men. At the back of the arena and a few metres to left of the stage space is Harper Pharmaceuticals, the company that develops AndroFeme. Harper is manned by the founder, James Harper. James's stand is the only stand at the conference promoting a testosterone preparation. The positioning of the stand works well for James, attracting interest for Harper. Attendees must pass the stand before and after talks that take place on the arena stage. As a number of these seminars reference the use of testosterone in alleviating menopausal symptoms, James attracts foot traffic after talks have been given.

Towards the end of the first day of the conference, it becomes clear that a number of clinical and pharmaceutical representatives are well acquainted. James is interested in talking to the lead representative of Theramex, who is attending the conference in order to promote HRT and an oral contraception. Their conversation centres around the rationale behind Theramex's decision *not* to consider producing a testosterone preparation for 'women'.

James notes the amount of business that he currently has in Europe as the only provider of a testosterone preparation designed with women's biological makeup in mind. The Theramex lead does not respond immediately. Others weigh in, responding that because there are alternatives available, such as *Tostran* and *Testogel,* it may not be worth the investment. James counters this rationale by highlighting the importance of stable dosage and the importance of creating preparations that are designed with the right demographic in mind – in the case of James's product, women. Continuing, it is explained that whilst higher potency preparations (such as Tostran or Testogel) may deliver effective

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[20] The term 'atrophy' has not been used in this thesis as multiple persons that I spoke with found the term to be degrading and distressing. In solidarity to this experience, I can, where possible look to incorporate other descriptive phrasing (Gross 2023).

results, they are designed with men in mind and that as such must be used only every few days by ‘women’. This he explains is likely to mean that dosage is sporadic, causing spikes and drops in testosterone levels. The ‘gold standard’, James explains, would be to maintain “nice even levels” as opposed to peaks and troughs. The conversation continues on the topic of licencing and then moves to patents. James outlines that when it comes to the pharmaceutical industry, patents are the most important thing. He explains that as a hormone has a specific molecular structure, one cannot ‘create’ a new version of a hormone. Varying the quantities of ingredients, potency, and the source that the hormone is derived from, however, *is* possible. Moreover, James clarifies that the delivery method is entirely patentable and often the ‘thing’ that renders a product popular.

James explains using AndroFeme as an example and how this patenting works. Essentially, as Harper patented the first testosterone cream for ‘women’ (AndroFeme) and as such the development of any similar product would have the potential to breach Harper’s patent. Ultimately, this means that by owning the patent, Harper Pharmaceuticals has the right to stop other companies from making, using, or selling a similar product without their permission. The market for selling pharmaceutical patents is not discussed. When the Theramex representative addresses James’s original question – “when will they be producing a testosterone preparation for women?” The increasingly intrigued group of conference attendees now partaking in this discussion wait with bated breath. The response is vague. There is, they elaborate, no immediate talk of creating a testosterone product for women at Theramex.[21]

Talk the Talk

A full scheduled timetable of talks taking place in multiple spaces occur each day of the conference. These talks vary in tone and content. Some feature an analytical break down of endocrinological material, while others are more personable in approach, concentrating on factors such as diet, pain management, future health outcomes, and sexual activity as topical menopausal issues. Some

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[21] It is worth noting that James would, as a consequence of patent law, receive payment from Theramex if they were to develop such a product, thus this conversation was arguable weighted with intention (Gurgula, 2020).

presentations appear to ‘speak’ more to the audience than others. It is interesting to observe which seminars get clinicians in particular, to raise their heads to take snaps of slides on their devices, immediately translating the content into social media stories with accompanying empowering messages around ‘health and wellbeing’. For example, talks on migraines, aging and improved wellness are favourable – these garner attention and engage conversation after the talk. In contrast, lectures on the correlation between the use of HRT, BRCA 1 and BRCA 2 genes and cancer risk, cause relative outrage. Terms such as outdated, unfounded, and problematic are used. These do not appear on social media posts.

The G-spot

1. The evidence to support the presence of the G-spot is weak.
2. Published scientific data highlight the fact that the G-spot does not even exist. In a recent review, Puppo et al. (1) proposed that G-spot amplification is an unnecessary and inefficacious procedure.
3. Nevertheless, introital injections of hyaluronic acid have been able to increase sexual satisfaction (2). It is unclear whether these finding are based on the anatomical changes or rather based on imagination of the patients treated.

Figure 33: Personal picture taken of slides used by speakers at the EMAS conference.

A number of lectures employ images of women’s bodies and genitalia while attending to their descriptive analysis and discussion topics. These include images of Clitoral Hypertrophy (a condition featuring an ‘abnormal’ enlargement of the clitoris, surgical interventions, and reconstructive procedures for vulval cancer, illustrations of labiaplasty and other cosmetic interventions, including diagrams of the ‘G-spot’, with information contending its existence as contentious. Debate also includes information on the provision of introital hyaluronic acid injections to increase sexual pleasure. Consent regarding the taking of photos is not addressed[22]. The topic of bodily intervention

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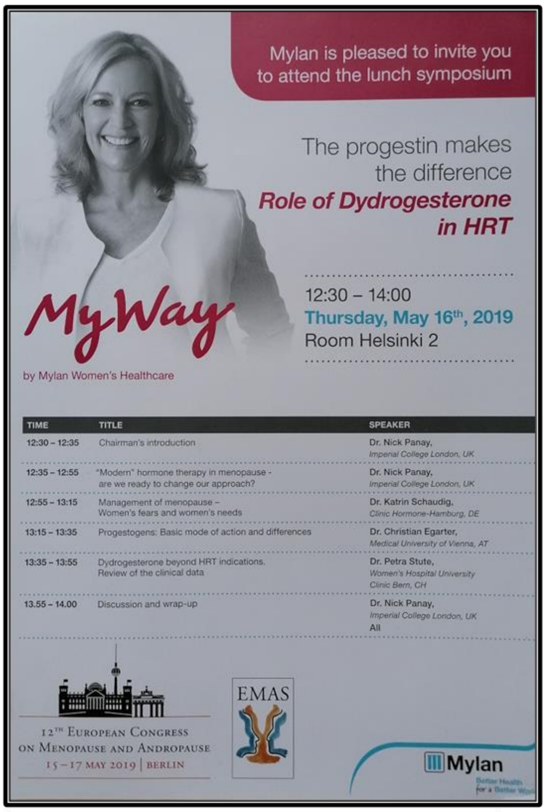
[22] It is noted that including these images is not done so without a full and conscious consideration of the objectifying nature in which these women’s bodies are depicted. The decision to do so, was made due to the belief that it would affirm and assist in the illustration of the problematic ways in which women are made mute in the making of menopausal medicine. I acknowledge these women as individuals and ask the reader to fully consider these images as problematic practice due to the fact that the women behind the images are left forgotten – they become a ‘representation’ of a ‘condition’ as opposed to a person in their own right (Svenaeus, 2023)

also extended to seminars addressing the use of laser therapy for vaginal muscular concerns. Seminars utilising depersonalised images of bodies are led by men only. These men lead the audience discussion on cosmetic intervention and labiaplasty, with other men being the only ones to contribute to discussion and debate. All men leading these discussions are white. All the bodies featured in the images used, including those used in medical illustrations, are possessing of a lighter skin tone.

When discussing cosmetic intervention and the undertaking of labiaplasty, the speaker displays guidance on decision making when determining whether to carry out Female Genital Cosmetic Surgery (FGCS). This includes advice that encourages clinicians to explain that there is variation in genital normalcy among women and that there is no current data to support that G-spot augmentation, hymenoplasty, vulvar and perineal bleaching/whitening, vaginal tightening procedures or other cosmetic procedures will increase sexual function or pleasure. In addition, further advice includes explaining that surgery should not be offered to women under the age of 18 and that women undertaking FGCS will need to be evaluated by a clinician with expertise in vulvovaginal diseases. The speaker highlights that this should include paying attention to a woman’s psychological, sexual and social context and as such, that women undertaking FGCS should undergo an evaluation by an experienced mental health provider, in which their motivations for seeking surgical intervention are established. They make note of the fact that FGCS is not exempt from complications and that informed consent must always be given highlighting that surgeons performing the procedures should refrain from solicitous advertising or the promotion of certain procedures without a sound scientific rationale. This is followed by reminding attendees that any surgeon performing FGCS should have sufficient training in performing the specific procedure and have knowledge of the anatomy, physiology and pathophysiology of the vulva, vagina and adjacent organs. When referencing psychological presentation, the speakers take their time, including the importance of paying attention to the presentation of low mood, body dysmorphic thinking or generalised anxiety. They note that a clinician should be mindful of whether a patient has any history of eating disorder or has undergone plastic surgery in the past.

Dividing time between talks is a challenge because discussions of many similar topics have been scheduled to take place at the same time but are led by different speakers. Groups of attendees choose to divide themselves up, sending different people to different talks, organising a rendezvous point where they can meet up and swap feedback on content and speakers. Upon reconvening it is noticeable that the majority of comments pertain to the speakers and their demeanour, as opposed to the content presented. Aside from the juice bar and coffee hangout spaces, there are no shops or restaurants available to conference attendees. A number of conversations address this in relation to options for lunch. These concerns are however soon addressed with reference to the circulating flyers advertising lunch symposiums. The symposiums include scheduled speakers discussing particular topics and are funded by different pharmaceutical companies at the conference.



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The progestin makes the difference

Role of Dydrogesterone in HRT

12:30 – 14:00
Thursday, May 16th, 2019
Room Helsinki 2

MyWay
by Mylan Women's Healthcare

TIME	TITLE	SPEAKER
12:30 – 12:35	Chairman's introduction	**Dr. Nick Panay,** *Imperial College London, UK*
12:35 – 12:55	"Modern" hormone therapy in menopause - are we ready to change our approach?	**Dr. Nick Panay,** *Imperial College London, UK*
12:55 – 13:15	Management of menopause – Women's fears and women's needs	**Dr. Katrin Schaudig,** *Clinic Hormone-Hamburg, DE*
13:15 – 13:35	Progestogens: Basic mode of action and differences	**Dr. Christian Egarter,** *Medical University of Vienna, AT*
13:35 – 13:55	Dydrogesterone beyond HRT indications. Review of the clinical data	**Dr. Petra Stute,** *Women's Hospital University Clinic Bern, CH*
13.55 – 14.00	Discussion and wrap-up	**Dr. Nick Panay,** *Imperial College London, UK* All

12TH EUROPEAN CONGRESS
ON MENOPAUSE AND ANDROPAUSE
15 – 17 MAY 2019 | BERLIN

Figure 34: Personal picture taken of the flyer given to EMAS conference attendees.

Attendees of the conference arrive outside the spaces where talks are scheduled to take place and are asked to line up for entry. Pharma reps are waiting by the entrances to the conference rooms and asking attendees as they enter if they are vegetarian. Brown bags containing a sandwich, a piece of fruit, a bottle of water and a cereal bar are handed out before attendees are ushered to take their seats. Friendship groups both established and new have formed, and 'cliques' and can be observed. Alongside professional occupation (e.g., clinical practitioner, service manager, pharmaceuticals etc.), groups of attendees seem to segregate themselves according to geography, with attendees from the same country opting to stay in close proximity to one another. As the lunchtime talks get underway, each speaker states their conflict of interest before presenting their 'data'. Attendees are slightly fidgety. Having spent the morning in lectures, conversations within the now established cliques turned to the irritation of having to attend a 90-minute symposium in order to receive a sandwich. Though attendees are free to leave the room whenever they like, each door is manned by a pharma rep, on hand to scan conference lanyards when attendees enter and exit the room. The scanning of the lanyard allows both the conference officials and pharma reps to keep track of how many people were attending particular talks or seminars, and thus which topics were the most popular. Certain geographic groups do not seem fazed by causing distractions or interruptions. They converse at an audible level, incurring irritated glances from both the speakers and the seemingly British clinicians who can be noted to attempt to not crumple their cereal bar wrappers *too* loudly. A few groups, after finishing their food, leave. Others seem to think this rude and remain in attendance until the presentations are over. After the hour mark passes, most of the audience are multitasking between phones, laptops, and their conference timetables, chewing the ends of pencils as they circle talks due to take place over the coming days. Some of the men at the back of the room can be seen eyeing untouched lunch bags keenly. One approaches a rep who, smiling, offers out the bag. Returning triumphant, they proceed to munch loudly. A few more follow suit. Watching clinical professionals in expensive suits eat out of brown paper bags is off-putting. In the proceeding hours, discussions of large-scale clinical trials are accompanied by breadcrumbs on ties.

Testosterone Taken to Task.

At the end of the first day, three speakers are scheduled to deliver talks in the ‘Dublin’ conference space, with no scheduled clashes. A drinks reception has also been scheduled after the talks, supposedly to incite those that might be keen to sneak away and start their evening explorations of Berlin a little early to stay. Australian professor Grace Brenham is due to present her data on a large-scale systematic review she has recently completed, evaluating the correlation between improvement of menopausal symptoms and use of testosterone among perimenopausal and menopausal patients. Professor Brenham is talking to James (the founder of Harper Pharmaceuticals) at his stand prior to beginning their talk. It transpires that the two are well acquainted and that they have partnered on various research projects together in the past. As well as conducting research, Professor Brenham reveals that she is a practitioner, and that she prescribes AndroFeme to a number of patients that she sees. This, Brenham states, has (in her estimation) had a great effect on improving patients' reported symptoms. Professor Brenham and James are friendly with one another; Brenham teases James about boring attendees with anecdotes, and the jibes are taken with good humour. Professor Brenham elaborates regarding her research when questioned. Details and cards are exchanged. The menopause practitioners in attendance are excited to hear Brenham speak.

As conference attendees move through to the Dublin 2[23] Lecture theatre, there is a hum of conversation. A good proportion of attendees have remained for the end-of-the-day talks. Prosecco and canapes are in peripheral view to the right of the conference room when one enters. As drinks are piled onto silver trays, the doors to Dublin 2 close, leaving attendees staring wistfully in the direction of the closed doors. Before Professor Brenham presents, two other speakers discuss the topic of menopause with 'humour'. The attention of some attendees is captured, but others are firmly engaged in email filtering at this point in the day. Professor Brenham begins their talk personably, with quips and amusing anecdotes. The style of research, however, is difficult to humanise, and delivery finds an efficient melodic monotone as discussion shifts to the large-scale review. While some attendees appear distracted, a number of practising clinicians are engaged. Brenham explains that while their team observed a positive correlation between use of testosterone in menopausal patients and an increase or return of libido, no other significant causal correlations could be observed. Professor Brenham explains that though they may prescribe testosterone to patients and note 'anecdotal' reports of improvements in mood, energy, and cognitive function (including concentration), the evidence and data reviewed in the study they conducted does not support these findings.[24]

Upon detailing this, there is a distinctive 'prickle' from some of the practitioners in attendance. Overhearing snippets of conversation, the concerns lie with the publishing of data that contends the use of testosterone for symptoms beyond libido. Fundamentally and to distil the concern, it would seem that as insufficient evidence could be referenced to support a positive correlation between testosterone and factors such as energy, mood, and cognitive function, would

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[23] The whereabouts of Dublin 1 was sadly never ascertained.

[24] A pseudonym has been used for Professor Brenham in order to protect her anonymity. The paper referred to is Islam et al. (2019).

practitioners need to, for want of a better phrasing, have to alter their ‘pitch’ to patients? While libido is an indicator that may prompt clinicians to mention testosterone to patients, clinicians (observed in this research) also noted use of testosterone to be important in improving of other symptoms too, such as mood, energy, and concentration. Should HRT not alleviate or improve these symptoms, clinicians may be inclined to offer testosterone as an additional hormone to use as part of a patient’s HRT programme. Professor Brenham’ research therefore encroaches on this space. It changes the rules. Brenham is not on the team.

Leaving the lecture theatre, the arena space is now filled with waiters holding trays of drinks and hors d'oeuvres. Conversation can be overheard. There are quick explanations as to why Brenham’ findings are incorrect. The complexity of sexuality is mentioned, as is the difficulty of measuring correlations between hormone use and the improvement of symptoms such as cognition. James weighs in, noting that no findings does not necessarily mean no correlation – just that there may not be enough evidence at this stage to support a correlation. Nods and murmurs confirm agreement. More research is needed. As the day draws to a close, a number of attendees are discussing dinner plans. Clinicians are organising taxis and routes to restaurants. They have been invited to dinner by various pharma companies.

Picture Perfect Patriarchy

The first important observation to explore from the EMAS conference observations may be the role of multiple patriarchal oppressions triangulated through a variety of mechanisms. Not only are there specific gendered messages in which hormones and the body are assigned pink and blue flags, there is also an uncomfortable intellectual encroachment of patriarchal power on ‘feminine’ medical discourse. The majority of speakers who are afforded larger spaces, longer speaking times and bigger audiences are nearly all men, and they are consistently introduced as ‘leading experts’ and *the* authority in the field of perimenopausal and menopausal health. The esteemed role of the discussion mediator is equally predominantly ‘performed’ by men.

Most concerning to this research, however, are the mechanisms by which ‘women’s’ bodies are subject to scrutiny, intervention, and control (Varghese and Kumar 2020, Hendl and Jansky 2021, Cahn, Crawford & Waldma, 2022). ‘Fem-tech’ solutions are provided at every turn – and solutions to ‘fix’ and correct what is out of balance and distasteful are presented not only by pharma reps but also by leading academics working the field of ‘women’s’ health in mid-later life. Topical lectures taking place on Female Genital Cosmetic Surgery (FGCS), including discussions on labiaplasty, hymenoplasty, genital bleaching and whitening are particularly disconcerting to analyse, not to mention discussions of acidic injections. Once again, all of these lectures were delivered by men. Practitioners make note of the importance of a ‘rationale’ and need to ensure ‘ethical practice’ when performing invasive procedures, but do not position FGCS as inherently problematic.

Of particular concern is the list of considerations outlined for FGCS practitioners. To briefly recap these included the advice that clinicians should remain mindful that:

1) *There is variation in genital normalcy among women.*
2) *There is no current data to support the notion that G-spot augmentation, hymenoplasty, vulvar and perineal bleaching/whitening, vaginal tightening procedures or other cosmetic procedures will increase sexual function or pleasure.*
3) *Surgery should not be offered to women under the age of 18.*
4) *Women undertaking FGCS will need to be evaluated by a clinician with expertise in vulvovaginal diseases, including attention to a woman’s psychological, sexual, and social context.*
5) *Women undertaking FGCS should undergo an evaluation by an experienced mental health provider where motivations for seeking surgical intervention are established and include consideration of whether a patient’s expectations are clear and realistic.*
6) *FGCS is not exempt from complications.*
7) *Informed consent must always be given.*
8) *Surgeons performing the procedures should refrain from solicitous advertising or the promotion of certain procedures without a sound scientific rationale.*

9) *Surgeons should not perform a procedure they do not agree with and be able to explain the rationale for performing any procedure to the patient.*
10) *Any surgeon performing FGCS should have sufficient training in performing the specific procedure and have knowledge of the anatomy, physiology and pathophysiology of the vulva, vagina, and adjacent organs.*

The fact that these recommendations are made in the instance is worthy of note. It indicates that the advice being negated or corrected in these lectures has been, or continues not to be, adopted by clinicians operating in the FGCS field. For example, the assurance that there is no current data to support "*G-spot augmentation, hymenoplasty, vulvar and perineal bleaching/whitening, vaginal tightening procedures or other cosmetic procedures… [as] increase[ing] sexual function or pleasure"* highlights that clinicians may still promote this line of discourse to potential patients. This sentiment is echoed in the statement *"surgeons performing the procedures should refrain from solicitous advertising or the promotion of certain procedures without a sound scientific basis."* Points 4 and 5, which reference an individual's mental health, are also interesting to consider. 'Women' are asked to undertake evaluations as to whether their decision making is grounded in conscious choice, and it is emphasised that any 'expectations' should be appropriately managed. At no point are the patriarchal oppressive overtones in which vulva-possessing persons feel the *need* to have their bodies operated upon addressed. Rather, procedures in which the vulva, vagina and clitoris are operated upon are discussed in greater detail by clinicians working in the field of FGCS as soon as the slide on considerations has been displayed.

Laser that Labia

The representation of vulvovaginal technologies at EMAS was unexpected. Whilst the repping of hormonal treatments by pharma teams seemed in some ways 'necessary', the presentation of intervening technologies such as the use of a laser to 'correct' vulvovaginal symptoms was disconcerting and re-positioned perimenopausal and menopausal treatment within the remit of enhancement. Or, to harken back to the chapter prior – return or transformation.

Thick with the theme of intervention, technologies on show at the conference promised to lighten, tighten and brighten every inch of the ageing feminine form and made a discernible project out of ‘women’s’ bodies, suggesting that they would be able to ‘fix’ what was ailing. Multiple iterations of the same narrative were communicated regarding ‘physical comfort’ on the part of the patient, with reps emphasising that it was of the upmost importance to them in the provision of care. In a lengthy conversation, a particular rep outlined how part of the benefit of their technology was that it offered the opportunity for patients to respond to the person administering treatment if they were in distress. This could be achieved by pressing a button on a hand-held device to communicate that the laser was burning or too painful. Something about this sentiment – about stripping those undergoing the laser procedure of their voice – infers a sense of shame. Rather than being able to express discomfort vocally, a button could be pressed, minimising the engagement that needed to be maintained between practitioner and (to use the reps’ term) client. Equally, knowledge that the procedure was indeed utilising a ‘laser’ was, in other contexts, seemingly underplayed. The concept of pain was mitigated. Marketing material boasted comfort and ease, yet the realities are seemingly less so. A subjective analysis reveals intervention involving distress via a mechanism that has been built into the device to provide feedback as to the experience of discomfort is prevalent. Moreover, the context in which women’s pain is normalised persists throughout these pharmaceutical presentations and may be added to an ever-expanding rhetoric in which there is an expectation of ‘suffering ‘unspoken, in order please the patriarchy (Burton, Starecheski & Snyder 2023).

A high proportion of representatives at the conference can be seen to be promoting various iterations of the same vulvovaginal laser equipment. Speaking with the Mansfield Health Clinical Director upon returning from the conference and as mentioned in Chapter 2, the question was posed as to whether *they* ever considered using or implementing laser therapy. Cerys explained that the supporting evidence for the use of laser was not conclusive in inferring a positive outcome. When carefully reviewing materials and conferring with clinicians for confirmation it was affirmed that the use of laser needed to be consistent. If an individual undergoing treatment discontinued the care for 12 months or more, any ‘benefits’ that had been obtained would be reversed, and the vulval ‘plasticity’ would return to its original ‘state’. Continuing, Cerys affirmingly noted that offering such treatment communicated a very specific message. In this sense, any technology that featured in the clinic not only needed to serve a purpose but needed to communicate an appropriate message.

The space, equipment and technology was (as has been explored) full of socio-political nuance and meaning, and decisions about technologies were made carefully due to their ability to communicate a context about the essentiality of particular kinds of care. Whilst laser therapy had been presented as an option, it was confirmed by Cerys that the decision was made to purchase the DEXA scanner instead. This choice communicated a position. It highlights how, in providing a technology with ‘space’, the prioritising of particular narratives that elevated the importance of certain parts of the body as they relate to menopause were preferred. In the case of the DEXA scanner, its presence and affordance of space serves to draw attention to the importance of our skeleton as our bones exist as part of the anatomy of endocrinology. This is an arguably more empowering affordance than verifying the vulva.

The decision to use youthful, clean-shaven white vulvas in promotional materials at the conference is also important to highlight. It communicates that, to a viewer, the image of an aged genital region displaying pubic hair would seemingly be inappropriate. Equally, the promotion of technologies designed to ‘correct ’ageing bodies presents not only gendered ideologies in which bodies need to conform to youthful parameters (as connoted by the image of the dancer that suggested that the 4RFH can combat all aspects of aging) but also racial hierarchies (Ferranti 2011). The majority of all marketing material for menopausal treatments at the conference (and as observed in a wider context) continue to employ the use of white models, replicating a problematic trend in which messages regarding access to medical treatment for perimenopause and menopause are culturally and racially specific. It is white middle-class professionals that are portrayed as providing access to care, with tokenistic stock photography called upon by major companies to distill or create the effect of diversity.

Tackling Testosterone

As has been outlined throughout this thesis, there is currently no testosterone preparation available via the NHS that is patented to contain a lower dose of testosterone compared with preparations such as Tostran or Testogel (products designed to treat functional hypogonadism in men).Tostran and Testogel contain a higher dose of testosterone than is needed for menopausal persons, requiring patients to stagger applications, supposedly making (as James confirms) the maintenance of a consistent dosing more challenging. AndroFeme is designed to contain a targeted dose of testosterone appropriate for menopausal persons. As the product is not widely available in the UK, prescribing it is considerably more costly to patients. At the time this research was undertaken, AndroFeme as prescribed by Mansfield Health would incur the private prescription fee of £37, the cost of a consultation with a specialist of £295, and the testosterone itself, at £95 a tube. Should a patient require the addition of testosterone to their HRT, they would also need to submit to semi-regular blood testing, at an additional cost also. During fieldwork, discussions about the relationships that patients had with the 'physical' testosterone product yielded interesting insights. Whilst one may expect the packaging to form an important part of the relationship to the product, in many instances it was dismissed as entirely inconsequential. Interest in using testosterone ultimately stemmed from a desire to see an improvement in symptoms. It did not, in this sense, seemingly matter to most patients what colour packaging the formula was wrapped in, so long as it aided in the alleviation of symptoms. Patients communicated enjoying the ability to apply AndroFeme every day (as opposed to every few days, as would be the case with Tostran or Testogel) as they found that they could, in doing so, more easily incorporate it into the HRT routine.

Figure 35: Personal picture taken of the promotional material used for AndroFeme at the EMAS conference.

Similar sentiments were echoed by practitioners. The main concerns for clinicians seemingly connected to their patients' needs, as opposed to the 'superficiality' of gendered messaging. How testosterone was being translated was ultimately largely inconsequential. Ensuring access to adequate treatment for patients was instead the greatest matter of concern. Regardless of this, as EMAS reveals, marketing remains *the* silver bullet for pharmaceutical companies when it comes to promoting hormones. As conversations suggested, one cannot own or change the essential characteristics of a chemical compound, but one can change its ‘wrapping’ in order to take on any guise one might desire.

To use AndroFeme as an example, the iterations of gendered messages are visible and communicate the allure of the binary. Care is taken to feminise the formula. Not only does the name weaken associations to testosterone itself by calling upon the term ‘andro ’as opposed to ‘testo’, but it also utilises the word ‘feme’ to emphasize the targeted audience for whom the product is designed. The packaging enlists the assistance of a pink colour scheme and graphically redesigns the chemical compound of testosterone to resemble a prismatic honeycomb. The information leaflet for the product that Harper Pharmaceuticals is handing out at EMAS equally calls upon this theme. It employs the same pick colour scheme, and a wide pink banner introduces the formula as ‘Testosterone for Women’.

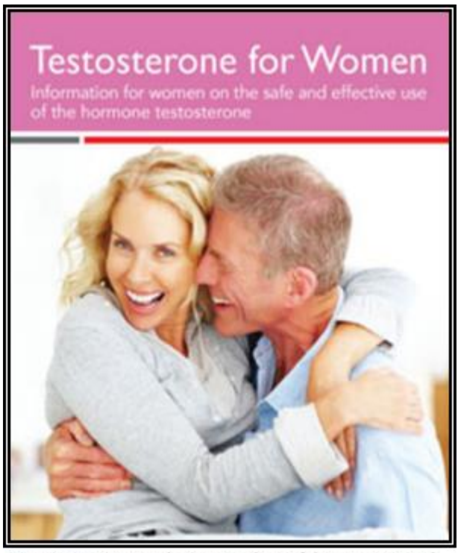


Figure 36: Personal picture taken of the promotional material used for AndroFeme at the EMAS conference.

On the front of the leaflet a model is pictured sitting on the lap of their supposed partner. They laugh and smile, their faces pressed together. The image would suggest they are perhaps sharing a joke. With their arms wrapped tightly around one another, the partner’s hand is visibly pressed into the waist of the model just below the breast. The angle of the face is positioned so nose and mouth are pointed towards the model’s ear and neck. It suggests a sexual or intimate context. The most interesting thing about this image is the suggestion that the impact of AndroFeme is not *only* for the menopausal patient, but for their partner too. In improving symptoms such as low libido, the benefits to heterosexual men are made apparent. Permission to use testosterone is thus granted by the patriarchy, and menopausal persons are afforded use due to the potentially advantageous impact it could have on improving a partner’s sex life. Moreover, while feminising testosterone could be read as threatening – a possible dilution of masculine ‘potency’, in this instance we see a culturally protective mechanism at play. In rebranding the formula as ‘testosterone for women’ it is suggested that this hormone is not testosterone as traditionally understood. It is *different* to ‘proper’ testosterone. It is women’s testosterone, something apart from the ‘regular’ testosterone known to belong to men.

Conceptions of the Conference

The EMAS conference infers the aging body to be a sight of construction – a place in which consistent work to maintain balance is necessary. In the case of marketing material for 4RFH, for example, each inch of the body is mapped out with corresponding arrows deliberately placed to highlight the areas that require attention. Similar iterations are communicated with attention paid to vulvovaginal intervention. References to collagen, elastin and plasticity all repeat across lectures and in materials, implying that the vulva and vagina are sites that should remain constant and controlled. In a number of lectures, the use of sling and mesh as methods to guard against GSMA are discussed. In each session, it is concluded that the evidence is mixed. As the body ages, as children are born and as pelvic floors fall, we all begin to leak, but this leaking is seemingly highly inappropriate, however normal it may be. Statistically, after childbirth most women will experience some form of urinary incontinence, and yet we consistently attempt to fix and resolve the issue of urine, as opposed to getting comfortable with a lack of bladder control (Lynch et al. 2020). This ‘treatment’ of the aging body may well occur as a consequence of the threat it poses in relation to the erasure and blurring of boundaries relating to clear categorical gendered difference. As women grow beards and men struggle to maintain erections, so too does the fabric of conceptual categorical difference fade, and thus our handle on the structural fabric of the medical world as we know it slips.

Observations from EMAS ultimately highlight the reach of patriarchal power, demonstrating how medical discourse affirms its existence in both obvious and subtle ways. Capitalist ventures can be observed to limit access to available treatment options, which encourages us to consider the darker side of an industry in which the lines between treatment and enhancement are becoming increasingly blurred. Included within this consideration should be the acknowledgment of not only patriarchal power, but systematic oppression – as is conveyed by the representation of the types of persons that may be perimenopausal or menopausal: white heteronormative women.

Whilst the presentation of patriarchy as it is enacted at the conference may not welcome a deconstruction of its messaging, in doing so we are able to acknowledge the complexities involved in disentangling the actions of HRT and hormones more generally from sociocultural constructs and pressures as they pertain to aging and a perimenopausal or menopausal woman's need to remain in 'balance'. We may consider how these messages can present obstacles for professionals when explaining hormonal function to patients and appreciate the difficulties involved in undertaking a task without drawing upon shared metaphors, or outdated, inappropriate gendered scripts.

Whilst all the hormone replacement therapies presented in the EMAS space can be seen to draw upon derivative messaging (from the 'natural' to the 'empowered'), the positioning of testosterone in particular showcases our gendered messaging as it specifically relates to medical spaces and places. Testosterone continues to be called upon as a marker of masculinity, which limits its subversive potential. The fervent gendered inversion of messaging of the kind that is portrayed in the AndroFeme materials as it showcases the need to shore up distinct categories in communicating the biological. Deconstructing these kinds of messages – communicated in different forms at the conference – ultimately encourages us to consider alternative ways to think about our hormonal makeup, and how we may better communicate messages about HRT and the body in a more gender-neutral, diverse and inclusive manner when we are making menopause.

CHAPTER 6

Menopause and the Media

This final data chapter explores how medical framings of menopause move out beyond the clinical environment, and as they do so in what ways they inevitable get altered. I bring together a number of separate accounts about how discussions about the menopause entered both mainstream and social media during the course of my project. Although they initially may appear disconnected, the descriptions show how key claims and ideas about menopause moved into new spaces and as a result engaged with new female audiences. The central focus is on how clinical concepts extended into media domains, often being presented side-by-side with non-clinical accounts. It considers how diversifying the clinical landscape via a variety of media channels may well be viewed as problematic because of the risk of misinformation, it nevertheless offers opportunities for building new networks between people who may otherwise struggle to find connection.

Examining the medical framing of menopause through both traditional and contemporary forms of media, I explore the role of clinical expertise in these channels, and the extent to which it can now claim to be distinct and more objective than other accounts. Specific attention will be paid to the complicated entanglement of the clinical expert with the influential 'celebrity' figure, highlighting the 'alignment' of these figures as a newly emerging, yet nevertheless important, partnership that increasingly shapes contemporary menopausal discourse and the landscape of women's health more broadly. Thus, embedded within this discussion is an exploration of the ways in which menopause increasingly features as part of many women's identity. For example, in a description on the lengths taken by women to obtain HRT during nationwide shortages, and arguments made by some that it was their 'right' to acquire this medication, I reflect on the ways in which hormones have come to represent more than just medical treatment: HRT has, instead, become aligned with claims for justice, visibility and finally being taken seriously.

The changing authority of medical knowledge in media spaces suggests that traditional clinical hierarchies are potentially 'threatened' in an ever-emerging climate of 'accessibility', in which the distinction between lay person and expert becomes conflated and blurred. The chapter considers the ways in which medical knowledge and authority functions in increasingly public debates about menopause, and how such knowledge may exist differently in different spaces. As such, analysis questions the processes and means by which certain forms of knowledge offer an authoritative voice influencing public opinion in a social world that is increasingly more fragmented, unstable and multiple. The question of who is seen to have authority and legitimacy in the context of menopausal health is illustrated in an account of the 'Davina Effect'. This describes the spikes and surges of HRT demand in the UK that were attributed to media outputs featuring, or relating to, the celebrity Davina McCall. However, I argue that a more insightful understanding of this is not the simple assumption that her influence suddenly made more women seek HRT, but that what people called the Davina Effect was really a complex combination of medical information that successfully combined *with* emotive storytelling. This alternative framing encourages a reader to think critically about the mechanisms enabling clinical aspects of menopause to appear in the media sphere.

While glandular 'charlatans' undoubtedly operated in the 20th century, the contemporary reach, impetus and impact of a clinical 'influencer' culture in current menopausal discourse is essential to consider. As menopause moves outside of the clinic and into our devices (in a number of differing ways) the roles adopted by both clinician and patient, as well as the way medical decision-making happens is rapidly changing. The patient, in a growing arena of empowerment and advocacy, arguably can be seen to become a site that *produces* power as opposed to becoming a subject of it (Andreassen & Tondsen 2010; Lober & Flowers 2011; Cavillo, Roman & Roa 2013; Househ, Borycki & Kushniruk 2014; Benetoli, Chen & Aslani 2018; Zamora 2022). This suggests that traditional medical systems are under threat and may well already be shifting. While the NHS may be predicated upon a socialist model of healthcare for all (Corrigan 2019, Seaton 2023), the institutions themselves frequently reproduced traditional models both of medical, and patriarchal, authority. As the clinical aspects of menopause move into, and onto, different media platforms; as medics work side by side with celebrities; and as influencers are increasingly positioned as experts, a reader is asked to consider, who truly holds authority when it comes to making menopause?

The Red Ford Mustang

The first time I heard about Baader-Meinhof Phenomenon or ‘Frequency Bias’ (Zwicky 2006). I was driving to Mansfield Health. Trundling along the M40 listening to a podcast describing the phenomenon, it was explained that Baader-Meinhof relates to the experience whereby, after learning about some phenomenon, you start to see said phenomenon everywhere. The sensation is thought to occur most often after hearing details of something serious. For instance, if a member of the public were to learn about a crime that had been committed in their local area by someone driving a red Ford Mustang (to use the example of a fiesta seemed so much less impactful), they may find themselves seeing red Ford Mustangs wherever they go. This experience may manifest itself beyond physical sightings also. One may begin to notice red Ford Mustangs in other ways. They may seem to find their way into conversations with a colleague, or suddenly appear on an advert on the television. You may notice that car being driven in a movie, or a TV show. It can cause a discomfort in which, after hearing about it, that crimson convertible seems impossible to avoid.

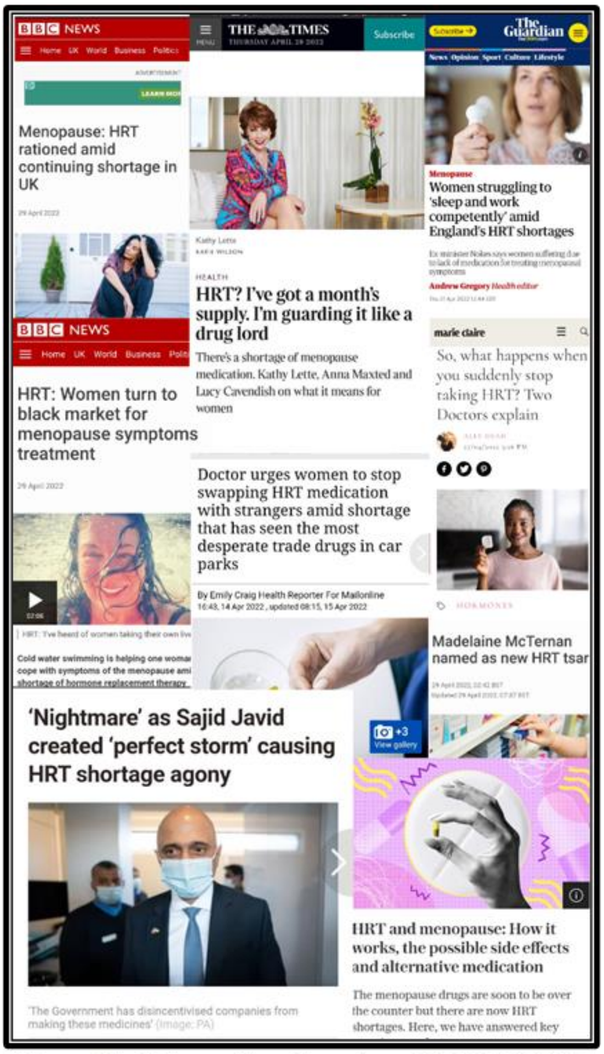
Linguist Arnold Zwicky (2006) defines the occurrence of Frequency Bias, or as he terms it, ‘Frequency Illusion’, as sequential. We first notice something a number of times, before moving to a state of belief: “I guess that thing I keep noticing truly does happen!” or “that idea I’ve had seems to be popping up a great deal – maybe there’s something in it…”. This, he argues, stems from the concurrence of Selective Attention and Confirmation Bias. In the case of Selective Attention, Zwicky explains how the brain can become adept at fine-tuning itself, developing the ability to turn non-relevant information into emblematic ‘white noise’. In essence, this means that when a subject matter or idea that is ‘close at hand’ presents itself, (such as the appearance of a red Ford Mustang outside of your house) the brain will keenly notice this and/or surface previously learnt information that may be relevant (e.g., those that drive red Ford Mustangs can be involved in crime – with perhaps the emergence of a concurrent instinct to call the police).

For anyone who has ever studied a particular topic in detail, the experience of frequent ‘noticing’ is likely familiar. It is the startling impression that your subject matter seems to appear everywhere you go. You might spot it on the cover of a book being read by the person sitting opposite you on the tube. You may hear it being discussed on the radio, or see it referenced on the news. Regardless of where it ‘pops up’, you begin to become certain that *now* is the moment the world is seeing *your* topic.

Whilst there is of course the possibility that now *is* your topic’s moment, it is also important to consider how paying attention to a subject matter can keenly focus a mind to return to it; over and over and over again. Upon deciding that this thesis would be focusing on menopause and the experiences of those navigating care and treatment, relevant content seemingly started to appear everywhere. When these situations would occur, I calmly reminded myself to think about frequency bias. I reminded myself to consider the possibility that my heightened awareness of menopause was likely causing me to pay more attention to the topic as opposed to my mounting suspicion that the world was *actually* having a metaphorical hot flush. However, the sensation that I was becoming a magnet for menopause became increasingly difficult to ignore. As opposed to being contained within the world of the clinic, my subject matter, my research, was seemingly spilling out beyond it. It brought forth the sensation of trying to hold water in cupped hands. Each time you think it’s securely contained, kept in the clinic, it starts to trickle out. Sealing spots only seemed to result in the emergence of new cracks; a steady stream began to flow. Paying attention to this, it was hard not to consider the possibility that the experience being navigated – the frequent encountering of menopause outside of the parameters of the clinic – was not to be explained away as a result of cognitive fine tuning. Increasingly it seemed, menopause was experiencing its watershed moment.

HRT Hits Headlines.

There were two notable instances that provide weight to the argument that menopause had become a proverbial ‘red convertible’ and a mainstream topic over course of this research. Namely, two HRT shortages occurred in the UK – first in 2019, and then again in 2022.



Menopause: HRT rationed amid continuing shortage in UK

HRT: Women turn to black market for menopause symptoms treatment

Cold water swimming is helping one woman cope with symptoms of the menopause amid shortage of hormone replacement therapy

HRT? I've got a month's supply. I'm guarding it like a drug lord

There's a shortage of menopause medication. Kathy Lette, Anna Maxted and Lucy Cavendish on what it means for women

Doctor urges women to stop swapping HRT medication with strangers amid shortage that has seen the most desperate trade drugs in car parks

By Emily Craig Health Reporter For Mailonline
16:43, 14 Apr 2022, updated 08:15, 15 Apr 2022

Women struggling to 'sleep and work competently' amid England's HRT shortages

Andrew Gregory Health editor

So, what happens when you suddenly stop taking HRT? Two Doctors explain

Madelaine McTernan named as new HRT tsar

'Nightmare' as Sajid Javid created 'perfect storm' causing HRT shortage agony

'The Government has disincentivised companies from making these medicines' (Image: PA)

HRT and menopause: How it works, the possible side effects and alternative medication

The menopause drugs are soon to be over the counter but there are now HRT shortages. Here, we have answered key

Figure 37: Collage of headlines from 2022 (BBC 2022; Cavendish 2022; Craig 2022; Head 2022; Phillips 2022; Walker & Russel 2022; Whitehead 2022).

The first supply issue hit the headlines while I was conducting fieldwork in the clinic. This meant I was able to witness the impact of said shortages on clinical conduct first hand. The second however occurred *after* fieldwork had taken place. In the spring of 2022, from across the pond in California, notifications started chiming. Headlines exclaimed in bold aggressive lettering that HRT shortages were driving 'users' to drastic measures: "HRT shortage leaving menopausal women suicidal and causing relationship breakdowns" (Oppenheim 2022). The issue had little to do with doctors refusing to prescribe HRT. People were, it was reported able to obtain prescriptions[25]. Instead, pharmacists could not dispense medications because of stock shortages from limited pharmaceutical production. Exploring the measures people took to obtain HRT, journalists jumped on the bandwagon and a number of stories were published focusing on people meeting in carparks to 'swap' HRT. These exchanges (predominantly facilitated via online forums) helped those looking to acquire HRT connect with others on the hunt for hormones. Some reports even mentioned 'swaps' as excess supplies were traded; what one woman had too much of (say Oestrogel), being exchanged for what they needed (say

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[25] a factor worth noting as it highlights progressive change from when the research began – a period in which many participants detailed their struggles to get their GP to affirm their menopausal state and prescribe HRT.

Utrogestan). But more generally, what these events meant was that HRT and the treatment of menopause instantly became a newsworthy topic.

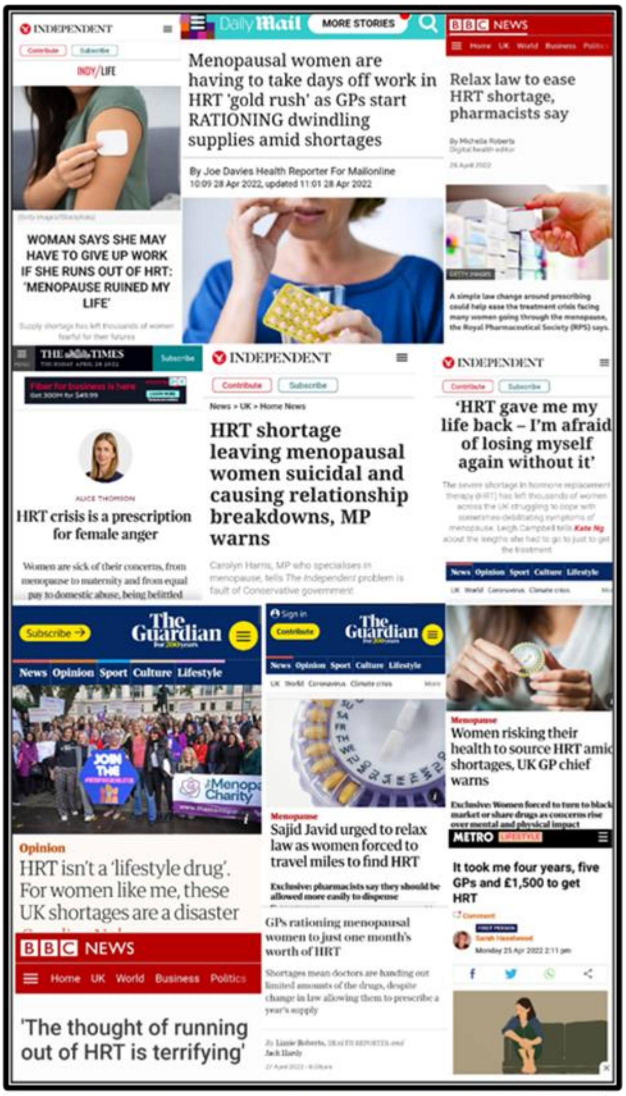
These carpark 'swaps' aptly capture the complexity of menopausal discourse and the means by which clinical aspects of menopause entered the media sphere. While on the one hand HRT is considered to be part of a highly individualised form of clinical care – a means of restoration that should be regulated by a doctor – it rapidly also became a tradable impersonal commodity –to be bought, sold and swapped to the highest bidder. Unsurprisingly, medical professionals weighed in. They urged people to refrain from altering their doses of HRT, or changing their delivery method (e.g., switching from a patch to a gel) without consulting a physician. Of course, these requests were seemingly disregarded, and black-market, trading on the tarmac continued to be reported.

Perhaps it is most interesting to consider is the role of the clinician within this. In the context of the clinic, HRT is calmly discussed by professionals as a natural 'return' to the proper hormonal state, a means to 'correct' a hormone insufficiency. The role of the clinician is presented as a facilitator of this, rather than a gatekeeper. The conversation centres on the patient, on the woman reclaiming her 'natural' state. *Yet,* in the context of a supply chain issue, in the midst of a nationwide HRT shortage, women were reminded that HRT can *only* be obtained through legitimate clinical avenues. This directly challenged the idea that women were somehow reclaiming their lives and bodies themselves.

The Davina Effect

The HRT shortages experienced in the UK in 2022 were never explicitly acknowledged as relating to an increase in public awareness, but speculation this was the cause was rife. Indeed, after the airing of the Channel 4 documentary *Sex, Myths and the Menopause* (2021), requests for HRT prescriptions rose considerably. Figures suggest that in the span of one year, pharmacists dispensed an additional 8 million variations of HRT – an increase of 35 percent on the previous year. The documentary was hosted by the celebrity Davina McCall, a popular TV presenter who drew directly on her own experiences of the menopause. The subsequent increase in demand for HRT was dubbed by journalists as the 'Davina Effect' but it split opinions considerably.

Some noted that the such media attention offered a much-needed insight into the often-overlooked plight of those experiencing menopausal symptoms. Others, however, highlighted the manner in which HRT was positioned in the documentary as an unproblematic ‘cure all’ that could lead to all sorts of problems in the future.


INDEPENDENT

INDY/LIFE

WOMAN SAYS SHE MAY HAVE TO GIVE UP WORK IF SHE RUNS OUT OF HRT: 'MENOPAUSE RUINED MY LIFE'

Daily Mail

Menopausal women are having to take days off work in HRT 'gold rush' as GPs start RATIONING dwindling supplies amid shortages

By Joe Davies Health Reporter For Mailonline
10:09 28 Apr 2022, updated 11:01 28 Apr 2022

BBC NEWS

Relax law to ease HRT shortage, pharmacists say

A simple law change around prescribing could help ease the treatment crisis facing many women going through the menopause, the Royal Pharmaceutical Society (RPS) says.

THE TIMES

ALICE THOMSON

HRT crisis is a prescription for female anger

Women are sick of their concerns, from menopause to maternity and from equal pay to domestic abuse, being belittled

INDEPENDENT

News > UK > Home News

HRT shortage leaving menopausal women suicidal and causing relationship breakdowns, MP warns

Carolyn Harris, MP who specialises in menopause, tells The Independent problem is fault of Conservative government

INDEPENDENT

‘HRT gave me my life back – I’m afraid of losing myself again without it’

The Guardian

Opinion

HRT isn’t a ‘lifestyle drug’. For women like me, these UK shortages are a disaster

The Guardian

Menopause

Sajid Javid urged to relax law as women forced to travel miles to find HRT

Exclusive: pharmacists say they should be allowed more easily to dispense

Menopause

Women risking their health to source HRT amid shortages, UK GP chief warns

Exclusive: Women forced to turn to black market or share drugs as concerns rise over mental and physical impact

METRO

It took me four years, five GPs and £1,500 to get HRT

Monday 25 Apr 2022 2:11 pm

GPs rationing menopausal women to just one month’s worth of HRT

Shortages mean doctors are handing out limited amounts of the drugs, despite change in law allowing them to prescribe a year’s supply

By Lizzie Roberts, HEALTH REPORTER and Jack Hardy

BBC NEWS

'The thought of running out of HRT is terrifying'

Figure 38: Collage of headlines from 2022 (Davies 2022; Haselwood 2022; Gregory & Cambell 2022; Ng 2022; Nokes 2022; Oppenheim 2022; Roberts 2022; Roberts & Hardy 2022; Roxby & Reed 2022; Thomson 2022).

Regardless which side of the argument one adopts, it is hard to ignore the likelihood that the Davina Effect directly impacted HRT prescribing cultures and as such, pharmaceutical demand (BMS 2022; Davis 2022; Furness 2021; The Pharmaceutical Journal 2022). The menopausal space grew exponentially as a result. Demand for menopausal care and treatment increased nationally. And this also meant it did for Mansfield Health as well. Concern regarding the ability to obtain HRT propelled conversations in the media around whether a woman actually ‘needed’ HRT. This kind of question divided clinicians, academics, and the public in general. More interestingly in the context of this research, however, it drew attention to the ways in which menopause came to be conceived in the mainstream: As a temporal biological period that has always existed but is now widely over-pathologized? (Mattern

2019) Or alternatively, as a hormone deficiency that has not been taken seriously in the past, because it affects women rather than men?

The influence of celebrities such as Davina became an integral part of this story, not only with reference to communicating information about menopause, but in creating menopause in particular ways. While it is easy enough to attribute prescribing practices directly to the documentary, the *real* Davina Effect is arguably more complex. I would propose that what was key was the combining of medical information (which holds a certain kind of authority) with personable anecdotes and emotive storytelling from women (which adds a different kind of validity). At its core, then, the Davina Effect demonstrated how clinical aspects of menopause, when moved into media spheres, become inextricably combined with other kinds of conceptual ideologies that inform women's experiences of menopause and their pursuit of treatment. Ultimately, the Davina Effect speaks to the ways in which the boundaries between the medical and non-medical necessarily become blurred in media spheres.

Social 'Media'

The 'menopause movement' – a term used to refer to persons committed to spreading certain kinds of information about perimenopause, menopause, and HRT (primarily via social media channels and in other online spaces) – garnered traction gradually. Given the meteoric rise of interest in and public awareness of menopause, it's easy to assume that such engagement appeared all at once. However, commitment to the menopause movement developed steadily – a progression of resharing, commenting and posting. Equally, this movement revolved around a few key figureheads, of which Claire was one. Claire's presence on social media, (specifically her following on Instagram) was a topic of conversation from the beginning of fieldwork. During the winter months of 2018, she would pop into the administrative office, phone in hand, poring over the comments received on her latest post. Claire's social media following had been substantial when research began, but nothing close to the reach she obtained in just a few short years. Over the initial few months of observations, numbers increased in a consistent fashion – day by day, her following grew. Moving swiftly past the few thousand mark, Claire began to be teased for becoming an 'Instagram celebrity' in the clinic. In the spring of 2019, the label of ‘celebrity’ however seemingly became legitimate – she was approaching the 100k mark, and interest was on the rise.

During the launch of her first book, Claire herself mentioned her social media feat, noting “it was at least something her daughters could be proud of!” Though perhaps intended as a throw-away remark, Claire’s comment was revealing. Whether conscious or not, it highlighted the means by which success and respect is, in contemporary society, increasingly measured in relation to online notoriety. While Instagram was originally designed to support communication via the visual – a space to appreciate artistically filtered selfies or amateur arthouse photography, it has over time, proved popular with businesses and celebrities alike. The platform offers the opportunity to curate a conception – to build an identity synonymous with a ‘brand’. Not only are we able to search for specific people through their handles, accessing a window into their world that’s projected by their personal pinboard; we can find topical trends too. The power of hashtagging can allow users to gain access to a wide variety of content that engages with the same topic.

The art of what makes an Instagram profile appealing is both temporally and generationally specific. (Djafarova & Bowes 2021) For example, ‘Gen Z’ can be seen to buck the millennial trend for ‘perfect posing’ by opting to embrace more authentic self-styling. Despite differences in algorithmic appeal, however, there are conceptual similarities that can be observed when it comes to social media success. If one is able to strike a balance in content creation that feels accessible, vulnerable, and authentically altruistic, opportunity for mass appeal becomes not only feasible, but probable. Claire’s early Instagram posts hinged on this concept of authentic altruism. Unanchored in the visual, Claire posted no pictures of beautifully arranged kale or acai berry smoothies consumed that day, nor images of her consulting in Birchwood House. Rather, her posts by and large, reflected the experiences of others. At a later date, when asking Claire how she went about deciding what to post and why, she explained she was motivated to share stories from her patients – those that may resonate with others.

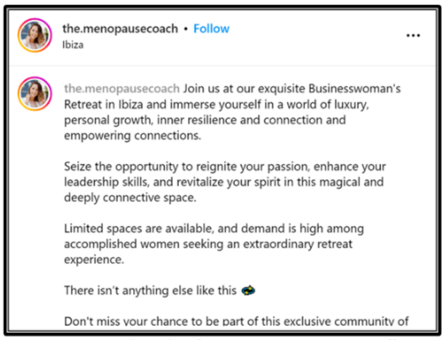
The overall setup of each post reflected the same format. A topical point of discussion (such as low mood) was addressed by means of a stock visual image (such as a person with their head in their hands), and underneath the image, a detailed description drawing upon a conversation with a patient was provided. If a patient described how every morning they awoke feeling as if they had been hit by a bus, she would post a picture of a bus accompanied by a description referencing this feeling, and toward the end of the descriptive text, there would be suggestions and encouragements to seek help from a healthcare provider. She appeared in the post, but subtly – as an advocate, a facilitator, and a point of support for conversation. Every now and then, pictures of Claire were posted. Usually, these images were taken at conferences, or sometimes in yoga poses with descriptors surrounding the improvement she had observed in her 'body practice' as a result of diet, commitment to consistency and, of course, HRT. Occasionally, a modest plug for an external event would appear (e.g., a workshop taking place at Mansfield Health or an article she had uploaded on to her website). For the most part however, the patient remained at the heart of Claire's content creation – it reflected the everyday experiences of those living through menopause.

A similar observation to the Davina Effect may be observed here. The power of Claire's posts lay not purely in the communication of the clinical aspects of menopause. Rather, their reach was relevant because of the way they *combined* the clinical aspects of menopause with anecdotes and storytelling.

Fundamentally, Claire's social-media posting achieved something metaphorically parallel to her work with hormones. A balance – an equal and carefully considered spread of business and person. Though Claire's posting of general topics and experiences may seem relatively standard in their originality (a story from a patient consult), they offered something key to those engaging with it: a proximity to the familiar. The conversational pull expressed through Claire's use of language enabled those engaging to feel they were cared for; in some way, they too were a patient of hers.

The function and relevance of Claire's Instagram posts are important to acknowledge as they featured in the development of this research. Under each image uploaded there were not only a multitude of 'likes', but hundreds of comments too. These comments predominantly reflected personal thoughts and opinions regarding the content that had been uploaded. They tended to lend support to what Claire was communicating, remarking with comments such as "spot on" or "my thoughts exactly". However, they also outlined detailed personal experiences too. Sometimes these comments were so long they had to be posted in two parts. Posts were often picked up on and replied to by other commentors with their own stories, and so on. Additional accounts were tagged, and peer support was fostered. In the early days of Claire's activity on social media she would respond to certain comments – straightforward and to the point, she would advise with clear action pointers – "you should make an appointment with your GP to discuss this…". As her following grew however, responding to individual comments or messages proved unfeasible, which she highlighted in her Instagram biography: "Cannot give individual advice".

The menopause space on social media is interesting as it highlights a complex tension between forces for support and forces for exploitation. Over the period of time Claire was growing her own social media following, the commentors on the comments – the people weighing in on others' distress – were also carving out a space for themselves. The advent of new forms of supporting schemes such as 'menopause coaching' proved increasingly popular, and a number of accounts claiming to help 'treat' menopause started to appear. Indeed, during the period in which this research was taking place, numerous enquiries from 'midlife guides' appeared in the project's Instagram inbox, all claiming to help with the navigation of symptoms. Thus, within the social media space opportunities for exploitation of those seeking support grew in line with the increasing expansion of the legitimate menopause movement.



the.menopausecoach Join us at our exquisite Businesswoman's Retreat in Ibiza and immerse yourself in a world of luxury, personal growth, inner resilience and connection and empowering connections.

Seize the opportunity to reignite your passion, enhance your leadership skills, and revitalize your spirit in this magical and deeply connective space.

Limited spaces are available, and demand is high among accomplished women seeking an extraordinary retreat experience.

There isn't anything else like this

Don't miss your chance to be part of this exclusive community of

Figure 39: Screenshot taken from an Instagram account offering 'coaching' support to menopausal persons.

Once again this relates pertinently to the ways in which menopause is made in media spaces. While the combining of personable experiences with clinical aspects of menopause ensures women are able to receive information in a relatable fashion, it also increases the risk for the clinical aspects of menopause to be diminished or ignored entirely. With a few carefully worded sentences, a promotion of oestrogen here and progesterone there, the influencer becomes the expert and lines between legitimate clinical figures and unscrupulous salesmen become difficult to police. Thus, the Davina Effect formula - the blurring of boundaries between clinical and personal – was extensively played out in social media spaces, where there is little control or regulation to keep the two distinct.

Evangelical About HRT

Whether inadvertently or not, Claire’s engagement with perimenopause and menopause on social media propelled her public profile to a new level. She increasingly was recognised as a menopause authority in a UK context and as such, celebrity came to call. Claire’s first venture into television was on the ITV talk show ‘Lorraine’. As it would turn out, Lorraine (a popular British Television host) was one of Claire’s patients and felt strongly that conversations about perimenopause and menopause needed to reach a wider demographic of women. Lorraine had expressed interest in menopause prior to Claire’s appearance on the show. The celebrity Meg Matthews (ex-wife to Noel Gallagher, star of the British Britpop band Oasis and another patient of Claire) had appeared on Lorraine to discuss her own experiences navigating perimenopause. Meg had created the platform ‘Meg’s Menopause’, which, at the time, was garnering traction from those seeking advice and support for navigating their perimenopause and menopause. Meg visited Mansfield Heath shortly before appearing on Lorraine. It had caused frustrations in the administrative office as Meg had, in equal parts, both ignored staff and equally insisted on being filmed for social media as she navigated her way around the clinic. During Meg’s appearance on Lorraine, she discussed her use of HRT as *“life changing”*. She and Lorraine exchanged the kind of banter where full sentences can’t quite be caught. Excitement and agreement about the impact HRT predominated, rather than a coherent presentation of content, and one line in particular is salient: Meg’s comment that *“now you can take HRT until you’re 99, no problem”*.

Figure 40: Screen shot from an episode of Lorraine where Meg Matthews is being interviewed about their menopausal experience.

Claire’s appearance on Lorraine also drew on her own experiences; she allows viewers into her life, explaining that, even as a menopause specialist, she missed the signs, jovially highlighting how one of her daughters said to her: *“mummy I* *think you need to get your period, because you're really grumpy".* Claire explains that this was the catalyst for realising her periods had stopped and she could be entering perimenopause. Claire is informative and approachable; she speaks candidly and clearly to Lorraine, highlighting the increasing number of women that are frequenting the clinic as a result of not being able to access support for their symptoms. Claire provides a specific rationale as to why the occurrence of menopause must be understood and appreciated in temporal terms. She explains to Lorraine: "*In Victorian times you used to die quite soon after your menopause but now of course you don't".*

The topic of HRT is broached by Lorraine. She directs the following at Claire: *"You're an evangelical about this and thank God you are".* The shot pans between Lorraine, Claire and the HRT that Claire has brought for the purposes of the filming. Wide shots reveal pink boxes and tubes that are used as props in the discussion of application techniques and options. The ease of conversation is notable. Claire talks about HRT like a familiar friend. Having observed her consultations, the approach displayed is similar to that exhibited between Claire and a cared-for patient; it's informative without being patronising. It covers the complexities of menopause in a way that feels inviting as opposed to overwhelming. Equally, her use of language conveys authority – the decision is made for the viewer in static terms: "*Women under the age of 40* ***have*** *to have hormones… because of the real risk of diseases going forward".*

Lorraine uses the last latter portion of the interview to pose questions from viewers to Claire. The common concern of breast cancer risk is highlighted and Claire offers the following response: *"when people have the natural oestrogen with the natural progesterone there's no risk in the first 5 years, and after that the risk is very low… a woman who's overweight or obese has a far greater risk of breast cancer than a woman taking HRT, and as you know, a lot of women who take HRT actually lose weight, exercise more and have a healthy lifestyle.* "The question of age is also encountered. Lorraine presents a query from a viewer about whether she may be *"too old"* to consider using HRT. Claire outlines briefly the small increased risk that does occur after the age of 60 (or 10 years after menopause has taken place), yet in tandem takes time to highlight the ages of some patients she sees in her clinic. Indeed, her initial response to the query before covering the context of risk is: *"no one's too old for anything are they…".*

Toward the end of the interview, Lorraine poses a query from a viewer who asks whether she should use HRT even if she has no symptoms, because of the possible benefits HRT may have in relation to aging (such as maintaining optimal bone density). Claire responds to this question in an interesting manner. Sidestepping the risk of saying on national television that HRT may be used as a preventative mechanism to guard against conditions related to aging (a position contrary to that of the BMS and IMS) she flips the narrative, responding with: *"A lot… do have symptoms but don't realise, so there's a questionnaire… available on my website – when people fill it out things like memory problems, just feeling a bit more tired, a bit more fatigued, joint pains, urinary symptoms are very common – so actually when they tick the boxes and then you give them HRT they say gosh I feel so much better"*. Closing out the interview, Lorraine makes a final remark: *"You'll have changed her life, because you certainly changed mine."*

Figure 42: Screenshot taken of HRT displayed on Claire's segment of Lorraine.

A few factors are interesting in the respective appearances of Claire and Meg on *Lorraine*. Firstly, in regard to the position outlined by Meg Matthews – that you are able to "*take HRT until you're 99, no problem"* – we can observe that it is seemingly informed by conversations that have taken place between Meg and clinicians where this option has been proffered as a possibility. The clinical advice and guidance surrounding this decision as it pertains to treatment, however, remains contrasting. While many feel that those using HRT should be able to continue taking it for as long as they feel it is beneficial, others question such an approach. Factors to consider (such as those outlined in Claire's later response) relate to the time in which HRT is initiated, along with others, such as contradictory risk factors relating to an individual's susceptibility to particular conditions). Meg's position that you can continue to "*take HRT until you are 99 no problem"* thus may prove persuasive for many, yet the importance of due diligence in evidential medical fact checking is equally ignored. In doing so, the safety of a proportion of the population is dismissed without recognition[26]. This serves to highlight the power not only that the celebrity figure has in relation to their reach, but the dangers in those with a non-clinical backgrounds providing support and advice pertaining to medical issues. Whilst not necessarily ‘wrong’ (many do continue to take HRT happily for the rest of their lives) it is concerning to consider the fact that for many, Meg’s mandate would prove enough to contradict a clinician’s advice about rationales for discontinuing HRT.

Similarly, Claire’s appearance on Lorraine presents some themes that require exploration. Whilst, clinically, Claire’s position is accurate, there are nuances to her delivery and her use of language that should be considered. Throughout, references to the divine are called upon. Lorraine comments that Claire is *“evangelical”* about HRT, following this with a *“thank God you are”*. Such sentiment presents the use of HRT as an intervention that is transformative – “*you’ll change her life because you’ve certainly changed mine.”* From this position, HRT is not presented as an *option* for menopausal symptoms, but rather rationalised as a necessity. Concerns of viewers are mediated with humour – a touch of the personal is incorporated by reference to Claire’s own ‘missing’ of her menopause. After all, it was her daughter that drew attention to the fact as opposed to her knowledge and expertise. This grounds the viewer in relatability – of course they could miss the signs. Equally her comments about her daughter render Claire a relatable figure – she is likely, akin to a number of audience members tuning in, a mother who has been perhaps too overwhelmed with the pressures of everyday life to recognise her own perimenopausal symptoms when they ensue.

Of equal importance, is the position Claire adopts pertaining to particular groups. Claire expresses that “*a woman who’s overweight or obese has a far greater risk of breast cancer than a woman taking HRT”.* Claire expresses authority in her position that women under the age of 40 experiencing a decline in hormone levels “*have to have hormones… because of the real risk of diseases going forward”* (supposedly as a result of Premature Ovarian Insufficiency (POI)). Use of the language ‘have’ removes the concept of shared decision-making entirely. While again, the advice provided is clinically sound (a person

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[26] Not all persons can take HRT until they are aged 99 for a variety of medically significant reasons.

experiencing a decline in hormone levels at that age as a result of a total hysterectomy or POI will suffer exponentially with symptoms should they choose *not* to use HRT), the choice to pursue treatment is unique to each individual. As such, their decision-making process pertaining to this choice should include a sense of empowered authority relating to their unique and individual circumstance.

The final comment to consider is Claire's rationale as it pertains to the history of menopause itself. She notes: "*In Victorian times you used to die quite soon after your menopause but now of course you don't". This position, however popular, has been found fallible. As Susan Mattern elaborates in *The Slow Moon Climbs* (2019), the 'history' of menopause we most commonly communicate is both subjective and largely predicated upon the experiences of those in a Global North context. Presenting examples from scholars practising in the fields of evolutionary biology, history, and anthropology, Mattern highlights how the narrative of 'death after menopause' is historically problematic, explicating that for the majority of human history, menopause was not perceived nor pathologised as a medical condition, and that contrary to popular opinion, persons have been experiencing menopause for millennia. Indeed, Mattern notes that in "traditional" societies (as termed by the communities themselves) menopause was considered an essential life stage that may well have led to the development of society as we know it. The positioning of menopause as a medical or pathologised state, Mattern argues, only began to occur in the 18th Century and was in keeping with the rise of a professional medical class resolved to establishing categories in order to help define and categorise upsetting symptoms known to leave 'women' weak and defenceless in a labour-driven society (e.g., hysteria or melancholia). Thus, in the context of Claire's comment, whilst it provides a viable and tempting account in which HRT is simply 'correcting' a condition that we have only recently come to encounter, it promotes a *position* – an understanding that draws upon contemporary culture and medical discourse relating to menopause that has emerged and been born out of patriarchal oppression, and a context in which women's bodies require fixing, stabilising and balancing in order to function appropriately.

This exploration of both Meg's and Claire's appearance on *Lorraine* demonstrates the way in which clinical aspects of menopause were represented in mainstream television. Fundamentally, in both appearances, what may be observed is a lack of nuance. Of course, while it is fair to argue there is only so much that can be communicated in a short segment on morning television about the complexities of depleting hormone levels, it can equally be noted that the message ought to be that an individual *should* undergo a thorough clinical assessment before commencing any form of treatment *including* HRT. While this isn't negated by either guest, it is definitely downplayed. The result is that such television sections serve to create an unquestioned demand for HRT, rather than it being a possible outcome of an encounter between professional and patient.

The detailed description in this section also serves to highlight how ideas of knowledge exist differently in different spaces. For a brief topic on television, menopause has to be presented in a clear and straightforward way, meaning that there is no time or toom to convey areas of doubt and uncertainty. The facts thus presented by Claire do their job well; they comfortingly iron out the bumps and present a straightforward narrative – menopause is medical and requires intervention. But, of course, this ignores the fact that in reality all medical evidence is based on probabilities and limitations, and that without mentioning these, claims can be misleadingly simple. The result is a particular kind of knowledge that omits detail and highlights only the positive.. Perhaps most interesting of all, is how, by appearing on this platforms, Claire accepts this as a necessary trade-oof, and in so doing embraces the space where celebrity and clinical coexist.

Returning to a crucial analytical point of this thesis, menopause is not understood as a temporal state that should be endured by those struggling with symptoms. Nor is HRT considered unnecessary. Quite the contrary. Treatment options are available and should be able to be explored and pursued as a person sees fit. The object of exploration in this narrative is about the 'condition' of menopause itself. Where understandings may be born from and the manner in which accounts of the historical develop to inform our navigation of the contemporary. Critical consideration as to the parameters of the fictive and social work of science is thus encouraged.

Making Communities

Biological knowledge and medical technology have increasingly become domains in which new forms of relating can take place. As new diagnostic categories emerge and the way in which we identify at-risk groups evolves, the drive to be ‘healthy’ unites many sectors of society that may previously not have been connected. Resonating with Anderson’s (2006) notion of imagined communities, these new social formations are as real as any other. What binds them – and what is constructed – is a common narrative.

In addition, the rise of digital technologies, including the internet and social media, have amplified this trend to such a degree that it now feels commonplace for active and meaningful virtual communities to emerge – including communities that are based around a particular health issue or concern. As has been explored throughout this thesis (but particularly in this chapter this is very much the case for menopause. Not only are women finding one another virtually; they are also seeking guidance, support and medical insight in these digital spaces. The use of social networks as ‘locales’ to seek knowledge, information and advice (especially that which runs in parallel or even in contrast to the formal biomedical care women receive) has been observed to serve a multitude of functions within this research. In particular, these ‘communities’ have proved to be a central means by which women make sense of their experience and situation. Through their interactions with others in varying forms of media – be that by following an influencer or watching a doctor on morning television – another form of menopause is made.

It is here that Rabinow’s argument of ‘biosociality’ (2022) is useful to consider. Social researchers have regularly referred to biosociality, yet it is often augmented and conflated with a growing number of other related ideas (such as biological citizenship, therapeutic citizenship, citizen science, etc.) (Hacking 2006) It is therefore worth emphasising that biosociality is *distinct* from the growing interest in biosocial studies, as it refers to how social life is made and enacted according to the claim of biological status as opposed to framing human adaptation in terms of both social and biological determinants. Despite the fact that the concept of biosociality has now been applied to a range of groups with diverse medical conditions, at-risk biomarkers, or involved in health-orientated activities, there is limited research that actually explores the nature of such social collectives. There is little interest in how life is lived through these new associations, or in the relationship between virtual vs face-to-face encounters, and on the limits of and obstructions to this kind of social identity. In other words, there has been limited exploration as to how this kind of collectivity plays out in situ. Consequently, how it connects to or competes with the other forms of social life to which its members contribute is not often considered. In the case of menopause, the meaningful relationships constructed between women in online spaces requires further consideration.

Fundamentally, it is essential to recognise that while social media (as has been acknowledged) may operate in a variety of problematic ways, diluting medical advice and circulating misinformation, it also provides opportunities to make visible the experiences of otherwise marginalised menopausal communities. Returning to the analysis presented in Chapter 3, which considered the ways in which Mansfield Health proved exclusionary to particular persons through its spatial configuration, online spaces have the potential to operate entirely differently. For those women previously kept on the margins of menopausal discourse, social media proves affirming. It offers the opportunity to engage with others who are navigating similar experiences, providing comfort, solace, and support. We may consider the example of the support group for women of colour presented in Chapter 3, and the brief consideration that this space helped affirm attendee's lived menopausal experiences. Online spaces, and in particular social media, provide a means through which this mechanism of support may be amplified. Core to this is that the accessibility of domains such as Instagram provide ways to showcase the plurality of menopause and menopausal communities; women do not all have to have the same experiences in order for them to be valid, or heard. They allow for representation that moves beyond the dominant normative representations in much mainstream menopause discourse, and instead, represent menopause in the multiple.

Whilst exploration in this chapter has thus far attempted to provide a somewhat celebratory interpretation of emerging forms of social life in the media, it has also raised caveats that require further thought. For example, the presence of influencers and menopause 'coaches' in media spaces is concerning. Such figures as examined, may not only offer non-medically mediated, harmful advice to individuals, they also equally have their voices and messages amplified through the 'bubble effect' of social media, which can contribute to the formation of a strong counter-position and foster unhelpful resistance to mainstream medical support. Biosociality is constituted on the basis of specific biological knowledge. However, over time, patterns and norms of social interaction stabilise what is known; they stabilise biomedical knowledge. This means that particular values and discourses develop shared systems, and in turn, discrepancies or unwanted variations are addressed and dealt with by the group. What is interesting and important to consider in the context of *this* research is the ways in which the group formation is changing dramatically – no longer is menopause and its treatment determined within a purely medical framework; rather, a complex system of interrelating actors now take the stage. From celebrities and influencers, to pharmaceutical companies and patients themselves, the power dynamics are shifting in favour of the non-medical. Clinical aspects of menopause are presented in the media, but they are done so only in a carefully curated fashion.

The most obvious 'anthropological' contribution to make in response to the changing landscape of menopause is to contend that the ways that we are seeing knowledge about menopause and its associated medical treatment demonstrates the forging of new forms of social life; connecting people together in ways that they may never have felt linked before. For the most part, this may be read as positive. It fosters opportunities for community, peer support and activism that gives voice to those that need it most[27], and it puts pressure on those that fund an under-resourced system to meet specific demands. However, and as has been observed, sometimes this appears less clearly. There can be a trend towards the medicalization of all aspects of life, a shift to make the individual, the woman – rather than the state – responsible for her own essential care. There can be an increase in rumours and misinformation (particularly in mainstream media) that outline objectives deriving from a conception of menopause as a state we need to fix. This – as has been explored – increases a patriarchal discourse and culture in which 'risk' dominates decision-making around menopause. Moreover, it is a particular kind of risk – a risk of disappointing others by making the 'wrong' decision around the treatment of menopause. Most pertinently, there is of course

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[27] As can be seen in the lobbying for parliament to change legislation meaning women are able to access HRT at a yearly set fee.

the possibility that these new forms of relating can equally increase the exclusion of those who (for different reasons) do not have equal access to these forms, and so are denied the opportunity to take part in these new social movements.

It's important to highlight that whilst the impact of COVID 19 has been explored in relation to the trajectory of this research, one area of omission is the need for a fuller analysis that considers the ways in which the pandemic may have facilitated increased interest in perimenopause and menopause. Whether as a consequence of people having more time to engage with media, or simply as a heightened awareness of the body and its processes, we must consider the tangible shift that has occurred in relation to the development of policy that acknowledges menopause as an important area of priority in women's health. Since the pandemic, the UK has seen the forming of a national UK Menopause Task Force (GOV 2022), the establishment of a Menopause Pathway Improvement Programme within NHS England (GOV 2022), the development of policy that addresses the need for menopause support in the workplace (GOV 2022) and a strong focus on menopause within the 2022 Women's Health Strategy (GOV 2022)[28].

We have also seen the development of 'tracking' applications that position themselves as aids to help women monitor their symptoms, and in doing so, provide women with a greater level of autonomy to seek support for their menopause. Whilst of course we can position the development of such applications as an extension of hierarchical control or 'biopower' (Foucault 1976), we can equally acknowledge them as a further means by which menopause may become an emancipatory and empowered space. Such apps may herald a shift away from a top-down hierarchical clinical model, with the patient presented with more autonomy and the 'power' to be able to steer the trajectory of their care (for better or worse) as a consequence of 'doing the work' of monitoring their symptoms. In a culture of self-monitoring and an increased engagement with technology, it is ultimately interesting to query: would menopause have been made in the same way *without* the pandemic?

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[28] Menopause is referenced 134 times within the strategy overview (GOV 2022).

“If it’s Good Enough for Lorraine”.

Concepts of new imagined communities, collectivity (ibid) and the clinical aspects of menopause as presented in the media are well illustrated in one particular account shared with me during the first national UK lockdown. In the following vignette, I present Maya’s story, which highlights how she finds connection and comfort in hearing about the experiences of celebrities she has seen on television and on Instagram. Her narrative emphasises how the viewing of these figures has helped her to forge a new sense of her menopausal journey and her social identity too.

Maya first contacted me via the project website. Interested in the research that was being undertaken, she was keen to divulge her experience of navigating symptoms and, equally, to talk about the prompt that made the most difference to her when it came to seeking menopausal care – witnessing the Meg Matthews segment on Lorraine. Maya makes time for a phone call in the spring of 2020 and the beginnings of our discussion fell immediately to health in a manner that seemed strangely permissive – unique to a time of vigilant self-monitoring. Maya explained how she and her daughter were both self-isolating due to autoimmune conditions, so had the time to talk. Unlike the majority of subjects whose accounts were drawn upon in this thesis, Maya was not a patient of Mansfield Health. Rather, as Maya described, she was someone who had “hooked into Claire and the gang that hang around on social” after exploring the support networks for menopause on Instagram. All of Maya’s prior and ongoing care and treatment had been and was being provided by the NHS.

The first thing Maya wanted to establish was that her menopause was “probably not like most people’s – hot flushes and mood swings – the things I saw my mum go through”. Maya explains that she had experienced no real problems with periods until she entered her 30s. At this time however, Maya started to experience heavy and uncomfortable bleeding, which was eventually identified as fibroids. At 37, Maya was referred for and ultimately ended up undergoing a total hysterectomy. As Maya explained it, “they left my ovaries in but didn’t tell me I could experience menopausal symptoms quickly. I was given a booklet and told don’t have sex with your husband for 6 weeks… I worked for a sexual assault referral system at the time… the way the nurse approached it [pause], it was just so, abrupt, she needed to be a bit more open you know?” Maya returned to the clinic for a check-up and to see how her scarring was healing; her interactions with the team did not extend beyond this final ‘check’. There was no endocrine or menopausal consult – Maya was discharged from the services care.

The first symptom Maya started experiencing was dryness around the vulva. At the time, Maya said she had been undertaking a lot of exercise in the form of spinning (cycling on a stationary bicycle), so she thought that the irritation might be a result of that. Maya also explained that she had been diagnosed with kidney cancer a short while before - “they found [it] through a routine scan and removed my kidney and it was all OK… no radiation, no medication, a very short experience – but I thought, well maybe the dryness and soreness is connected to my kidneys? I had no idea this was being caused by my hysterectomy”. Maya explained how she would use Vaseline when spinning so she could continue participating and that that “was the only way to get through it.” Shortly after, Maya describes how she started to notice she was becoming irritated by small things, alongside migraine headaches that started to become gradually more debilitating. “In the end, [the headaches] were so bad they disrupted my work… [I would] projectile vomit”. This was happening multiple times a month, accompanied with more symptoms – “a dry mouth, brain fog, and lots of others within 5 months”. Again, Maya thought she could “simply put them (the symptoms) down to cancer.”

The turning point for Maya came in the form of morning television. “It was the interview with Meg Matthews – I saw her on Lorraine, and she didn’t have hot flushes either, just terrible migraines. Then I started to do a lot of research and realised OH MY GOD! I’m menopausal. I always thought it was hot flushes, not anything else! “After seeing the interview Maya wanted to make an appointment with her GP. “I thought, if it’s good enough for Lorraine, it’s good enough for me!”. Explaining how she had been struggling with vaginal dryness for some time, Maya’s GP recommended oestradiol cream for her vulval discomfort. “I didn’t realise you could stay on it though, so I came off after 6 months!” In relation to the migraines, Maya’s GP recommended HRT. “They said they couldn’t believe I hadn’t been referred to a menopause clinic; they just couldn’t believe it hadn’t been sorted after the hysterectomy – I was a convert at this point. I started Evorel 50 patches - even within a month the migraines were gone.” Later in the year, Maya decided to start using testosterone. She described how, although her migraines were now well managed, the brain fog and low libido were still bothersome. “I thought it would be nice to start on Testogel – one pump once a week: 1.25 grams – it was OK but not much va-va-voom. I did a blood test, and my testosterone levels were low, so I moved to twice a week. It was good at first but now… still not a lot of interest there…”.

Maya explained to me how, understandably, her cancer diagnosis had taken central focus in her life after her hysterectomy, and that as a result, it was difficult to take note of anything else going on in the body, including menopause. Maya highlighted that it wasn’t until watching the Lorraine episode she even thought about it – “I recorded and rewound the interview and showed it to my husband – I couldn’t believe it. Now I talk to so many women about it. I hope it will lead to a conversation with women; there’s a total lack of support. It is changing but not quickly enough… I do Instagram. I found the information and [ability to] interact with other people – well I found that a positive place… [but it] depends on who you follow [as to whether or not it is a] good space for you.”

Maya’s engagement with treatment is curious. Though actively aware that changes are occurring in the body and that discomfort is peaking, the decision to seek advice and support occurs only after catching a segment on morning television. While Maya contends that the rationale for this is due to the belief that symptoms are the result of an earlier cancer diagnosis, this in itself is disconcerting. Maya describes having to apply Vaseline to her vulva in order to exercise, or in her own words, ‘get through it’. The noted level of discomfort appears seemingly permissible, dismissed as a possible result of ongoing issues with kidneys and thus acceptable to endure. In Maya’s depiction of the post-operative support provided to her after the hysterectomy, care appears to be lacking. She describes the nurse responsible for providing her with information as “abrupt”, adding that she felt she “needed to be more open”. Further, as the post-operative check-up showed no cause for concern and no further information was provided when her scarring was inspected, one can appreciate why Maya did not seek further advice when beginning to notice changes in her health. Nonetheless and while we may recognise how a diagnosis of kidney cancer could obscure the onset of menopausal symptoms, it does not account for why Maya did not seek support for symptoms when they persisted. She notes experiencing projectile vomiting as a result of intense migraines, irritability, pain and dryness of the labia, vagina, and mouth as well as difficulty in focusing and thinking – symptoms that would warrant investigation even if they were associated with the kidneys.

The depiction given by the exclamation “OH MY GOD” by Maya seems to infer a ‘penny drop’ moment: a realisation that this was what was happening to her. Maya even mentions recording the interview and watching it again with their husband, seeking validation of the epiphany. Whilst it is plausible to contend that the reason this interview ‘stuck’ with Maya is due to the depiction of symptoms relating to her own lived experience, an alternative reading is also plausible. Maya’s account speaks of trust. In her own words, “if it's good enough for Lorraine, it's good enough for me”. The fact that this particular information reached Maya via the platform it did, that it was advocated for by someone she felt she knew and trusted, seemingly made all the difference in affirming her subsequent decision to pursue care.

The role of a television presenter thus bears relevance. Although easy to dismiss as superficial or unimportant to Maya’s narrative, the contrary is contended: that Lorraine’s advocacy was the determining factor in encouraging Maya to seek support. Maya is ideologically affirmed in their experience by someone trusted – someone that feels known. The position of the presenter (whether artificial or not) offers something important. In times of flux, the presenter is consistent. Their daily presence is fixed and reassuring. Regardless of an individual’s preoccupations, stress or worries, the schedule of the presenter remains regular. While their ‘influence’ may vary from person to person, the assurance provided in circumstances such as Maya’s is key. It opens up important conversations surrounding the roles of advocates and the importance of exploring this in relation to healthcare. In Maya’s perception, it is Lorraine’s recommendations that she views as valuable and what ultimately provided her with the confidence to seek support.

However, while the endorsement by *Lorraine* is important, I would argue that Maya’s action is born less out of a liking for Lorraine, and more out of a combination of celebrity trust *and* medical validity. Maya clearly had an unpleasant experience with medical professionals, but was willing to revisit this when the clinical was in a format she felt comfortable – one that was combined with a celebrity status that invoked a sense of trust. Her original negative experience took place in a traditional clinical space. But her penny-drop moment happened in her living room while watching TV. It's perhaps worth noting, as a corollary to this, that Birchwood House, as described in Chapter 3, itself adopts this fusion of clinical and domestic. In its spatial configuration it presents itself as somewhat like your living room. Thus, just as Mansfield Health expanded its reach into living rooms, so too was the living room transposed in the Mansfield Health clinic.

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In a context where (as this chapter has outlined) celebrity reigns supreme, we must consider the sources that will resonate with persons experiencing menopausal symptoms the most, and the impact and trajectory this will have upon their health. Will it be the GP they have had to book a month in advance, and with whom they will be given only a 7-minute slot? Or will it be the person they can check in with daily on Instagram, or the celebrity they share a cup of tea with from the comfort of their own home that they listen to?

A final discussion is now offered that considers the impact of the clinical aspects of menopause being presented in the media. During observations, and more generally while conducting this research, the ease with which one may confuse the similar-sounding bioidentical and body-identical HRT became apparent. Claire had, on a number of occasions, engaged in lengthy conversations with me regarding this. There was no denying that, for Claire, the practice of prescribing bioidentical hormones was problematic.

To provide context from the previous chapter, body-identical hormones, such as Oestrogel and Utrogestan, are labelled as such because they mimic the molecular structure of hormones being replaced in the body and are prescribed and regulated by a physician. Bioidentical hormones contrastingly, are compounded. This essentially means the ingredients are combined or altered without explanation as to the process of how and where components were sourced. A number of private clinics prescribe bioidentical HRT and have managed to relay what is 'dodgy medicine' by means of a very seductive sales pitch. The compounded nature of the bioidentical 'package' means that the bioidentical therapy is presented as unique and bespoke to the individual. Clinics will perform a blood or saliva test and then create a personal 'prescription' of hormones that will be matched to a patient's needs. They often include additional vitamin supplements too. The issue with this is that hormones, as we have spent much time considering, are not stable nor measurable across time. They ebb and flow. From a medical perspective, it is appreciated that while you can measure hormone levels in order to provide a general 'bracketing' for a patient (e.g. determining whether levels of a particular hormone are low, average, or high), accurate readings are a fallacy, as they change (even over the course of a day), rendering the creation and marketing of a bespoke hormonal product unfeasible.

Of course, we must appreciate the appeal of this type of treatment and the way that it is marketed. Claire discussed how many women tended to view bioidentical as more 'natural' or a safer alternative to traditional HRT – a conception that is often capitalised upon by endorsers and providers of bioidentical hormones. From a patient perspective, a cocktail of hormones designed specifically for the individual is a very attractive. It may be perceived as flattering or communicate care – in the same manner that care at the clinic has been related to a form of treatment, the same is likely true for prescribers of bioidentical hormones. People experiencing symptoms are supplied with a course of treatment created just for *them*.

While the nature of compounding may be seductive, these hormones are unregulated. In essence, this means there is no guarantee that the hormones you are using are the same as those you have been told you are using; they may contain other ingredients, from unregulated sources. For Claire, the marketing of bioidentical hormones was of great concern – not only due to the ethics, but also the safety of patients. She explained that the treatment of menopause is fundamentally based upon the replacement of hormones that are diminishing. For menopause, this includes oestrogen, progesterone, and in some cases, testosterone – not a myriad of others packaged into a bespoke treatment regime. But in instances where these were prescribed, the method of delivery was, in her estimation, often equally problematic.

For example, in the case of progesterone, the hormone that protects the lining of the womb, there were reports from patients of its prescription in transdermal form. The absorption of progesterone via the skin is known to be unreliable as it is difficult to regulate the dose, and often the womb can, as a consequence, be left unprotected. Consequently, Claire reported a number of women visiting the clinic complaining of extremely heavy bleeding following their engagement with bioidentical treatment. Claire highlighted that this was likely a consequence of the womb being left inadequately protected while other hormones were prescribed and commented that these patients may have been left susceptible to the development of health risks had they not sought advice or care.

Why comment upon this in relation to menopause media? Well, if we consider the vignette depicting Maya's experience and the trust and credibility she placed in Lorraine (and figures she endorsed through their appearance on her show), we can make sense of instances in which recommendation by association can be a cause for concern. The accessibility of information for patients in contemporary society can be problematic (for both patient and physician). Though the ability to scan through enormous quantities of data may render a patient further informed, and in certain instances leave them better placed to make informed judgments about their health, it also may render many susceptible to influence and manipulation. While, for Maya, watching the segment with Meg Matthews on Lorraine resulted in her engagement with a GP, it is easy to see how on unregulated platforms, information may circulate freely and without critique. What's more, for private consulting practices, there remains little accountability from regulating bodies – clinics will be subject to inspection from the Care Quality Commission (CQC), but the time between inspection varies, meaning that stringent monitoring is unlikely.

Finally, and worth noting, is the fact that, when it comes to using HRT (particularly the use of testosterone), not all clinicians are united in their opinions. Indeed, at clinical conferences, jokes were made about the different arenas of medicine and their approaches to treatment. Endocrinologists were regularly referred to as the bookworms too hesitant with their hormones, whereas gynaecologists were ruthlessly mocked as "too dumb to do menopause". Put simply, forms of knowledge are not devoid or easy to separate from the individual. As a result, competing knowledges exist and inform the milieu of menopause.

To use the example of Maya's continuation of testosterone, she highlights that it was good in the beginning, but that this effect faded; yet she is still continuing to take it. Thus, we can see how it may well represent more to Maya than just a hormone. It is the recommendation of the person or persons trusted. Patients thus can be seen to seek out their own care based on their reading of the information they find from the sources they trust. As has been explored in this chapter, in the case of the Davina Effect, the Meg Matthews appearance, and the endorsement of Lorraine, we can observe how the position of celebrity in the menopausal discourse is key. However, and as explored by Jermyn (2023), it is a particular *kind* of celebrity. Persons are looking to the familiar trusted figures they associate with on television and social media to help guide their decision-making around menopausal care. The key factor to highlight is that these celebrities have created a platform with no medical expertise of their own.

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In this chapter, we have been able to draw attention to the clinical aspects of menopause as they are presented in the media and as such the ways in which menopause and the making of it, proves exceptionally complex to 'contain'. Just as hormones are difficult to make static, so too are the spaces and places in which conversations about menopause and the menopausal body increasingly occur. Whilst on the one hand, we may consider popularised platforms such as Instagram to offer a mechanism by which women are able to support one another and build communities, we can equally appreciate the diluting quality such information sharing can cause. In the context of menopause in the mainstream, questions pertaining to whether increased activity on spotlighted platforms are helpful remains a contentious concern in the making of menopause.

While arguments covered in previous chapters about 'making menopause' have focused mainly on the individual, their symptoms, and their treatment. This chapter, in contrast, has described how the media has served to link common experiences, connections and ties across individuals – so that these women have something in common and have not simply suffered as individuals.

Fundamentally it has examined how, in an age of technological advancement, people increasingly turn to 'nonclinical' media environments that often feel safer and more familiar. People like Claire who enter these spaces are appealing to women because it meets them where they feel most comfortable. In tandem, it is important to underscore the consequences of this – that nontrusted nonclinical persons might share misinformation alongside. Tangible opportunities for exploitation are created, while a ‘pick and mix’ approach to information emerges as individuals select what they wish to receive, and what to ignore. Treatment as a result becomes further fragmented with traditional care seeking practices and clinical expertise diminished. The traditional hierarchies in which organisations such as the BMS hold positions of ‘power’ over public opinion are, as a result of these shifts in information sharing, becoming less relevant, posing important questions for the future of menopausal medicine and women’s health more broadly.

CHAPTER 7

Menopausal Anarchy

As we arrive at the final chapter of our discussion, we must engage in a brief consideration of the key thematic ideas that have been explored in this thesis. Overarchingly, discussion has been concerned with what I have termed the ‘making of menopause’. I have described this not as linear nor singular process, but rather a convergence of differing factors (social, economic, cultural, medical etc.) that all convalesce to inform the way menopause is conceived, acted upon, and inevitably ‘made’ in contemporary culture.

Throughout, menopause has been positioned as fluid. Different forces and influences have been examined as involved in the continuation of menopause being shaped in new and emerging ways. Thus, despite the compulsion from different voices to try and define what menopause is, or what it might refer to biologically, in practice, menopause has been observed as never truly achieving stability due to the fact that it always involves a combination of differing claims, forms of knowledge, and competing interests.

Against this backdrop, the focus of this thesis has been to examine the specific role of medicine and clinical knowledge in the contemporary making of menopause. At the heart of this examination has been a focus on the role of hormones, and the multiple ways in which they affect the body. While offering a powerful way to conceive of menopause in physiological terms, the complex nature of hormones has been presented as meaning they can never provide a singular nor bounded account of the diverse and often far-reaching experiences of menopause women report.

Throughout this thesis, I have attempted to showcase how in many ways, contemporary narratives about menopause are not nearly as new as some may assume; rather that the ideas about menopause and women’s bodies which prevail, have tended to encompass cultural concepts about gender and aging that prove remarkably enduring. The current positioning of menopause, which often includes an enthusiasm regarding the use of HRT, has thus been examined as a modern framing of long-standing ideas, expectations and norms relating to aging, and women’s role in society.

Exploration has also engaged with the new spaces where clinical information and knowledge about women's bodily processes may be presented and disseminated. At the heart of this, has been a widespread questioning of what constitutes medical expertise and an engaging of women's firsthand experiences as a form of knowledge as important to consider as clinical expertise. This has queried how the medical profession may no longer have full control over the ways in which menopause is talked about, understood, or legitimated in wider society. The process of opening up this debate has been identified as liberating in allowing some women to escape negative, patriarchal practices embedded in traditional menopause care. Equally it has underscored the ways in which new domains for information dissemination (though in need of moderation) offer potential opportunities to increase the visibility and support offered to often marginalised menopausal communities.

Ultimately, this PhD has raised questions surrounding how the body and forms of knowledge pertaining to menopause are rarely defined in value free terms. It has emphasised the ever emerging and creative ways in which the menopausal body is constructed and reconstructed through a variety of differing and relational mechanisms.

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To return to the preface from which this thesis began, a reader is asked to consider that first posed central question: did I bet on the right horse?

Something to consider is how getting 'close to any sort of 'action' can ultimately, make it harder to see. In the case of a horse race, when those numbered stalls open and you're stood at the sidelines, your view is almost completely concealed. Dirt flies and hooves pound, leaving only blurred shapes and strips of colour to truly be made out. You find yourself wondering as horses fall away after the finish line – did I miss it? Is it over?

My father always said you can only really *appreciate* a race after it has been run, however if you have to settle for second best: watch it at a distance. Only then are you able to take in the magnitude of what unfolds. Almost six years exactly after this PhD began, I find myself left, sitting at the back of the stands revelling in what *feels* like it just took place. I wonder; did I really see the race being ran as I should have? Or did I miss a vital part of the action? Did I get too close to really *see* what was happening?

Like the bookmaker, the anthropologist has to stand close to the track. We have to get our feet dirty and hold the odds in our head in order to get the job done. With bated breath, we consider when the inevitable might ensue or the unbelievable may be uncovered. However, just like in the context of a race, it's only after the main event has passed that we are truly able to take a step back, climb up in the stalls and consider how it all unfolded. Something I find myself pondering as I pour over the final points left to make in this discussion is whether remaining an impartial observer is, for the anthropologist, a bit like being a bookie with a bet – we can tell you we're not invested but deep down there is always the sneaking suspicion that we are gambling gals at heart. In the context of this research, I feel affirmed to say to you, the reader, that yes, I did indeed bet on the right horse. The return on those odds though? That's another matter entirely.

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Briefly I will now recap the chapters which have come prior to this discussion. We may remind ourselves that Chapter 1 engaged with the ways in which menopause has historically been presented and subsequently 'treated' in the Global North. We paid attention to the patriarchal practices embedded in constructs of menopause as a state, considering the ways in which 'interventions' may be understood as reflective of a wider cultural context in which women's bodies are positioned as a site of construction – something that requires 'fixing'. This sits in opposition and in contrast with men's bodies, which simply require 'improvement'. This point was stressed via considerations of stories surrounding the synthesis of testosterone. Analysis detailed how testosterone is inherently embedded with concepts of masculinity, and as such, highlights testosterone as having a high sociocultural value. The history of menopause and the development of HRT was explored, and considerations were afforded to how the use of testosterone in a contemporary context by women experiencing menopausal symptoms is, as this research has explored, somewhat of an anarchistic act when it comes to repositioning the usefulness of hormones. The use of testosterone by women is emphasised as a disruptive practice, not only to traditional gendered assumptions surrounding what different bodies ‘do’, but equally with regards to which parts of the body or (to be more specific) which hormones belong to which gender. Attention was then turned to the anthropological underpinnings that have informed the approach this research has adopted. Chapter 2 explored the processes by which this research came to be undertaken. It paid attention to the conditions in which stories and accounts were collected and highlighted the impact COVID 19 had upon the trajectory of the research. Chapters 3 and 4 provided accounts from within the clinic. The function of space and place in the making of menopause were detailed in Chapter 3, with specific attention paid to how space can function as an extension of care in and of itself. This culminated in a consideration as to how in the same breath, space can serve to ‘exclude’ certain persons from the environments in which menopausal treatment occurs. Chapter 4 followed and explored the rituals of care that underscored the practice of clinicians at Mansfield Health. Concepts of ‘return’ and ‘transformation’ were positioned as important within patient narratives, and this was explored in tandem with a consideration of the patriarchal expectations embedded in women’s rationales for seeking support. Women’s mitigation of pain highlighted how justifications for seeking support were thematically connected with concepts of ‘duty’. Chapters 5 and 6 took us outside of the parameters of the clinic, with Chapter 5 providing insights from the EMAS conference in Berlin. Chapter 5 explicitly explored the materiality of menopause and paid attention to the oppressive patriarchal mechanisms by which women’s bodies continue to be positioned as a site of labour in need of intervention. Chapter 6 brought the observations to a close via an exploration of how menopause has become a pertinent point of public interest during the time period over which this research was conducted. This chapter expanded upon the role of the media and celebrity, as well as querying how the parameters of treatment and enhancement in menopausal care are becoming less clearly defined. Chapter 6 highlighted how decision-making during menopause can increasingly be seen to occur in non-clinical spaces and paid particular attention to outlining the role of social and traditional media in influencing medical decision making as well as the ways in which clinical aspects of menopause are presented in the media.

Translational Tactics

One of the biggest concerns in writing this thesis was that it would land as a denouncement of menopause as a physiologically *real* experience. For this reason, it is important to stress that this research has not sought to convey a narrative in which menopause appears as a fictitious phenomenon. On the contrary, it recognises the symptoms of menopause as highly tangible, holding the narratives that were collected from women that participated with gentle compassion and in the highest regard. This research does not make the claim that menopause is materially 'made up' per se, rather, it considers the multiple and complex mechanisms through which menopause becomes imbued with specific and ever-evolving meaning. Thus, it is not argued that menopause is imperceptible without context, but rather that it is the context that renders menopause specific. Drawing upon Berlant (2011) it is contended that menopause is not only brought into being by the physiological – the medical literature, the appointment between clinician and patient, or the accompanying HRT treatment – it is also, as this research has examined, formed by the non-linguistic, the non-measurable. Menopause may be considered as shaped by mood, by feelings and by atmosphere by wants desires and more. Thus, the existence of menopause is not what has been queried. Rather, what has been explored is, the ways in which menopause is experienced, and the nature of those experiences.

This research has as outlined been informed by the work of Annemarie Mol in its consideration of the ways in which a 'translation' of menopause must occur, making menopause mean something unique and specific in differing contexts. For example, while a patient-information leaflet may describe menopause as the cessation of the menstrual cycle for a period of 12 calendar months, in the context of the clinic, as we have demonstrated via the analysis of ethnographic observations, the way in which menopause is construed and constructed involves much more than this. Variations in time, place, equipment, HRT treatment, and in the nature of private and public healthcare all contribute to the emergence of a slightly different "menopause" – one that may be explored, observed, and understood as new in each varying context. The multiplicity of influential factors presented are not a means of suggesting that menopause is consequently fragmented, but rather an attempt to showcase how menopause is made to cohere through a range of tactics including the collection of symptoms via the GCS score, the taking of blood tests, the discussion of symptoms, the weighing of bodies, the analysis of lifestyle, and, of course, the administration of hormones.

The analysis of the ethnographic observations has considered how actions associated with menopause (from treatments to rituals of care) exist within, and are complicated by, conditions of the patriarchy. In particular, it considers how menopause has been understood as a condition in need of intervention. Historically, this intervention has involved a noted ‘lack’ of shared decision-making between clinician and patient[29]. Be that in favour of, or against the use of hormones to alleviate menopausal symptoms, the positionality of the patient is often an afterthought, with the context of the hierarchical medical system taking precedence. Drawing upon poststructuralism, the analysis throughout has intended to reframe the disease-illness distinction and explore relationships between subject and object (such as the patient and the hormone), boundaries (such as how hormones are used in specific ways), difference (how testosterone in the context of the clinic was positioned in feminine gendered terms), situatedness (how menopause is conceived of differently according to space and place), and ontology (the relational dynamics between all of these things) as existing in dialogue with one another. These strands of analysis have asked the reader to consider the multiplicity of menopause in-practice and in situ, but more importantly, to consider the woman navigating this period of time in her life as unique, specific, and complex.

The processes through which the concept of menopause was seen to be shaped - in clinical interactions, in social and conventional media, and in professional and commercial contexts – are suggested as manifestations of Mol’s concept of ‘translation’, as this term distils much of what was observed both inside and outside of the clinic. Menopause is ‘made sense of’ under a medical framework, yet an individual’s experience requires ‘translation’. In the context of the clinic, we may consider the ways in which Kate can be seen to tease out Carol’s experience – she employs encouraging tactics and helps to put Carol at ease when discussing something intensely personal. The clinician (or other associated professional) ultimately therefore is found to elicit the wants from

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[29] Although nonconsensual removal of the ovaries does now seem to have fallen out of practice it does shockingly still occur. See the case of Tony Dixon in 2018.

the menopausal person before a mutual construction of goals can occur together. The GCS, the DEXA scanner, the dummy hormone products, among others, become mechanisms through which translation is facilitated. Within this process there is one underlying predicated assumption: that the menopausal person wishes to be restored and/or, renewed. There is always the promise of change; there is always the promise of transformation.

Querying Gender

Throughout this thesis, the parameters of gender have been examined in tandem with concepts of identity. Analysis has drawn upon theory that not only queries the materiality of gender but equally explores the complex mechanisms by which it may be mapped onto the biological body. The research has examined how gendered perceptions take seat in medical discourse and biological imaginings. Akin to Judith Butler's iterations of the concept of gender in *Gender Trouble*, it has attempted to treat gender as an unstable entity that, like "so many [other] styles of the flesh… [is] an identity tentatively constructed in time, instituted in an exterior space through a stylized repetition of acts." We have demonstrated that the experience of menopause is indeed gendered. From the vulvovaginal laser equipment displayed at EMAS, to Carol's desire to maintain a sex life that causes her to be in pain, gendered expectation litter conversations regarding women's experiences of menopause. Equally and important to consider are the ways in which concepts of women's 'duty' operates in conversations about menopause. There is an expectation upon women to provide 'care' in multiple ways. Menopause arguably can become a space for women to rectify injustice, however this is as a part of the process of treating menopause, rather than as part of a conversation where the relative responsibilities and efforts of men and women in maintaining relationships may be addressed. In keeping with Butler's analysis, it is important to recognise that the very identity of menopause is specific, and as such, unstable. Menopause is not just, as the title of this thesis would suggest, made. Rather, it is remade – in line with the changing discourses that are prevalent at any one time.

In the current cultural climate, anxieties surrounding the erasure of gendered identity are palpable. What is known and what is stable are increasingly called into question, and a growing tension surrounding concepts of identity emerges.

The gendered body, once ‘protected’ under a rhetoric of scientific discourse, is no longer afforded space in the same way. Moreover, whilst ‘distinction’ or ideas surrounding a knowable binary may continue to be affirmed within our medical rhetoric, in other spaces, the concept of the sexed body existing in absolute terms is a contentious matter of debate.

It is well documented that during periods of cultural ‘transition’, a reaction *against* ‘difference’ can often be observed. This is usually accompanied with a pronounced effort to shore up existing ways of thinking about a particular idea. In the context of hormones, a useful example to illustrate this is the debate that surrounded the runner Caster Semenya, and her levels of testosterone. Semenya was famously barred from competing because she refused to artificially suppress her testosterone levels. As a woman, Semenya’s levels of testosterone were discussed in the media as equivalent to those of a man, with concern centralising around whether she should be barred from running with other women as a result of her levels[30]. The discursive action – where testosterone becomes imbued with a unique masculine personality – served a purpose. It retained testosterone as ‘a male hormone’ and highlighted the impact of the hormone as it pertains to men’s bodies. This retention allows comforting traditions in which medicine neatly aligns with existing gendered models that infer a stable knowable world to be maintained. Despite narratives within behavioural sciences that align high levels of testosterone with competitiveness (and therefore a propensity to ‘win’) there is limited evidence to suggest that testosterone levels provide any advantage to athletes. The levels of testosterone in winning athletes *have* been measured, and indeed, no correlation between these levels and ‘winning’ has been able to be identified (Bristol 2021, Neuroscience 2021). Of course, we may argue that higher levels of testosterone in women could mean they are able to build muscle more easily, thus providing them with the advantage of being able to train more effectively, however should we extend this line of analysis here, we would need to do so for multiple forms of privilege. If an athlete grows up with access to better training equipment for example, would *this* mean they were more likely to win?

Whilst the above reference opens up a controversial debate in contemporary society (namely, the participation of trans athletes in sporting events), it is called

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[30] For more information, see Brenner (2021).

upon in the context of this discussion as it aptly highlights the ways in which debates around the body, biology, sex and gender are imbued with tense, culturally relative and specific discourse. Moreover, it explicates how there are often specific ‘rules’ pertaining to the parameters of inclusion and exclusion of certain bodies in sectors of society. This thesis has not sought to dismiss the importance of wanting to maintain a knowable social order that aligns sex and gender. On the contrary, it appreciates the need for stability and biological certainty. What it has attempted to illustrate, however, are the ways in which knowledge is imbued with cultural – *and historic* – narratives that coalesce in such a way as to make the body, and indeed menopause, what it is.

Making Menopause

Presenting an analysis that adequately captures how menopause is imbued with sociocultural context is a complex task. After all, how can something biomedically tangible equally be described as ‘constructed’? The phrase ‘socially constructed’ has, throughout the process of writing this thesis, been considered as somewhat problematic. Fundamentally, this concern rests on the binary implicit in the idea that if menopause is real, it cannot be socially constructed. However, as anthropologists (and particularly those that adopt a post-structuralist approach) will argue, just because something is constructed, it doesn’t mean that it is not real. This may appear simple, but it’s important to pay attention to – particularly in the context of the medical – as our understandings of the body and its functions are punctuated by deep-seated assumptions pertaining to what is known. The heart pumps blood, the kidneys filter impurities, the eardrums register sound, and so on. It is, however, what we make those functions *mean* that involves the process of construction. In a non-related medical example, we may consider the action of writing this discussion. As these words spill onto the page, they are marked with meaning. They thread together a series of disparate thoughts and in doing so, make a thesis. Thus, the words are real, their intention and the way they ‘land’, however – *that* is made.

The making of ‘meaning’, in the context of hormones and of menopause, involves multiple intersecting contexts. There is of course the biological: what that hormone does. However, there is also the political, the social and the world of the individual, all of which exist in conversation with the use of that hormone.

Each of these circumstances interacts with the other to form the unique experience in which the hormone is ‘embodied’ by the individual. Thus, there is no one version of a hormone. It is made to mean something entirely different in different contexts. The most interesting (and arguably provocative) means to illustrate this is to consider how the menopausal woman will use the same chemical derivative as an individual looking to change their gender or sexed identity. In each context, the hormones that are used are the same; the bodies absorb the same treatment modality, in the same way, and yet, the intended outcome is vastly different. It is ‘made’ to be different. This making occurs in both material and symbolic ways. As we have seen in the consideration of testosterone, it is feminised. It is placed in a pink tube, and titled AndroFeme. It is given in minimal quantities. Blood tests are carried out, and as such, masculinising effects are avoided. Patients are encouraged to rub the preparation onto the upper thigh, making hair growth easy to address. Inevitably, testosterone and its use among menopausal women is made to be feminine.

The materiality of the hormone remains the same however. The materiality of *all* hormones remain the same. A person using estradiol to transition – to achieve their true sense of self – is using the same chemical compound as a menopausal woman. The treatment exists tangibly. It is identical in each context, yet the *meaning* attributed to it renders it specific, depending on the circumstance. To stress, this meaning is not ‘made up’, it is real – it is made to be real via the careful dosage instructions, the practices of care and more. The outcome is, interestingly, likely the same. It is gender-affirming for both the menopausal woman and the theoretical transitioning patient. The hormone is the same, but via the ontological politics – the conditions it exists within, from the mundane to the complex – are entirely different. Hormones, therefore, are indeed used to enact change, but they remain specific to their context. And this context means everything.

Beyond the Binary

Whilst the comparison between the transgender experience and the menopausal experience may land with some contentiously, there are important conditions of circumstance to observe that are pertinent within the context of this discussion. Although often positioned in opposition, the transgender body, and the menopausal body feature in public discourse in similar ways. The transgender body is often crudely and reductively presented as something purely physical – the person is eroded and replaced by an overwhelming focus on the individual's genital configuration. In the same breath, the menopausal woman is routinely discussed in relation to her 'function' – her ovarian function, her dry vagina, her waning libido. Her personhood is ignored, and she becomes an entity in need of intervention (Steinke 2019). In both instances, these persons may be seen as placed on the margins of gender. Their bodies change, and in doing so, their identities shift. A number of trans authors and menopausal authors alike have noted the ways in which they see these transformations occurring in both physical and mental ways – how the configuration of self exists in a state of flux.

Julia Serrano (2007), for example, notes her experiences of transition in *Whipping Girl*, highlighting how close to the surface her emotions became as she began using oestrogen. This leads Serrano to highlight how, in reality, men and women (whatever we come to mean by this definition) are actually closer than we may think. She writes: "I have found that women and men are not separated by an insurmountable chasm, as many people believe. Actually, most of us are only a hormone prescription away from being perceived as the opposite sex."

Similarly, in *The Testosterone Files* (2006), Max Wolf Valerio discusses his transition from lesbian feminist to heterosexual man and describes his transition as "a unique intensive fire." He considers how in changing his gender identity he makes an "erotically charged boundary crossing". Wolf goes on to compare the experience to that of a person navigating the menopausal transition. He notes "a woman I know going through menopause reports that she too [can see with] clarity and sometimes feels like a wise owl, who can see for a very long distance."

This sort of analysis is also evident in the memoir of Darcey Steinke (2019). Reflecting upon her relationship with gender, Stienke explores how her experience of menopause brought with it a need to query the permeable state of gender. She describes how, with each hot 'flush', she felt her femininity coming apart, not just figuratively but physically. She describes how, through the repetitive action of 'flashing', her femininity not only felt eroded, but 'burnt' away. In an engaging metaphor, she outlines the symbolic pertinence of this, highlighting how it is through *heat* that physical matter may be transformed.

Outlining these similarities is done not as an 'observation' but as a discursive action – a means to *really* consider the labour we engage in to keep these bodies separate, to hold them in binary opposition despite their similarities (by engaging in the same treatment modalities, being objectified etc.). This 'separation' is not without means. It serves to stabilise an ever-threatened gendered context in which the binary is becoming 'boring'. As the exploration of the historic context of menopause demonstrates, hormones carry with them stories that 'make' gender. Thus, the consideration that "most of us are only a hormone prescription away from being perceived as the opposite sex" destabilises these stories. It disrupts the structuralist paradigm in which gender aligns with the sex we were assigned at birth. It requires 'labour' to reaffirm and shore up meaning. In the context of menopause, hormones reaffirm and restore. They are prescribed in particular ways and are given particular meanings, yet to move this consideration further, the use of hormones can also be politically charged. To call upon Preciado (2017) discussing their use of testosterone as a political and performative act:

> *"I'm not taking testosterone to change myself into a man, nor as a physical strategy of transsexualism; I take it to foil what society wanted to make of me, so that I can write, fuck, feel a form of pleasure that is post-pornographic, add a molecular prostheses to my low-tech transgendered identity composed of dildos, texts, and moving images"* (ibid).

Important to the analytical development of this thesis is the concept of 'body talk', - the ways in which women's bodies have been discussed in an objectified way in medical spaces throughout history. In Chapter 1 we considered how women's bodies have been rendered as 'parts' in depictions, with authors discussing 'diseased ovaries', the 'moth eaten pubis', 'sagging breasts' and so on. Within these accounts, a binary positioning of a normal versus an abnormal body feature – a woman was placed in comparison to an imagined 'functioning' body, and her failure to meet the expectation of said functioning body meant that discussions focused upon her 'brokenness'. In contemporary conditions, and to return to Steinke (ibid), we can observe that the problematising of women's bodies persists. Women are still rendered as a site of construction and narratives still consider the ways in which fluctuations in bodily state are unacceptable.

Despite this, we can equally observe the ways in which body function is increasingly being reclaimed and positioned as a site of inclusivity and empowerment. We now utilise phrases such as ‘vulva possessing persons’, ‘persons who menstruate’, ‘birthing people’ and so on, to linguistically account for the plurality of gendered experience. In this sense, it is interesting to explore how we may be returning to depictions of the body that relate more to ‘functionality’ than to identity, but that the process of doing so is rooted in a desire for inclusivity as opposed to stigmatisation. These linguistic shifts can prove contentious. On the one hand many argue that changes in the way we speak about the body facilitate a more inclusive consideration of *all people* and better represent the evolving landscape in which identity and body process are *not* intertwined. Equally and to counter this, for many, identity is argued to be inextricably linked to processes of the body, and as such, linguistic changes in which gender is not acknowledged in certain processes (such as childbirth) are thought to erode an individual’s identity. Once again it must be acknowledged that there is not necessarily a single ‘answer’ to this debate, but rather an observation. Just as we have observed the context in which the meaning of hormones may be made (e.g., they *mean* something fundamentally different for a menopausal woman to a person transitioning), so too can we observe in the context of language and the body how phrasing can mean different things to different people. Discussing the body in relation to its function can be at once both distressing to some and liberating to others – the context is key. The situation is the same in both instances, but the interpretation is what renders it unique.

Care as *the* treatment

Traditional anthropological work has largely linked the term ‘care’ to medical contexts *only*, and equally, to particular professionals caring for patients (invariably those associated with the work of ‘body labour’ – which I term as care that mostly implicates nurses, carers and others involved in treating the body with a form of physical touch). A more ‘current’ and renewed interest in themes of care however recognizes caring relationships as more complex.

Equally, it identifies how care and caring relationships may take place in many different spaces and places. Care is relational, if not reciprocal, and often involves more actors than simply the carer and cared-for. In the context of this thesis, the multiplicity of experience of the numerous actors (both material, social and spatial) have been emphasized as imperative in forming a situatedness of care. In the context of the clinic for example, it is not one thing that makes up the meaning of menopause, it is everything involved in the interaction – the plush velvet cushions, the bespoke tube of testosterone, the glossy leaflets, the hour spent with a patient. All of this defines and distils the relationship of care that a patient experiences. Thus, when considering what is meant by care as a form of treatment, it is essential that the multiplicity of forms that care can take is accounted for.

The majority of this ethnographic research was carried out before the COVID 19 pandemic. All observations between clinician and patient took place in a context where meeting face to face for a clinical appointment was not only the norm but was also expected. Post pandemic, this has changed. The clinic now offers their appointments virtually, and this raises queries regarding the context of care and the mechanisms that were observed – mechanisms in which care was communicated analytically as a form of treatment in and of itself. It is easy enough to infer that virtual spaces are detrimental to social interactions. They make it easier to disengage, they suit only some people, some of the time, and they exclude people due to accessibility issues of various kinds. This is to make, however, a somewhat simplistic observation. A world in which we increasingly live online presents opportunities as well as limitations when it comes to the context of caring for menopause and does not necessarily erode the formations of care that were observed in the clinic. For many of the women that took part in this research, there was one major barrier that impacted their likelihood to seek support: fear. Whether due to a difficult experience with a GP, a lack of self-belief or an entrenched patriarchal assumption that they should simply 'suck it up' as women have done before, fear was something to mitigate and overcome in pursuit of care. In making ways of overcoming this fear more accessible (such as a shift in the provision of online appointments) it is possible that this obstacle is (in part) addressed. Moreover, how people present themselves, how they behave, and the kind of things they are able to talk about all take place in a different way; a kind of social grammar goes along with online spaces that frame virtual environment not as simply crude substitutes 'for the real thing', but as arguably new and creative opportunities for the menopausal patient, relative, carer, support folk, and researchers alike.

Thus, technology in multiple forms can be seen as playing a pivotal role and providing a genuine benefit in the care and support of people experiencing menopausal symptoms (be that via the access to peer support online, or the ability to attend a clinical appointment virtually). The concern, of course, is the potential for people to retreat from communities of care in the everyday. In one rather devastating conversation with Kate, she explained how as a GP she often opted to see her elderly patients in person, as taking their blood pressure provided them with a form of care for which there is no zoom substitute: touch. Thus, the current context of menopause is complicated in a post-COVID virtual world. The advent of the pandemic meant a lot for menopause; it propelled conversations. It elucidated the role of oestrogen in immune response and gave rise to advocacy in parliament. Yet, the observations in this research would suggest that so much of what was provided at the clinic, so much of what made menopause in *this* context, had little to do with menopause as an intellectual entity. Rather, it had everything to do with recentring engagement on the individual at the appointment. It was learning about the patient– how many children she had, who her partner was, where she worked, what she wanted most out of life. It is this that made menopause, and it is its absence that this thesis argues needs to be addressed in public systems of care.

This sentiment is affirmed by Mol in ‘The Logic of Care’, (2011) and agency (and indeed forms of power) can *flow* between participants in the process (patients, nurses, doctors, pharmacists etc.), and equally between objects (Blood tests, DEXA scans, HRT, leaflets etc.). What Mol contrasts to the logic of care is the ‘logic of choice’. Although, in the context of the Global North, individual choice may be placed as centrally important when it comes to decision-making surrounding our health and wellbeing, Mol considers how ‘choice’ can in reality become problematic in the context of good care. She argues that care is a relational process that involves negotiations on the part of the patient and clinician, and other associated factors, such as the form of treatment, the natural environment and others. Thus, Mol argues that ‘choice’ is not truly ever exercised only by individuals but is part of an active decision-making process in which good care is irreducible to the act of any ‘one’ choice. Thus, in the context of menopause, a patient’s engagement is so much more than the decision to use HRT; it is everything surrounding it – the adaptations in lifestyle, the support of the social network system, the access to treatment and more.

When considering menopause and the ways in which ‘care’ is provided, it is the ‘multiple’ that must once again be considered. The strategies employed by practitioners help to make sense of the ambiguities at play. As perimenopause and menopause ultimately places a woman in a state of hormonal ‘flux’, care must remain in motion. Menopause is not a static circumstance, but one that changes, and as such, requires a ‘tinkering’ and rearrangement of care to take place, with different solutions provided that relate to the individual patient as they move through the changes being experienced. It requires flexibility and for doctoring to be shared. “For treatments can only be adjusted properly if the experiences of patients are carefully attended to” (Mol 2008, p. 99).

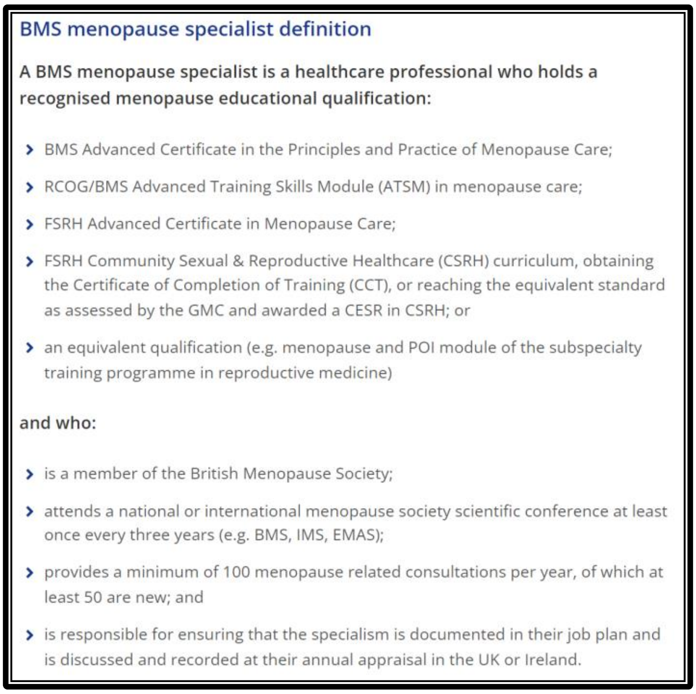
Heavy HRT hitters and the NHS

The concept of hierarchy rears its head in this thesis in a number of contexts. Not only can it be observed to ‘play out’ in relation to evidence and understanding, but it also equally appears in relation to clinical practice, professionalism, and competency. For many patients observed at the clinic, seeking care privately was not a ‘first choice’ for them. The experience recounted in patient narratives communicated a recurring context – they felt unsupported by their NHS GP and felt their menopause had been missed. For many, it was the lack of HRT prescribing on the part of their GP to help alleviate their symptoms that caused them the most concern. Countless narratives from women surfaced in which they discussed a sense of having needlessly suffered as a result of a GP’s ‘incompetency’ to spot the signs of their perimenopause and menopause.

From the position of the clinic, it would be ill advised *not* to assume menopause as a proverbial smoking gun. Women were self-referring under the assumption that they were struggling with symptoms of menopause. Yet the question remains, is this position (the one in which a GP has ‘missed menopause’) a reflection of poor clinical expertise, or simply an increasingly widespread belief that we should consider the culprit menopause before another underlying cause is proven guilty? The purpose of posing this question is not necessarily to delineate whether there is a ‘right’ answer, but to examine the messy and often unclear parameters under which symptomatic presentation of perimenopause and menopause occurs and is imbued with and impacted by the multiple forms of clinical hierarchy that surround decision-making. Whilst clinicians at the clinic communicated a position in which menopause was the likely cause for symptoms emerging in women of that age group, it is contentious to infer that a GP who previously gave a different diagnosis is failing a woman by extension.

During the process of this research, Claire was removed from the list of accredited menopause specialists on the BMS website. This was (albeit a colloquial account) due to the fact that she was not following HRT prescribing guidelines set out by the BMS. In short, Claire routinely prescribed oestrogen at a higher dose than was recommended by the BMS (for example 4 pumps per day as opposed to the advised 1-2). Whilst there is no evidence to suggest that such prescribing is dangerous, it is equally not licensed, nor a recommended option for routine practice. A physician *may* opt to prescribe higher doses should they feel there is cause – for example, when a patient shows low absorption rates or requires a higher dose due to their age (specifically if they are younger and have entered menopause as a result of surgery), but this would be considered ‘off-licence’ prescribing, as opposed to standard practice.

The British Menopause Society (2023) has specific requirements set out that practitioners must meet in order to be deemed a specialist (see figure 43). Beyond this, a BMS menopause specialist is expected to adhere to both national guidelines *and* recommendations from the BMS; particularly in relation to the use



BMS menopause specialist definition

A BMS menopause specialist is a healthcare professional who holds a recognised menopause educational qualification:

- BMS Advanced Certificate in the Principles and Practice of Menopause Care;
- RCOG/BMS Advanced Training Skills Module (ATSM) in menopause care;
- FSRH Advanced Certificate in Menopause Care;
- FSRH Community Sexual & Reproductive Healthcare (CSRH) curriculum, obtaining the Certificate of Completion of Training (CCT), or reaching the equivalent standard as assessed by the GMC and awarded a CESR in CSRH; or
- an equivalent qualification (e.g. menopause and POI module of the subspecialty training programme in reproductive medicine)

and who:

- is a member of the British Menopause Society;
- attends a national or international menopause society scientific conference at least once every three years (e.g. BMS, IMS, EMAS);
- provides a minimum of 100 menopause related consultations per year, of which at least 50 are new; and
- is responsible for ensuring that the specialism is documented in their job plan and is discussed and recorded at their annual appraisal in the UK or Ireland.

Figure 43: Screenshot of the BMS specialist definition (2023)

and prescribing of HRT. It is further stipulated that they must spearhead educational campaigns and work well within the community and with other relevant menopause professionals.

Thus, the accreditation communicates a particular ‘ruling’. The professional will adhere to the guidelines and conduct set out by the BMS. They will act as a member of a clinically hierarchical system in which a clinician knows and respect the institution that makes the guidelines. So, what does it mean when a major player refuses to follow the rules?

When initially reaching out to Claire, she had a small website detailing her experience in menopausal medicine. The website contained some information about her special interest in menopause, her experience in working with perimenopausal and menopausal patients, and her commitment to supporting research and education that explores the impact of perimenopause and menopause. During the span of this PhD, she has gained a social-media following of hundreds of thousands of people , launched a menopause app that has received millions of downloads, built a website housing hundreds of resources that detail information on everything to do with perimenopause and menopause, and gained and maintained her position within the top ten most-successful health and wellbeing podcasts streamed by Apple in the UK. These achievements might be said to indicate that her decision to prescribe in *her* way is not without reasoning. The question of what defines someone as an expert is, in the context of this research, a point of contention. In the case of menopause, is being an expert something that *can* be conferred by the BMS? Or, in an ever-evolving technological landscape, is it through all the mechanisms outlined in this thesis – those that have been played out and explored in the context of the clinic and beyond – that an individual becomes a menopause expert?

Moreover, the threat posed by Claire is further complicated by the fact that she is not only refusing to follow the guidelines of the institution that in the context of menopausal care are considered to be the most pronounced and important, but also the ways in which she is moving the conversation into the hands of patients. She is encouraging shared decision-making, speaking up, and treatment advocacy. She is moving the parameters of an institution and complicating the systems in which menopause has always been made; she is remaking menopause to mean something different. In a context where the boundaries of the binary (patient-doctor, women-men, private-public) become ever eroded, practices of care that spill out from the clinic and into the in-between places (online, in social media, onto television) add to a discursive context in which menopause is made even more multiple.

Menopausal Models

As has been explored earlier in this thesis, the consultation model observed at the clinic required a collaboration for a patient's full range of symptoms to be made visible. It was the dynamic of the consultation that became the mechanism by which care, and thus treatment, was able to be truly facilitated – a gentle interaction that encouraged experiences (and thus symptoms) to emerge and be taken seriously in due course. In observing interactions, it is possible to acknowledge how the current provision of care via an NHS GP pathway inadvertently excludes women and fails to provide the opportunity to speak freely without time-pressured sensitivities. It is *this* model that makes little sense when it comes to treating menopausal women presenting with multiple debilitating symptoms.

Such a discussion is not intended to serve as a critique of GPs who struggle with limited consultation timeframes, but rather to provide an opportunity to consider the conditions under which women would feel supported, and thus consider the best and most appropriate models for menopausal treatment to be developed. Fundamentally, and as has been explored throughout, HRT is just one form of a woman's treatment for the perimenopause and menopause. For women to be offered the care they need requires a change within clinical practice that appreciates and understands time-rich consultations as part of the parameters of appropriate practice for treating menopausal patients. Fundamentally, time with a practitioner should not be a luxury, but a right. From observations, it is clear that we have to underscore the word 'care' and realise that it is itself a key form of treatment. Whilst not necessarily cost-effective in the short term, observing a model in which time-rich consultations may occur arguably affords long-term benefits to a public health system such as the NHS.

If menopause can be identified as a root cause for a myriad of symptoms a woman is presenting with at a GP's surgery over the course of months or even years, the burden of care *overall* is reduced. To reiterate, it is not just time that is an essential part of the treatment process, but the particular kind of time that allows for the reframing of a patient as a person, and the co-creation of clinical intimacy. Fundamentally, since the concept of menopause is built upon constructs in which factors such as gender, self-worth and other psychological elements that complexly interrelate, then longer consultations make sense as a way of coming to understand these complex conceptions, and thus being able to provide better care. It is such understandings and appreciations that should lie at the heart of the model of care. As opposed to continuing to position private menopausal healthcare as the antithesis of the NHS – rather than continuing to recycle the narrative of private vs public, us vs them – perhaps a more appropriate approach is to consider how usable examples of care practices could be employed in separate perimenopausal and menopausal spaces in order to provide women with the resources they need and are entitled to. For example, would menopausal care be better were it routinely provided in a community sexual-health setting? Could there be dedicated menopause day at a GP surgery? Creative conversations are needed in order to appropriately consider how to meet the needs of a historically overlooked and marginalised section of the population.

In reading this, one may feel divided. There are many who feel that menopause is reaching a point of panic – with the unnecessary prescribing of HRT to patients that may have otherwise not even sought out hormonal treatments in the first instance eventually deciding that HRT is right for them. This, it is argued, is not the central issue of concern. Rather, it is the mechanisms and means by which, and the parameters under which, menopause is made. The time afforded to listening to the patient and to explaining the treatment options, to caring for them in the right ways – that is the process by which the issue of women being made to feel invisible may be resolved. The way in which hormones happen to help is just one benefit among others.

Problematising Privilege

This research lacks diversity. In multiple instances, there have been references to women in the plural. It is important to recognise, however, that the category ‘women’ is exceptionally broad, and contemporarily ever expanding. As feminists have theorised, there is no ‘one’ woman – there are many, each possessing their own unique and specific experience of navigating a patriarchal world that afflicts some more than others. In short, the concept of intersectionality, in which contexts such as an individual’s class, age, race and gender are understood to intersect and overlap in order to create both connected and interdependent systems of discrimination and disadvantage must be recognised. The research findings presented ultimately capture the experiences of a subsection of society. Whilst it has been argued in various moments that the women represented within this research are more diverse than perhaps one would first assume, and that the research itself came to represent a broader population of participants beyond the parameters of the clinic, it still ultimately provides a Eurocentric narrative populated by the accounts of the most privileged: white, heterosexual women. This positionality is acknowledged not with rationales but with questions. Namely, what are the circumstances that need to be addressed in order for menopause to be framed and reframed as an issue that afflicts all women as opposed to a privileged subgroup in society? The crux of this query is not to delineate how to make decisions about women, but rather to consider how to enable and empower all women to feel confident, informed and supported in making decisions about their care regardless of access to privilege.

The historic context is essential to consider here. Menopause doesn’t exist in isolation from the circumstances in which its modern conception emerged. During the process of conducting this research, a rather interesting novel surfaced during a procrastinet search. It was written in the 1920s, by Gertrude Atherton, and is titled *Black Oxen* (1923). Set against the backdrop of post-World-War-I America, the story revolves around the character Madame Zattiany, an age-defying woman with an alluring air of mystery. Madame Zattiany appears to onlookers to be exceptionally young and vibrant, despite her actual age of seventy. Eventually, it is revealed that she has been undergoing ‘rejuvenation treatments in Switzerland (namely X rays of the ovaries, which was, at the time, a popular treatment for menopause). In the novel, Madame Zattiany becomes the subject of intense public fascination. Her allure captures the attention of the younger generation, and she finds herself involved in a variety of romantic entanglements. Although the novel explores the implications of rejuvenation for personal identity, the role of women in society and the consequences of societal pressures surrounding aging (namely how such pressures impact relationships and individual self-worth), it also presents harrowing eugenic implications in which the pursuit of 'youth' should be reserved for some and not for others. This context, this history, this eugenic backdrop against which menopause has emerged must be acknowledged, as its echoes can be felt in the ways in which certain persons are afforded better access to care and treatment for their menopause in contemporary society than others.

Whilst solutions would willingly be presented, the issues embedded in this problematic context of access are not easily undone; they require enquiry and a willingness to accept and acknowledge the active work on the part of caregivers and policymakers that must be undertaken to destabilise the colonial eugenic context from which menopause was first made.

Menopause Made?

I'm looking at a bottle of Testogel. It's positioned neatly alongside moisturiser and other facial products in the bathroom of someone using the formulation to action certain masculinising effects. I turn it over in my hands – feel the weight of it. I examine the blue label and place the Testogel back on the shelf. It stares at me inconspicuously. Now nestled between toothbrush and toothpaste I consider how unassuming this little blue bottle appears. Testogel has become a part of this persons daily routine, a part of *their* making. I think about all of the ways in which hormones, but particularly *this* hormone means so much to so many, but equally how this meaning is still diversifying daily.

In coming to the close of this thesis, it's useful to acknowledge how, the parameters of hormonal care in the UK are becoming increasingly blurred. The use of HRT has become a topical point of interest that now features on multiple platforms, raising important questions regarding the relationship between the use of hormones and our conceptualisations of them. Specifically, how conceptions of hormones relate to, or are imbued with culturally-specific and gendered discourse. As this research has shifted across spaces, places and networks, attention has been paid to the impact of what happens when these conventional narratives about hormones and their uses stop 'making sense'. Doing so has highlighted how, rather than being absent, issues of gender and the constraints stemming from the patriarchy continue to be embedded in the processes of pursuing perimenopausal and menopausal treatment.

Patriarchal practices have been observed in multiple ways throughout this research in the context of menopause care. An uncomfortable intellectual encroachment of power on feminine (and feminist) discourse with specific gendered messaging being communicated to those undergoing care and treatment is evident. Hormones and the body can be seen to have been assigned value – value that pertains to ideas of 'proper' function. At the EMAS conference, topical lectures were given on Female Genital Cosmetic Surgery (FGCS), including discussions on labiaplasty, hymenoplasty, genital bleaching, and whitening. The technology on show at the conference included the use and 'display 'of laser treatments promising to lighten, tighten and brighten every inch of the ageing feminine form, thus making a discernible project out of women's bodies. Something about the displays at the conference felt reminiscent of that quote outlined from *Everything You Always Wanted to Know About Sex* (*But Were Afraid to Ask)* earlier in this thesis: "Having outlived their ovaries, they may have outlived their usefulness as human beings" (Reuben 1971: ibid).

Women's bodies, in the context of menopausal care, can ultimately be seen to become vehicles for conversations about gendered expectations that reflect deeply entrenched sociocultural patriarchal ideals and values. As Simone de Beauvoir (1949) writes: "The female body is marked within the masculine discourse, where[as] the masculine body, in its conflation with the universe, remains unmarked." Conversations regarding menopause, hormones and their functions thus, as has been explored throughout history, have rested upon clear categorical differences between 'men' and 'women', with this distinction articulated discursively through the (structuralist, dualist) gender binary. Testosterone, for example, through its excess or deficiency in bodies, can be seen as a disruptive substance that destabilises categories, highlighting the perhaps often-overlooked importance of the roles that hormones play in the construction of sexed identity in the sociological imagination. At a conference such as EMAS, in the clinic, and in the marketing material provided, professionals readily accept bodily states as highly complex, yet equally reiterate distinctions that rest upon concepts of clear, natural and immutable categorical difference. However, something important and essential that appears to unify gender within this project is the ageing process. Ageing bodies are problematised, regardless of gender. Like more complex understandings of hormones and gender, this treatment may well be a consequence of the threat the ageing body poses in terms of eroding and blurring the boundaries of clear categorical difference. As women grow beards and men struggle to maintain erections, so the fabric of conceptual-categorical difference fades.

Arguably however, it is women who are most ‘penalised’ for their aging. In many ways, they are stripped of an identity beyond their aging body, and whether intentional or not, the subtle mechanisms by which women’s bodies are seen as having value depending on whether they decide to pursue menopausal treatment can be damaging. As Steinke elucidates:

> *“It’s important to be honest about the symptoms. Hiding them does no good. I am not blind. I can see that I have a tummy, heavier thighs, grey strands in my pubic hair. The lines around my mouth are deeper, the dark circles under my eyes, which used to appear only when I was exhausted, now seem to be permanent. I look always a little burnt-out, a little feral. I want honesty. But the endless negative lists don’t help me, don’t lift me up”* (Steinke 2019)

The fundamental concept that this thesis has attempted to explore in relation to the differences experienced in aging between men and women is subtle but important – where women are fixed men are simply improved. It is the role of menopause to be a vessel for the binary conceptual demands of the patriarchy. The assumptions of a eugenic, capitalist, and patriarchal system might struggle to impose themselves on a purely ‘medical’ interpretation of menopause. It is for this reason that the concept of menopause becomes the object of an effort to re-make it. That effort to re-make menopause is characterised by the addition of contemporary ideals and standards about women that are not chosen by women – and it is against these ideals and standards that women are then judged to fall short. These standards – such as whiteness, hairlessness, sexual fulfilment of one’s partner, particular ideals of genital aesthetics – are derived from the fundamental binaries. It is these concrete targets that binary conceptions produce, and it is these targets that constitute the ways in which women are objects of the demand to be ‘fixed’. To call upon de Beauvoir once again, masculine bodies are equated with the universe. Their form needs no shaping. It simply is. The form of the female, however, cannot be allowed to transgress boundaries. The feminine must constantly be policed, and transgressions fixed.

Fundamentally, following menopause into a variety of spaces has led this research to uncover the depth and reach of gendered discourse, and as such, patriarchal power, demonstrating the breadth of its reach to extend further than might first be assumed, and certainly beyond the parameters of medical discourse. Questioning the purportedly apolitical space of medical discourse is key. As this research has shifted across spaces, places and networks, paying attention to the impact of what happens when conventional narratives about menopause stop ‘making sense’, significant observations have been collected. These highlight how the issues embedded in the processes of pursuing treatment are not simply personal, but intensely political. Observations demonstrate empowering practice by committed clinicians. However, in the narratives of women discussing their struggles to attain HRT through an NHS pathway, it has also revealed the barriers facing innumerable women seeking essential menopausal care in the UK today. It has highlighted the manner in which links between patriarchal power, capitalism and the ever-changing landscape upon which conversations about health, the body and treatment take place not only limit the access to available treatment options but supress the development of other options for women. Included within this is the reproduction of not only patriarchal power, but also wider systematic oppression in which women are unable to access treatment.

It is essential to stress is that the women and the stories presented in this thesis are not the accounts of cultural dupes manipulated by a capitalist system in which menopause becomes a means to sell things to them that they don’t need, nor are they are vessel’s that become filled with ideals, standards or objectives that are not of their own choosing. They are pragmatic, insightful people that make decisions in line with a complex interplay of different factors. The concept of ‘duty’ that has been explored is complex – there is duty to the self, to society, to loved ones, and to the biomedical system at large. Menopause is a space of social injustice, and the intention of this thesis is to create a ‘place’ where some of these stories and these tensions can be heard. After all, and to end with Steinke, wouldn’t we rather “read stories not of propped-up femininity, but of people who are disoriented but also electrified by their new hormonal configuration.”

A degree of ‘conflict’ has undoubtedly been embedded throughout this thesis. There has been the tension between the private and the NHS patient; the pharmaceutical industry that is motivated by profit and the medications produced to help alleviate women’s debilitating symptoms; the issues of ‘messaging’ which can at times seem empowering and in other moments appear patriarchally oppressive and of course, underpinning it all, are the themes of gender in which bodies are not plastic but rather fixed sexed entities – man and woman. This distinction has been emphasised as vitally important as we are able to see that, contrary to popular discourse in which the essentiality of sex and gender is positioned as simply ‘existing’, we have to engage in maintenance work to shore up this distinction. The development of all of this has left me to wonder whether “part of the work of life for everyone may be to synthesise the sexes”. (ibid). In the Gnostic Gospel of Thomas, Jesus says “When you make the two one…when you make the inside like the outside, and the outside like the inside, and the upper like the lower and when you make male and female into a single one, then you will enter the kingdom.” Perhaps this drive for distinction, this drive for ‘completeness’ involves more than the medical. Perhaps the want to fix, to maintain, to stabilise involves a quintessence that is more complex to capture and exists beyond the remint of simply wanting to fix the feminine.

There is one final factor to note – this thesis has, even in its attempt to draw out the distinct ways in which gender is problematically ‘replicated’ in biomedical spaces, contributed to a binary rhetoric. It has spoken of ‘men’ and of ‘women’ in the binary, and equally and in many instances divided up the body in relative terms. Bodies and selves have been explored in relation to a hormone’s presence, absence, or the capacity to acquire it. Thus, it could be argued that this thesis has contributed to the aforementioned cannon of work that attempts to ‘synthesise the sexes’. It is noted however that it is exceptionally complex it becomes to delineate such concepts *without* calling upon such shared understandings of binary separations. As such, we may consider how these messages can present obstacles for professionals when explaining hormonal function and appreciate the difficulties involved in undertaking such a task without drawing upon shared metaphors or existing cultural scripts. Exploring menopause ethnographically exposes gendered imaginaries and market logics. It renders visible invisible patriarchal orders reified through scientific discourses and pierces the veil between the ‘natural’ and the ‘social’. Deconstructing these messages encourages us to consider alternative ways to think about not only menopause, but the body and its processes in general. It tasks us to consider how we may better communicate messages about hormones and the body in a more gender-neutral and inclusive manner.

To revisit the central preface of this thesis that I have considered throughout, is menopause made? As has been exemplified in our exploration, menopause will be modelled and remodelled in line with the shifting and evolving social and cultural landscape within which it occurs. Thus, within this research, perhaps a version of menopause has been made, but the process in which ‘construction’ occurs will never be complete – like hormones that flow, so too does menopause remain in motion.

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Appendix 1: Covid-19 Impact Statement

1. Details on how COVID-19 has impacted and disrupted this research

Whilst training as an ethnographer may prepare you to deal with the unexpected, and to move flexibly through unpredictable contexts, the pandemic was not a circumstance that one could have predicted nor prepared for. COVID-19 imapacted this research in the following ways:

1. Completing fieldwork

Whilst the majority of fieldwork took place prior to the pandemic, the final stages of participant observation were impacted by the first national UK lockdown. Following the onset of COVID, communication with those that wished to participate in the research became more challenging. Clinicians were reconfiguring the ways in which services were going to operate and given the changing context of this, engaging with me as a researcher (understandably) became a waning priority. In tandem, following the announcement of government restrictions, all contact with people that wanted to participate in the research needed to occur remotely. As we explored in Chapter 2, online interactions are not considered 'less than' nor impossible to accommodate, however it must be acknowledged that the change in the conversational context requires a recalibration on the part of the researcher. We are asked to consider how best to capture the nuances of an interaction when the benefit of in person communication is not possible.

2. Writing- up in isolation

Trying to 'conceive' this thesis in the midst of a global pandemic proved exceptionally challenging. Having no access to a working space, a PhD cohort, nor an environment to engage with supervisors beyond the parameters of Zoom or Microsoft Teams meant that 'sense checking' any work became very difficult. Whilst we may recognise in the wake of COVID-19 that working remotely proves easy enough to accommodate at this time, we had little experience of conducting our working lives form within our own homes and configuring our daily routines without the support of others.
Moreover, in writing up this research it was important to reflect on the ways care had been accommodated and in the context of the pandemic, this was ultimately changing. This brought up many questions regarding the relevance

of the context I captured in a post-pandemic world. Whilst this impact has been wrestled with throughout the thesis it is important to acknowledge as it caused huge crises in confidence that slowed the writing process considerably.

3. A Very Personal Pandemic

Adjusting to the isolation that the pandemic restrictions invoked took a toll on my mental health. My fiancé at the time was working as part of the 'turn team' on the Intensive Care Unit (ICU) at Guys and St Thomas' Hospital. This put enormous stress and pressure on our relationship and eventually we separated. Shortly after this time I realised I was gay and needed to negotiate this change in my life with limited support. The decision was made to take an interruption of studies as a result of the difficulties I was experiencing and the impact it was having on my mental health, which continued to decline after this time. Finally, I contracted COVID-19 during the writing up stages and dealt with long term fatigue and 'brain fog'[31] that impacted my ability to write and think coherently. At the time of sublission these symptoms still have not resolved.

2. Conceiving COVID

In some ways, and as has been outlined in this thesis, the pandemic brought a new level of relevance to this research. Not only were we beginning to investigate the potential causal associations between oestrogen levels and COVID symptoms (which was highly relevant to research examining the use of hormones among perimenopausal and menopausal women), we were equally experiencing the forming of new health related networks in response to the growing of online communities. In considering the changing global landscape that was born out of the pandemic, COVID was conceived of in this research in the following ways:

1. Exploring the Online

To adjust to the changing context that arose out of the pandemic, focussed time toward the end of fieldwork was spent exploring the dynamics of online interactions within the menopausal space. As was explored in Chapter 6, this ensured that the ways in which menopause conversations were occurring in a

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[31] I never related more to women experiencing perimenopausal fatigue and brain fog than I did at this time.

COVID context was captured and equally ensured fieldwork did not 'stagnate' as a result of the restrictions placed on interacting with others.

2. Returning to Research

In line with the Covid-19 infection rates peaking and then subsiding, the accompanying government restrictions and the deterioration in my mental health, I adjusted my research and writing up plan repeatedly. I worked with my supervisors to ensure that the data was returned to methodically and we consistently considered how things had shifted as a consequence of the pandemic.

3. Reengaging with the findings post pandemic

During my interruption of studies, I took a step back from the research and stayed in limited communication with the people that participated in the research, thus when returning to the findings I ensured I remained conscious of the fact that I was looking at the context of the fieldwork retrospectively. The clinic did not truly 'exist' in the same way, but as has been contended throughout, nothing truly ever remains in a static fixed state – especially not menopause.

3. The Positives to a Pandemic

Guided by my supervisors, I focussed on writing a thesis that spoke to fluidity. The pandemic was unpredictable and for many, left them feeling adrift, confused, and unsure of themselves. In response to these feelings and the changing nature of my own queer identity, I consider the pandemic to have granted me a new way of engaging with my research and the women that shared their stories with me. It provided me with the opportunity to relate in new ways. Experiencing a state of flux like never before, the pandemic perhaps provided a means to reflect upon how feelings of flux can take a toll.