

**rites of the second spring: situational analysis of
postmenopausal hormone replacement therapy in
turkey**

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LIST OF ABBREVIATONS

CVD	Cardiovascular Diseases
DTCA	Direct to Consumer Advertising
EMAS	European Menopause and Andropause Society
ERT	Estrogen Replacement Therapy
FDA	Food and Drug Administration
HERS	Heart and Estrogen/progestin Replacement Study
HRT	Hormone Replacement Therapy
HT	Hormone Therapy
TSMO	Turkish Society of Menopause and Osteoporosis
NAMS	North American Menopause Society
SERM	Selective Estrogen Receptor Modulator
STEAR	Selective Tissue Estrogenic Activity Regulator
SSK	Sosyal Sigortalar Kurumu (Institution of Social Security)
WHI	Women's Health Initiative
WHO	World Health Organization
WTO	World Trade Organization

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ABSTRACT

This dissertation argues the medicalization of menopause in Turkey became possible due to the coexistence of changes that accompany the globalization of neoliberalism, such as the diffusion of the idea of the patient-as-consumer; and remnants of core ideals of modernity, such as the embrace of beliefs in Western science, technology and medicine that comprised “modern” identity. In this context, the increased influence of global pharmaceutical corporations and the neoliberal privatization of the health sector after the 1980s turned the modern subject formation of the “conscious citizen/woman” discourse into one of the “conscious consumer/woman.” The concept of *bilinç*, which can be translated as consciousness or awareness, constitutes one of the main discursive continuities between modernization project and the post 1980s neoliberal era.

The key to the dynamics of acceptance and refusal of HRT and the medicalization of menopause is the coexistence of multiple social worlds, each with their own concerns, interests, ideas and reactions to aging, gender, and being healthy. These social worlds in question are especially observed in the arena of the clinic, with the intersections, overlaps and mutual adjustments that menopausal women, doctors and pharmaceutical representatives engage in when faced with each others’ discourses. Using Adele Clarke’s situational analysis as the theoretical framework as an answer for the multiplicity question and keeping the focus on the “situation,” I aim to provide localized accounts of experiences drawn from nine months of ethnographical research done in gynecology clinics in Istanbul between 2006-2007, and archival research on the media representations of menopause and HRT in Turkey between 1999-2006.

1. Introduction

In May 2006, I had just arrived in Istanbul for my fieldwork. My very first interview on Turkish women's experiences of menopause and hormone replacement therapy (HRT) was with Zerrin Bornova, a pharmacology professor in a big public university. "Menopause was not invented in my grandmother's time," she said, "but I remember my mother going to the doctor for it. It was a hip thing back then. She and her friends used to get together and compare their menopauses." Later on, at various times and settings, on benches in hospital corridors, in waiting rooms or during tea parties, other women told me about their experiences of menopause, and how they were different from their mothers' experiences. Then I listened to gynecologists telling me what menopause is, and what it was at the time when they were medical students, and how treatments changed over time. "Second spring," which is also the title of this dissertation, has been used to refer to menopause in Turkey since the late 1990s. It was used encouragingly in newspaper articles promising a time of newfound freedom for women in this period of their lives, half-jokingly by doctors talking about "menopausal patients," as they call them, and sometimes bitterly by women suffering the symptoms of menopause. "Rites of the Second Spring" is a spin-off of Modris Eksteins' book *Rites of Spring: The Great War and the Birth of the Modern Age*, narrating the story of birth of modernity at the beginning of twentieth century (Eksteins 1989). The title of the book is based on Stravinsky's "Rite of Spring," which was turned into a ballet by Nijinsky, as told in one of the chapters.

This dissertation is about how menopause was "invented" in Turkey, and what HRT means as a risky and gendered medical technology in an era of increasingly global medical discourse in a country that has been desperate to modernize itself since the nineteenth century. My overall argument is that globalization of neoliberalism, such as the diffusion of the idea of patient-as-consumer; and the core ideals of modernity, such as the embrace of beliefs in Western science, technology and medicine that comprised the "modern" identity constitute the conditions of possibility for the medicalization of menopause in Turkey. The key to the dynamics of acceptance and refusal of hormone replacement therapy (HRT) and the medicalization of menopause is the coexistence of multiple social worlds, each with their own concerns, interests, ideas and reactions to

aging, gender, and being healthy. Concepts like duty, responsibility, consciousness or education, which have remained alive since the early periods of the modernization project in Turkey are used alongside newer concepts of risk, empowerment, individualism, and consumerism, which are elements of the global neoliberal discourse, during the negotiations these social worlds engage in around HRT and menopause.¹ Thus, my contribution to the broader existing literature on modernization and globalization lays in showing the discursive continuity between modernization projects and global transformations.

1.1 Modernity, Modernization, Globalization

Modernity and modernization are among the key concepts for this project. For the case of Turkish modernization, Nilüfer Göle's definition of modernity and modernization was the most relevant. Defining "modern" as indicating the "Western set of values of individualism, secularism, and equality produced by the Enlightenment, the industrial revolution, and pluralistic democracy," she added that "modern"

...does not have a synonym in Turkish. But it does have its own life and meaning in Turkish history. Rather than modernity, which refers to a given consciousness of the present time and state of development, the concept of "modernization" —expressing a political will to "become modern"— is used in the Turkish vocabulary of history and politics. Modernization can be interpreted as a continuous endeavor to overcome the lag in scientific, economic, and political development (Göle 1996, 7-8).

It is argued that projects of modernity ended or changed shape in a new era that started roughly with the fall of the Berlin Wall in 1989, after which the world ceased to be "bipolar." Some called the new condition "postmodernity," referring to a situation or

¹ These changes from the modernization framework to that of globalization and consumerism is mostly valid for a more privileged group of women and their interactions with the healthcare professionals. There is a big urban/rural difference, and definitely, important class difference in having access to healthcare. However, I believe that it is still important to track the changes happening for the "elite" or "privileged" ones, for it has —and still continues to— set the standards for those in the less privileged positions. The ideology, the identity is created by, for and around them, and then it is negotiated and recreated in other levels.

era after modernism, while others refer to it as a condition of “globalization” characterized by the decreasing importance of the nation-state relative to regimes of global governance, multinational corporations, and cultural convergences that transform local cultures and ways of living. As Laura Briggs noted in her study of reproductive control policies in Puerto Rico, “the term ‘globalization’ is a placeholder, a word with no exact meaning that we use in our contested efforts to describe the successors to development and colonialism” (Briggs 2002, 1). Globalization is yet another concept used to analyze phenomena on multiple levels. In an effort to define the concept, David Hess suggested examining globalization “as an empirical problem that can be analyzed across societal domains such as politics, economics, ethnic relationships, and civil-society and social movements” (Hess 2007, 15). In a similar effort, Diana Rhoten argued that globalization is “about the reconfiguration of state, market, and society and the reorganization of their roles, responsibilities and relations” (Rhoten 2000, 593). No matter how I define the terms in this project, in the overall literature globalization usually denotes changes affecting the globe, stressing the common points of these changes over local experiences. Postmodernity, on the other hand, implies a break with modernity, or a transcendence of the era in question. Because of my desire to show the effects of globalization without losing the uniqueness of the local context, and to emphasize continuity as well as change, I chose to use both terms interchangeably.

Throughout the dissertation I treat the modernization project (or process) as a continuum that changed significantly with the advent of globalization/postmodernity, but was not totally transformed. Modernity is a focal concept in this project because of its capacity to make historical sense of medical institutions and health care in Turkey, and because of my belief that it retains its importance as a governing mentality in the discourses on medicine, gender, women’s bodies, and science and technology (Campbell 2000). Even criticisms of the project of modernity and transformations, fragmentations, and recirculations of its elements happen through the categories defined by categories of modernity. One trap that should be avoided in theorizing about modernization and globalization is the universalist tendency of seeing modernity as a uniform project directed towards the creation of a homogenous identity, disregarding (or downplaying) the impact of local circumstances (Abraham 1998; Bozdoğan and Kasaba 1997). Deniz

Kandiyoti used the term “the local specificities of modernity” to signal significant variations in how the historically and socially constructed categories of “modern” affect the status of women of different local conditions and classes (1997).² I believe that these same “local specificities” need to be taken into account when discussing the effects of globalization on medicine.

The effects of globalization are felt by a great number of those people who live below the “global glass ceiling” (Hess 1995, 116). Those effects are not experienced evenly: there are uglier faces of the global scale changes like refugee camps and immigrant labor (Appadurai 2000), or socio-economic inequalities (Farmer 2005). The effects of globalization on medicine and healthcare have been manifold, for it is a process involving political, economical, socio-cultural and ecological systems, all of which have impacts on public health. The complexity of the concept of globalization requires a framework for the explanation of its impacts. Attempts at a conceptual framework to explain these effects have focused on economics (Woodward et al. 2001), both economic and political factors (Labonte and Torgerson 2002), or more complex, multi-causal frameworks (Huynen et al. 2005). Huynen et al. identified important features of globalization as “[the need for] global governance structures, global markets, global communication and the diffusion of information, global mobility, cross-cultural interaction, and global environmental changes” (2005). Some of these have more indirect effects on healthcare, like environmental changes and cross-cultural interaction, while others have more immediate effects. In this dissertation I focused on the latter. The former, direct effects are defined as “impacts on health systems and policies operating directly ... through international markets ... and direct effects on other influences on health at the population level” (Woodward et al. 2001, 876). Examples of such impacts are the effects of WTO’s policies on open trade, or their reflection in pharmaceutical prices (Petchesky 2002), and cross-border transmission of infectious disease (Farmer 2005). The effect of global policies through national economies is considered a second

² Deniz Kandiyoti is an influential theorist and researcher of gender and modernity in Turkey and Middle East whose studies are highly pertinent to this dissertation and will be cited frequently in the following sections.

category, including factors like public expenditure on health and household income (Woodward et al. 2001, 876).

At the institutional level, the changes wrought by globalization can be summarized as the increasing influence of international organizations like the World Bank, the International Money Fund, and the World Health Organization in defining economic and social policies including healthcare policies; growing number of public-private partnerships for health that result in further private involvement in shaping healthcare (Huynen et al. 2005); and decreased public spending in healthcare as a result of advocacy for neoliberal policies. Increased level of communication and geographical mobilization enables sharing of information, which eases the spread of knowledge, treatment and technologies, and has a positive effect on global health. However, the increased movement of goods and people also make it easier for diseases to spread (Farmer 2005; Huynen et al. 2005; Woodward et al. 2001).

Regardless of its effects, the governing discourses of globalization generally emanate from North America and/or Europe, conveniently and collectively referred to as “the West.” Co-constructed with knowledge and technologies that are disseminated to the rest of the world from the West, these discourses are interpreted differently in different local cultures, yet they still leave a universal trace. Menopause and HRT are no exceptions in this regard. During this project, my analytical concerns included contextualizing the research in such a way as to show the local specificities that appropriately reflect the historicity of the social worlds and the local context, and being able to deal with multiple meanings given to the same technology, which is HRT in this case, in line with Sandra Harding’s interpretation of “standpoint epistemologies” (Harding 1991/1998). Traced back to Hegel’s remarks on master/slave relations and later on to Marx, Engels, and Lukacs, who used this theory to explain the “standpoint of the proletariat,” standpoint epistemologies were further developed within feminist theory to reflect on gender relations. According to Harding,

These epistemologies propose that there are important resources for the production of knowledge to be found in starting off research projects from issues arising in women’s lives rather than only from the dominant androcentric conceptual frameworks of the disciplines and the larger social order (Harding 1998, 149).

Standpoint epistemology not only refers to the achievement of a gendered standpoint (that is, of being a woman with particular perspectives), but also makes it possible to see the different shapes that “being a woman” can take in different contexts. This context-based side of the theory is also important in understanding “how the Western idea of modernity is reconstructed and internalized locally” in the Turkish case (Göle 1997, 83). Canadian feminist sociologist Dorothy E. Smith’s understanding of the standpoint concept and her institutional ethnography furthered Harding’s framework for the purposes of this project. Smith defined institutional ethnography (IE) as a “new kind of sociology” that better addresses complexity and the extra-local qualities of texts without losing touch with the “material world.” She criticized poststructuralist and postmodern theories for losing touch with the lived world by creating a textual-based world that abstracts the subject and her/his experience (Smith 1999). Her suggestion for a standpoint for women is “not necessarily as a general attribute of women as class of persons, but as a mode of experience that is distinctive to women” (Smith 1999, 45).

Providing the localized experiences would not be complete without an analysis of the historical background of identities. This effort is in line with feminist historian Joan Wallach Scott’s argument for the importance of historicizing experience by focusing on the subject construction without essentializing it (Scott 1992). My emphasis on the historical development of modernization ideals and women’s identities in Turkey stems from this kind of a desire to include an element of historical awareness for subject formation. I treat the social worlds around menopause and HRT as “historicized subjects” themselves, which come together as the meaning of HRT is enacted and re-negotiated through their interaction.

All these concepts inform the analysis of this dissertation, which is mainly framed around Adele Clarke’s situational analysis. I will explain her theory and framework and my approach to it in the following parts of this chapter.

1.2 A Key Concept for Continuity: *Bilinç*

A key concept for this dissertation, and one that I kept on hearing during my fieldwork is *bilinç*, which translates to English as “consciousness” or “awareness.” It is a word that did not exist in Turkish language prior to the language revolution of Atatürk,

which started in 1932. The word itself was derived from the root *bilmek*, to know, and the earliest usage of the term was in 1942 (Nişanyan 2007). Usually translated to English as consciousness, it is used by different groups with slightly differing meanings, including as part of the name for menopause and osteoporosis awareness campaigns (*bilinçlendirme kampanyası*). The concept of *bilinç* denotes an achieved level of existence rather than one that naturally happens to all members of a class or gender, in parallel to standpoint epistemologies (Harding 1998). In the Turkish context, *bilinç* is attained mainly by formal education, and/or exposure to the “right” information through books or news media. Awareness of the outcomes of one’s situation is an important part of the concept, as well as some formal knowledge about it. At the same time, it can be situational, in the sense that different positions (standpoints) may require different kinds of *bilinç*. For example, a woman can have *bilinç* of a consumer such as knowing her rights in a transaction and complaining if necessary, but not have *bilinç* when it comes to healthcare, such as not having regular mammographies after a certain age.

During my fieldwork, I heard the word pronounced by doctors and women alike, and with different meanings. Usually, it is a concept defined by its existence or lack: there is a kind of dichotomy between those who have *bilinç* (*bilinçli*), and those who do not (*bilinçsiz*).³ Women defined themselves as having the *bilinç* to know that they are in menopause and to go the doctor, or others (like their mothers) as not having it. In this context, it carries covert references to education and urbanization, and traces of the modernization ideals. A slightly different meaning it has taken on is related to the more recent advent of consumerism, as having the *bilinç* to shop for doctors. Educating oneself through health information gathered from newspapers, popular books, or sometimes consciousness raising conferences explained above constituted another side of having *bilinç*. I will return to this concept in the last and concluding chapter of the dissertation, evaluated in the context of findings from the field.

³ Turkish is an agglutinative language that derives new words with suffixes. The suffixes “-li” and “-siz” are used to derive words that denote the presence or absence of the word that they follow.

1.3 Methodology

For this project, I used a triangulation of semi-structured interviews, participant observation, and archival research. All research took part in Istanbul, Turkey between June 2006 and March 2007. Istanbul is one of the biggest metropolises in the world, with over twelve million inhabitants providing a diverse population in terms of educational level, age, class and ethnic background. It consists both of a very rooted urban population and a population living in the outskirts/slums of the city, recently migrated from the rural areas. As the center of industry and business, Istanbul contains a significant working class population as well as the upper middle and middle class. This diversity is important to understand the processes of modernization and urbanization, which would be harder to capture in any other city in Turkey. The main fieldsites for the research were obstetrics and gynecology (ob/gyn) clinics in two public research hospitals⁴, a third one in a private hospital and several private practice offices of ob/gyn practitioners I interviewed.

In addition to the fieldsites that I conducted research, I attended to an international medical congress that took part in Istanbul, a women's health conference aimed at public, and a small workshop for ob/gyn professionals organized by Turkish Society of Menopause and Osteoporosis (TSMO). The archival research part comprised of tracking news reporting on menopause and HRT from five daily newspapers and five magazines scanned between the years 1999 and 2006.

1.3.1 Fieldsites

Most of the data used in this dissertation came from two main fieldsites in Istanbul: the gynecology and obstetrics clinic in Istanbul Eğitim ve Araştırma Hastanesi in Samatya, formerly known as SSK Samatya Hastanesi (from here on will be referred as Samatya), and menopause clinic in Istanbul Üniversitesi (Çapa) Tıp Fakültesi (from here on will be referred as Çapa). Although both of these are research hospitals, in terms of

⁴ The closest examples to the American notion of a research hospital in the Turkish medical system are hospitals tied to public medical schools, commonly referred to as *üniversite hastanesi* (university hospital). In the last five years several private medical schools opened their own research hospitals, yet public university hospitals are still the biggest, most well known and accessible research hospitals in Turkey.

patient population, the former can be considered as a public hospital and the latter, which is connected to a medical school, more of a research/university hospital. In addition to these two sites, I performed research in a smaller clinic in Osmaniye, staffed by doctors from Samatya simultaneously with the research in Samatya; and very briefly in the gynecology and obstetrics clinic of a private hospital in Yıldız, Beşiktaş (Boğaziçi Hastanesi) in between two fieldsites, in order to get an idea about the private sector. I also visited three private practices of doctors working part-time in these research hospitals. The reason I limited my inquiries about the private sector to these venues is that at the time that I was doing the fieldwork I could not reach any information about a special outpatient clinic for menopausal women in any of the private hospitals in Istanbul.

The choice of these sites responds to the diversity question. Until very recently the Turkish health system consisted of both public and private hospitals, and a three (or four) fold social security system in which public employees, artisans and workers have their own respective social security networks, each of which grant access to public health services, in addition to the private health insurance programs that pay for expenses in private hospitals. Shortly before I started the fieldwork in 2006, all public hospitals became accessible to everyone belonging to any kind of public social security, in an effort of social security reform combining three existing public social security institutions under one organization, named *T.C. Sosyal Güvenlik Kurumu* (Republic of Turkey Social Security Institution). University hospitals such as Çapa present a special case as they are both accessible by all public security networks, and are places where medical knowledge is produced and reproduced. Having an academic character, they have highly qualified medical personnel and better technological equipment than most public hospitals. They are accessible by the middle and lower classes, yet are sometimes preferred by people of higher economic status especially for cases requiring specialization. These characteristics give them a unique status in terms of having a broad and diverse patient composition, and being the center of medical knowledge production. Both Çapa and Samatya Hospitals accept patients with government-based health insurance, and are therefore more accessible by people from different classes and backgrounds as opposed to private clinics or hospitals.

Initially, I aimed to do research in Istanbul Cerrahpaşa Medical School Hospital instead of Çapa, another university/research hospital, because Turkish Society of Menopause and Osteoporosis (TSMO) is mainly located in Cerrahpaşa Medical School. However, the permission process took longer than I expected, and eventually I decided to apply for Çapa, where getting a permission proved to be much easier. Despite the fact that I could not get access to Cerrahpaşa, during the time I spent there handling the application process I met and interviewed some of the key people in the TSMO including Prof. Dr. Erdoğan Ertüngealp, the president for TSMO and the head of menopause clinic in Cerrahpaşa Hospital.

I started my first fieldsite, Samatya, on the second week of June 2006 and went on visiting the clinic three days of the week, after an initial week of being there every day, until the second week of August. My primary contact and key informant in Samatya, Dr. Şengül Bahar, introduced me to the rest of the staff, especially the younger assistants who are closer to her age and rank.⁵ The staff included several specialists and assistants who are studying to be ob/gyn specialists themselves. They had rotating lists of who was going to be where each day. There was a night duty/on call list, a Samatya clinic list, a surgery/operation room list and an Osmaniye clinic list. The clinic was staffed by two ob/gyn assistants, a family practitioner intern doing their ob/gyn training, a specialist present to supervise the assistants and step in if necessary, and a nurse. The responsible team was split between two clinics, obstetrics and gynecology, which are two separate rooms connected by a door in between. On the other side of the obstetric clinic was the ultrasound room and connected to that, another small room for family planning. On the side of the gynecology clinic there was the exam room, with two exam tables separated

⁵ The term *asistan* (assistant) in the Turkish medical system is used for a doctor who is in the process of specialization which would take anywhere between four to six years depending on the branch, upon completing six years of elementary medical education and graduating as a general practitioner. Thus, it corresponds roughly to the term “intern” in the medical culture of United States. In the sixth year of medical school the students do not take classes but work in different clinics of the university hospital they are attending to all through the year, under the supervision of assistants and professors, and they are called *interns*. I will stick to these “local” definitions throughout the dissertation.

by a curtain. Two doctors sitting in tables facing each other, in front of the computers would be asking questions to the patients, sending them to the exam room, prescribing them some drugs or entering the data for the patients in the computer; most of the time simultaneously, from 8:30 am to 4:00 pm, with one hour of lunch break in between. At any given time, there would be at least three people in the room and two more in the exam room, not including the doctors and the nurses. There was an additional personnel responsible for keeping the order in the door, calling the numbers, running errands and telling the usually confused patients where to go and what to do. Osmaniye was a little different from Samatya, with two separate rooms for obstetrics and gynecology clinics in different corridors. Another difference was the presence of digital boards outside the door showing numbers, instead of the personnel calling people inside. In both places, men were generally not allowed in the room, with a few exceptions at times when the clinic was not crowded and usually when they came for a bureaucratic reason like getting signatures for their wives, who had just given birth or had an operation.

My initial plan was to interview the doctors I met there and spend some time in the waiting room in Samatya ob/gyn clinic to find women who would agree to be interviewed. The doctors I met, however, asked me to come inside and sit with them during the visits, saying that it would be more useful for my research. In addition, they told me to go to Osmaniye too, because Samatya is known more as the “pregnancy clinic,” a place where mostly pregnant women go. I was told that there were more menopausal patients in Osmaniye. None of the doctors I asked why this is so could explain the reason, but they all thought there was a difference in numbers between Samatya and Osmaniye. So I started spending my field days inside the clinic, both in Samatya and Osmaniye, occasionally asking women who came for menopausal complaints for interviews. Sometimes doctors were helping me out, encouraging their patients to talk to me. This way of collecting data had its own advantages and disadvantages. On the plus side, I had the privilege of observing doctor-patient relations first hand, and getting a better grasp of the routine procedures, practices and the drugs prescribed. Also, some women placed more trust in me and accepted to be interviewed because I have been referred to them by the doctors, whom they trust and respect. However, I believe it may have caused them to speak in favor of doctors and doctor-

patient relations, biasing the interview. I tried to counterbalance that situation by interviewing a number of women that I met in the waiting room, and finding some informants outside the hospital settings, through other contacts. I interviewed the doctors either during their working hours when they are not busy, or after hours especially when they are in the hospital for the night shift.

My second fieldsite, Çapa, had a more specific patient population. They accepted only menopausal patients, three days of the week (Monday, Wednesday and Friday), and kept their files separate from the general ob/gyn clinic. On Mondays and Fridays the clinic was open between 9:00 am and 3:00 pm, and it accepted forty patients per day who came early in the morning to get numbers. On Wednesdays it started at 10:30 am, due to regular staff meetings and the number of patients to be accepted was thirty. Spatially, it was in the same place corridor as the ob/gyn clinic and was sharing the ultrasound machine with other rooms. Like Samatya, the menopause clinic was primarily carried on by one of the assistants, usually accompanied by a nurse and/or an *intern*, and another assistant specializing to become a family practitioner. In case there would be something they are not sure, they would go and ask an assistant higher in the rank, or find one of their professors. The general appearance of the place and its workings was much more orderly than Samatya, partly due to the fact that there were fewer patients and a working filing system that allowed them to see the patient's history. In a small room with no windows, patients would be called in by numbers displayed on a digital board outside, like Osmaniye, give the doctor their file, answer their questions and, if necessary, be examined at the back of the same room separated by a folding screen. There was a system of monthly rotation for the gynecology assistants to work in the menopause clinic.

In the private hospital leg of the study, which was initially nonexistent in my research plan, I visited a small private hospital and talked to the ob/gyn practitioner, Dr. Ahmet Üner. He agreed to be interviewed, and, like other doctors I met, offered a place in his office for me to sit and observe the patients and himself in practice. Unfortunately, the number of patients was quite low in that setting (4-5 patients per day), and I could not get any patient interviews there. However, combined with my observations from visiting other ob/gyn practitioners' private practices, the experience in Boğaziçi Hospital helped me understand the workings of an ob/gyn clinic in a private hospital, and the difference in

doctor-patient relations and patient population between private and public settings. My limited observations in the ob/gyn clinic in this small private hospital demonstrated differences between public and private hospitals in time allotted to and autonomy left to patients, both of which are higher in a private setting. Due to the small sample size, I refrain from drawing conclusions with regard to differences in approach to menopause and HRT, which was slightly more cautious in the private hospital than in public and research hospitals. Considering the fact that most private hospitals are staffed by specialists and professors working and teaching in public and research hospitals part time, it can be inferred that the medical approach would not be different between these two settings.

1.3.2 Interviews

Like the fieldsites, the structure and number of my planned interviews changed during the fieldwork. My initial plan was to do one-on-one interviews that would take approximately 45 minutes to an hour with 40 women of menopausal age and 20 ob/gyn practitioners, numbers equally distributed between two fieldsites. Shortly after I started the field, I realized the possibility of performing group interviews with women in settings in which they would be more comfortable than they would in the hospital, and have fewer time constraints. This would also enable me to see the different kinds of data that would emerge within group dynamics. I made three group interviews with a total of 12 women, in two different tea parties that I had access to through my personal contacts and one scheduled interview with four members of the folklore dance group “Sultans of Menopoz,” an amateur group of middle-aged women who became famous for a short while after their appearance on a TV show with that name. The first of these tea parties took place in July 2006 in Florya, which is an upper-middle-class neighborhood in Istanbul. It was hosted by Aysun Ketenci, a postmenopausal woman who had recently stopped working in her husband’s textile workshop as a manager. The second tea party took place in December 2006 in Sarıyer, a lower-middle-class neighborhood, and was hosted by Canan Evcil, a retired secretary who had lived in the same neighborhood all her life. I interviewed Sultans of Menopoz in June 2006 in the apartment complex where they all lived, in Ataşehir.

In addition to these group interviews, I ended up having one-on-one interviews with 31 women mostly in hospital settings, and 21 doctors. Nine of the interviews I made with women took part in Samatya, six of them in Osmaniye, 15 of them in Çapa, and one of them in the private practice of a gynecologist where she worked as a secretary. Five of the women interviewed entered menopause surgically, as opposed to 24 experiencing menopause naturally. Of these 24, two had premature menopause. The number of women who were taking HRT at the time of interviews was four. Of the remaining 23, 14 women have never been on HRT, and nine of them had taken HRT for a while but they were not taking any hormones at the time of interview. 14 women who never took HRT included six who were being tested before the decision of taking or rejecting HRT. Of the doctors interviewed, 16 were male and four were female. Eight of the doctors were ob/gyn professors in medical schools, seven were ob/gyn specialists working in hospitals, and six were assistants specializing on ob/gyn. Nine of these interviews took part in Samatya, three of them in Çapa, Five in Cerrahpaşa, and four of them in the private practices of doctors I met in hospitals, except for one that took part in a private hospital.

The duration of interviews averaged twenty minutes to half an hour, due to the time constraints of hospital settings: Women usually had to go make appointments for ultrasound or mammography, take their smear samples to pathology lab, or have to run home to take care of grandchildren after spending so many hours at the public hospitals where waiting times are quite long. In addition, I interviewed a drug representative who previously worked for Wyeth before the menopause market collapsed, which was an interview that gave me valuable background information.

Another change that happened in the field was my proposed method of snowball sampling while doing interviews with menopausal women, for most of them were unable to refer me to another woman of menopausal age. Some of them said that nobody around them wanted to talk about it, and some said that they did not know anyone else in their condition. I attribute this reluctance in talking about menopause to the social invisibility of menopause, especially outside a medicalized environment.⁶

⁶ The invisibility of menopause, to which I will turn in the following chapters, is indicative of the “implicated actors” in the arena of menopause and HRT in Turkey. In Clarke’s definition, implicated actors are “actors silenced or only discursively present—constructed by others for their

As I mentioned earlier, I interviewed doctors from Cerrahpaşa although it was not one of my fieldsites, sometimes in their offices in the hospital, and sometimes visiting their private practices. I had access to most of these people through my key informant in Cerrahpaşa, Prof. Dr. C. Tamer Erel, who was assigned as my advisor for the local IRB process I had to go through to get permission for doing fieldwork in Cerrahpaşa.

All of the interviews were semi-structured. Specific interview questions for women of menopausal age consisted of background questions on age, place of residence, education level, etc., and a second set of questions aimed towards their experiences with and attitudes toward HRT. For the physicians, the background questions were aimed at their education and employment background. A second set of questions on their personal and professional view of menopause and HRT, their prescription practices of HRT, and their perceptions of the patients who demand or refuse the treatment followed. Some examples for interview questions are as follows, although the wording and follow-up questions changed according to the specific interview:

For women of menopausal age:

1. Tell me a little about yourself, your education, what do you do, are you married, do you have any children, where are you from, etc.
2. When did you enter menopause? What changed in your life after that? Are there things that are better now? Do you have complaints?
3. What did you do for complaints if you have any?
4. What do you think about taking hormones?
5. How are your experiences with the doctors (on this matter)?
6. Was menopause different in your mother's time? Grandmothers? Do you know anything about how it was, what they did? What has changed since then?
7. (If they think there was a change) Why do you think the change happened?
8. What is the biggest change, in your opinion, in Turkish medical system during your lifetime?
9. In your opinion, what is the biggest problem of medical system in Turkey?

own purposes" (Clarke 2005). In this case, menopausal women themselves are the implicated actors of the arena.

For the physicians:

1. For the record, can you repeat where you work, how long have you been practicing, and where you graduated? (Did you study abroad? Where?)
2. Is the medical approach to menopause different today from how it was when you were in medical school or when you graduated? What is the difference?
3. Why do you think this change has occurred? (To what extent do you attribute it to pharmaceutical companies and globalization?)
4. Based on your experience, is the treatment and understanding of menopause different in Turkey from other countries?
5. What is your definition of menopause? What are the different types of HRT that are available in Turkey? Which ones are the most commonly used? Which firms produce them?
6. What is your professional view on HRT? Do you prescribe it? Under which circumstances you do (or do not)? (For what categories of patients is it indicated?)
7. What is the socio-economic background of your patients? What are their most common complaints on menopause? What is their attitude toward HRT?
8. What kind of patients are more willing to take HRT? Who are more resistant?
9. What is the biggest change, in your opinion, in Turkish medical system during your lifetime?
10. In your opinion, what is the biggest problem of medical system in Turkey?

Except for two interviews (one with a menopausal woman and one with a doctor), I recorded all interviews, with the written or verbal consent of the informants; and transcribed all, most of them in their entirety. All interviews took part in Turkish, and parts selected for quotes in the dissertation were translated into English during the dissertation writing process.

1.3.3 Conferences

In order to gain the background information on HRT and other drug use in menopause, and observe different ways of disseminating information and different

discourses adopted by different actors in the menopause/HRT field in Turkey, I attended several conferences and workshops during my fieldwork in Istanbul. The first one of these was the 7th annual international medical congress of EMAS, European Menopause and Andropause Society, which took part in Istanbul in June 3-7, 2006. It was aimed at doctors, sponsored by big pharmaceutical companies, and was a big event with people coming from different countries, mainly from Europe. The second one was a two day public health conference that took part between June 10-11, 2006 and is called “18+ Women’s Health Conference” aimed at informing the public about important women’s health issues. It had sponsors ranging from private hospitals to cosmetics companies. Both of them happened in June 2006. The last event I took part was a workshop organized by TSMO in February 2007 to inform doctors, especially ob/gyn practitioners, about latest developments and research in menopausal treatments and more specifically, HRT. It was closed to the public, was a more professional environment with a small number of doctors and was sponsored by Schering. I heard about the workshop when I was interviewing Prof. Dr. Erdoğan Ertüngealp, the head of TSMO, who also told me that they were having these information workshops every two weeks, to educate doctors.

1.3.4 Archival/Textual Research

The archival research part of the project included five daily newspapers, five magazines, popular books on menopause aimed to inform the public by the doctors and brochures and promotional materials on hormonal and other kind of drugs used during or after menopause. My initial idea of looking into medical journals and textbooks changed after spending some time in the field and deciding to focus on the more “popular” sources of knowledge, both for doctors and menopausal women, in meaning making for menopause and HRT. However, I kept three medical books written on the subject to illustrate the medical view, with the aim of focusing only on the definition of menopause and views on HRT; and serve as background information. These are: *Menopoz ve Osteoporoz* (Ertüngealp and Seyisoğlu 2000), *Menopoz - Osteoporoz Vademekum* (Ertüngealp et al. 1999) and *Menopoz Tedavisi ve Kanser* (Atasü et al. 2001).

The popular books on menopause that I included in my analysis are *Menopoz* (Poroy 2006), *Sağlıklı Menopoz* (Atasü and Güreli 2003), *99 Sayfada Menopoz*

(Seyisoğlu 2006) and *Klimakterium: Premenopoz, Menopoz, Postmenopoz, Senium: İkinci Bahar* (Kadayıfçı 2006) These are the books that can be found in the bookstores in Istanbul, most of them written by doctors for the purpose of “informing the public,” and increasing consciousness regarding menopause.

When selecting periodicals, I tried to choose those with high circulation and cover different examples of political spectrum. I scanned four monthly and one weekly magazines between the years of 1999 and 2006, to see the changes in the approach to menopause and HRT before and after the WHI study in 2002. Among these, *Elele* is a mainstream monthly women’s magazine, which is one of the oldest local women’s magazines in Turkey; *Marie Claire* is the “localized” version of an international women’s magazine; *Formsante* is a monthly woman’s/health magazine, *Aktüel* is a mainstream weekly news magazine and *Şebnem* (previously called *Hanımeli (Kadın Vizyon)* between 1999-2002) is an Islamic women’s magazine.

The five newspapers I selected are *Milliyet*, *Hürriyet*, *Akşam*, *Zaman* and *Radikal*. The first three are the biggest newspapers in Turkey in terms of total number of circulation and popularity, and they have are slightly right of the center in terms of political orientation. The fourth one is an important Islamic newspaper, and the last one is slightly more progressive, more popular among the educated middle and upper-middle classes. The selection is again based on diversity, and they were scanned for the same time period (1999-2006). Both newspapers and magazines are searched for news and articles on menopause and HRT.

The brochures and other promotional materials for drugs used in HRT were collected mostly from the conferences I attended: that is EMAS and 18+ Women’s Health conferences. Below is a list of brochures that I selected to include in the analysis and in brackets is the information about where I obtained them, except for those under the headline “EMAS Symposiums:”

- 2nd Istanbul Anti-aging medical aesthetics congress (Cerrahpaşa)

EMAS Symposiums:

- Organon Sponsored Symposium (Tibolone)

- Wyeth Sponsored Symposium (Roadmap to VMS)
- Schering Sponsored Symposium (Angeliq: Embrace Change)
- Merck Sponsored Symposium (Progestins and bleeding)
- Novo Nordisk Sponsored Symposium (Defining the ultra low dose)

Hormonal drugs

- Angeliq: HRT with Drospirenone (Schering) (EMAS)
- Estrogel & Ultrogestan Scientific Brochure (Besins) (EMAS)
- Fem7Evo (Merck) (EMAS)
- Activelle (Novo Nordisk) (EMAS) (+other products)

Non-hormonal drugs

- Actonel (Sanofi Aventis) (EMAS)
- Vazgeçilmez Mineral: Magnesium Diasporal (Med İlaç) (EMAS)
- Osteo-D: Osteoporoz Tedavisinde D Hormonu (Med İlaç) (EMAS)
- Remifemin Tablet (Farma Tıp) (EMAS)
- Remifemin Tablet (Farma Tıp) (18+)
- Remixin (Mikro-Gen) (EMAS)
- Isoflavin (Mikro-Gen) (EMAS)
- Dermapause-L Krem (Mikro-Gen) (EMAS)
- Gynogen (Biolina) (EMAS)
- Cal-D-Vita (Bayer) (EMAS)

Awareness Campaign Brochure

- Menopozda Yaşam Kalitesini Korumanın Sırları (TSMO) (18+)

1.3.5 Coding

After the first round of interviews and observations in the first fieldsite, transcriptions of all interviews and fieldnotes were analyzed to come up with the initial codes. Once all data is completed, the initial codes were revised by further analysis of

overall data. Lastly, interviews and fieldnotes were subjected to a sentence-based coding with the final set of codes using Atlas-ti. A list of initial codes can be seen in Appendix 1.

1.3.6 Maps and Situational Analysis

Following Adele Clarke's method of situational analysis (Clarke 2005), situational, relational, social worlds-arenas, and positional maps have been prepared to assist the analysis of data. These maps made it easier to grasp the broad picture of the whole situation around HRT, defining the important actors, arenas and relations between the actors, social worlds and concepts. Examples of ordered and messy situational maps can be seen in Appendix 2.

Situational analysis follows Adele Clarke's "social worlds and arenas" (Clarke, 1998; Clarke And Montini, 1993). She defines social worlds as "universes of mutual discourses," and arenas as places/instances where the different social worlds meet and interact. The key activity in these arenas is to establish and maintain boundaries between worlds. For the purposes of this project, Clarke and Montini's work on RU486 is useful as an example of how this suggested framework is applied to reproductive technologies (1993). In this article, the authors look at the heterogeneous constructions of RU486 by various actors, who they define as scientists, pharmaceutical companies, medical groups, antiabortion groups, women health movements, and downstream users and consumers of this technology as the invisible actors. In addition to that, RU486 is also defined as the nonhuman actor that has an unstable and multiple nature.⁷

In *Situational Analysis*, Adele Clarke gives the following explanation for the concepts of social worlds and arenas, informed by theories of Howard S. Becker and Anselm Strauss:

We assume multiple collective actors (social worlds) in all kinds of negotiations and conflicts in a broad substantive arena focused on matters about which all the involved social worlds and actors care enough to be

⁷ For an earlier attempt to use Clarke and Montini's "invisible and implicated actors" in the context of menopause in the STS literature see Marilys Guillemin's article on the working practices of an Australian menopause clinic explored through a framework of actor-network theory and symbolic interactionism (Guillemin 2000).

committed to act and to produce discourses about arena concerns (2005, 37).

An arena signifies a conceptual place that social worlds come together, rather than a spatial one (Clarke And Montini, 1993). For the case of HRT, I define two main arenas. The first one, medical conferences and workshops, is related to the knowledge production and dissemination on menopause and HRT within the medical profession. The second one, the clinic, includes the users of the HRT technology and those that decide who is going to use it. My approach to arenas gives more weight to the spatial/temporal element, for I believe that pointing to the material conditions of the arenas and their spatial/temporal aspects helps to clarify the nature of negotiations and clashes happening inside them. The framework I employ here focuses on two realms of knowledge production around HRT, which complement each other. Medical conferences and workshops are places where clinical research results are communicated to the medical professionals who in turn “translate” them into clinical practice. The way presentations are organized, venues are designed and conversations structured, as well as the presence of pharmaceutical companies in these professional events, shape the construction of HRT. These negotiations, clashes and appearance of various discourses in this process affect the second arena, the clinic, where the end-users of this technology and the clinicians come together, and are joined by drug representatives who also visit doctors in the same space. For the purpose of this project, I find the clinic to be a more important arena than the professional conferences, involving more intersections between social worlds.

Situational analysis adds a “cartographic” element to Anselm Strauss’ social worlds and arenas framework. The situational, social worlds/arenas, and positional maps mentioned above are aimed to support a grounded theory analysis and to put the situation at the center instead of the action. In Clarke’s words:

The situation per se becomes the ultimate unit of analysis, and understanding its elements and their relations is the primary goal (Clarke 2005).

1.4 Outline of Chapters

The dissertation has eight chapters, including the introduction and the conclusion. Chapter 1, Introduction, explains the main arguments and theoretical framework of the dissertation, elaborating on the methodology and giving a summary of chapters to come. My second chapter aims to give the historical background of the research field, seeking to answer a general question that I have been asked various times in slightly different forms: What is so unique about Turkey? This chapter locates Western-style medical institutions in Turkey against the backdrop of the overall modernization project, providing a background on how the healthcare system established as part of the state paternalism in the Kemalist era changed in time, and how these changes affected physician-patient relations, as well as medical culture in general. Gendering of the modernization project is another theme analyzed in this chapter, through the relations between changes in the gender identity and social, political and economic changes. This brief history answers the questions like: What are some of the symbolic parallels between medicine and the modernization project? How have these two projects been connected? What are the roles given to women in the process of modernization, what kind of identities they developed? How did these roles change in time, with political, economical and cultural changes? What stayed the same? How have women's bodies been constructed in the meantime? Where does change in medical thought and practice fall in that picture? Following the Turkish background, Chapter 3 broadens the focus to the anthropological and feminist literature on the meanings of menopause in different cultures, and the historical studies of medicalization of menopause in the Western medical tradition. Discussions around the WHI study and latest medical trends about HRT are included in this chapter, as well as the effects of the women's health movement and feminist reactions to HRT and medicalization of menopause at different historical points.

After these background chapters based on secondary literature, I move on to explore the current state of menopause and HRT in Turkey, using data from my fieldwork. Chapter 4 introduces different constructions of menopause and HRT in Turkey in early 2000s from the perspective of menopausal women. The meanings of menopause and HRT, including the invisibility of menopause in traditional and popular culture, menopause as a "natural" period of life, HRT as a pill that enables menstruation or causes

cancer, and women's reasons for taking and rejecting HRT are explained in this chapter, accompanied by excerpts from interviews with menopausal women and literature and self-narratives. Women's narratives are followed by the medical discourse and practices around menopause and HRT in Turkey in Chapter 5. The importance of language used to describe menopause, TSMO as a key institution in constructing menopause in Turkey, HRT prescription practices, and ways of learning for gynecologists in a highly contested scientific issue like HRT are some issues discussed in this chapter. In Chapter 6, I move to media and consciousness-raising as the intersection or bridge between the social worlds of doctors and women. News stories are cited and analyzed in this chapter, as well as the reactions of the medical world to media, and the consciousness raising campaigns examined through the example of a women's health conference. Chapter 7 focuses on the clinic as the main arena for menopause and HRT, following the theoretical framework I employ. It answers questions like: Where do these discourses come together, where do they clash and how are they negotiated? What happens in the course of these overlaps, clashes and negotiations? What are the different ways that doctors persuade women, companies convince doctors, women ask for HRT, or resist taking it? My last and concluding chapter discusses the circulation and transformation of the medical discourse on menopause and HRT, which stemmed from a Western, and mainly a Northern American cultural perspective, relocated to the Turkish context. These localizations and transformations can be observed in multiple levels of my data, through the relevant social worlds and arenas where they come into contact. The chapter elaborates on the tropes of "modern woman" and "consciousness" as threads that run through these worlds and combine them together. I chose not to include pharmaceutical companies as a separate social world and devote a chapter to them. Instead, I mentioned their presence in every chapter and traced their influence over the social worlds and arenas of menopause and HRT in Turkey, like the presence of pharmaceutical corporations in the clinic, and their role in organizing the medical conferences and consciousness-raising campaigns.

I used secondary sources in English and Turkish for this dissertation. The parts taken from secondary sources in Turkish and excerpts from interviews have been translated into English. Key Turkish terms are italicized, followed by English translations in brackets. Where no straight translation is possible or adequate, their meanings are

explained in footnotes. I chose to use Turkish characters (which are not present in English alphabet) in Turkish words instead of replacing them with their closest English equivalent. Unless otherwise stated, all translations are mine. In order to protect the privacy of my interviewees, especially the menopausal women, I used pseudonyms instead of their real names throughout the text.

2. Turkish Modernization, Gender and Medicine

One of the slogans in European Menopause and Andropause Society's 2006 annual congress opening ceremony was "Turkey the bridge: where the East meets West" which resembled the slogan advanced by Istanbul for the 2000 Olympics: "Let's meet where the continents meet." After noting the slogan during the conference I forgot about it because it repeated a familiar cliché. I forgot about it until I saw "Turkey at the Crossroads," the title for a relatively recent book written by two non-Turkish academicians, Dietrich Jung and Wolfango Piccoli, teaching in a Turkish private university in Ankara (Bilkent) in the late 1990s. Jung and Piccoli discussed the continuities of Ottoman-Turkish modernization and the position of Turkey in the "Greater Middle East" that was formed in the region after the Cold War. The title did not attract my attention at first, as I picked up the book from the library to use it for this very chapter on the background of Turkish modernization. I only noticed it after starting to read the Introduction, which began with a sentence on Turkey's uniqueness: "Turkey is often noted for its uniqueness, either in its geographic dimension as the gateway from Europe to Asia, or in the way the country combines 'being Western oriented though Turkish and Muslim at the same time'" (Jung and Piccoli 2001,1). More explanations for this uniqueness exist in the historical studies of Turkish modernization stretching back to the late Ottoman times. According to Selim Deringil:

The Ottoman state was unique in many ways. It was the only European Muslim power. It had emerged as the single most serious threat to European Christendom during the period when Europe was expanding as a result of the voyages of discovery and colonization in the late fifteenth and sixteenth centuries (Deringil 1999, 1).

The historical background is used as an explanation for pains of modernization as well as the explanation of uniqueness by other authors writing on Turkish modernization, like Bernard Lewis:

Westernization has posed grave problems of identity for a people who, after all, came from Asia, professed Islam, and belonged by old tradition to the Middle Eastern Islamic world where, for many centuries, they had been unchallenged leaders (Lewis 2002, xi).

Others see the history of Turkey as “fertile ground” for providing “substance to many of the theoretical issues in development literature” (Keyder 1987, 1). Jung and Piccoli echo this belief in introducing Turkey as offering the analyst “a broad and intricate fabric of cultural, social and historical threads” (Jung and Piccoli 2001, 1). In these studies, Turkey is used as a particularly rich example of development and modernization, allowing for multiple layers of analysis.

Both in the course of this project and outside of it, as a Turk I have been asked many times “So, what is so unique about Turkey?” During this research I realized that the uniqueness of Turkey is almost always explained in its being in the middle, in between, in “the crossroads,” being “the bridge,” or “the gateway” so frequently. It is not about where it came from or where it is going, but about being in an in-between situation, a state of being in a purgatory that never ends. Although being in a liminal state is not unique for countries subject to postcolonial studies and especially at this historical moment in the midst of postmodernity/globalization discussions, there is hardly any other country that defines itself and is defined by others with words like bridge, crossroads or gateway. No matter which allegory is used, the source of these definitions lies in the process of Turkish modernization. In this chapter, I aim to explain what modernization means and has meant for Turkey as a country; how modernization has shaped the identities of Turkish women, and how Western-style medicine took part in the process of modernization. This historical chapter unfolds the details of Turkish women becoming the symbols of modernization and public health becoming the responsibility of a social and paternalistic state, with doctors constituted among the educated elite to modernize and “heal” the country and women positioned to mediate the modernization project.

2.1 Turkish Modernization: A Brief Overview

The story of modernization in today’s Turkey starts before the foundation of the Turkish Republic. By the end of the nineteenth century, the Ottoman Empire faced military, territorial and economic decline, indicating the need for reform. Andreas Kazamias summarized the characteristics of modernization attempts in Ottoman times:

Several characteristics of the modernization movement in the Ottoman Empire are noteworthy. First, the initiative for change came from within rather than from without, although the forces which impelled change were

both external and internal; second, early modernization, or more appropriately, ‘Westernization’ or ‘Europeanization’, was conceived and engineered by an indigenous elite group consisting of sultans and their close followers; third, concrete manifestations of the reform movement began with changes in the military sector, although by a slow and compelling logic it spread to the social, political, and cultural sectors; fourth, the change was inspired by Europe, especially France; and finally, education in the broad meaning of the term was assigned a major role (Kazamias 1966, 50-51).

Although there were earlier attempts usually geared towards military reform, like the reform projects of Sultan Selim III and Sultan Mahmud II, the Tanzimat Period (1839-1876) can be considered as the starting point of modernization efforts to strengthen the empire (Kandiyoti 2003, 265). As Bozdoğan and Kasaba defined it “Ottoman and Turkish modernization was seen to be succeeding as an elite-driven, consensus-based, institution-building process that took its inspiration exclusively from the West” (1997, 3-4).

Tanzimat, which literally means reforms, started with the promulgation of the edict of Gülhane in 1839. The main difference between Tanzimat era reforms and those that preceded them was the new emphasis on the judicial and consultative procedures, where secularization of education and the legal system were important issues (Zürcher 1998). Especially increased incorporation with the West and the secular educational institutions helped the emergence of a new elite who generally studied in Europe and believed in the importance of science, progress and democracy as the virtues to save their country. Young Ottomans and Young Turks, and later on the elite of the Turkish Republic came from this cultural heritage, and determined the character of Turkish modernization (Lewis 2002). The importance of science for the Ottoman and early Republican elite is frequently cited in the literature on Turkish modernization. Against that argument, Hanioglu drew attention to a more pragmatic side to these reformers’ policies in his analysis of the Young Turks:

While the faith of the leading Young Turks in ‘science’ endured as an underlying element, the more the Young Turk movement engaged in practical political activity, the less its earlier yearning for a society shaped by scientific doctrines is evidenced in its activities and propaganda (Hanioglu 2001, 289).

Legal and political reforms continued through the first Constitutional Period that started in 1876 with the efforts of the Young Ottomans and ended in 1878 with the closing of the first Ottoman Parliament by Sultan Abdülhamit II. The oppressive regime of Abdülhamit II ended with a coup by *İttihat ve Terakki Cemiyeti*, Committee of Union and Progress (CUP) and starting of the Second Constitutional Period in 1908. CUP was the organization of Young Turks that was founded as an underground organization by a group of students studying at *Askeri Tıbbiye* (Military Medical Academy) of the time (Lewis 2002; Terzioğlu 1998, 25; Zürcher 1995, 39). Kazamias described the foundation of CUP as such:

It was among the cadets of the Imperial Medical School, within the Old Seraglio, that the first revolutionary group, the Committee of Union and Progress, was formed in 1889. Patterned after the famed Italian Carbonari, this committee, which marked the beginning of the Young Turk movement, adopted as its express purpose the overthrow of Abdul-Hamid and his despotic government. The revolutionary spirit soon spread throughout the medical school and overflowed into other government military and naval schools and into the Mulkiye (Kazamias 1966, 100).

Shortly after CUP came to power, the country got engaged in a series of wars, including the First World War, which resulted with the defeat of the Ottoman Empire along with Germany. A distinguishing characteristic of Turkish modernization is that most institutionalized modernization efforts occurred after a War of Independence was fought against the colonization projects of the British, French, Russians, Italians and Greeks on the former Ottoman Empire territory. There had been a brief period of occupation by these forces after the First World War, with first unorganized, then organized resistance and a full-fledged war against them roughly between 1918 and 1923. It is difficult to call this period one of formal colonization, yet the reaction that it caused resembled that of a colonized nation fighting for independence. We should also add to it the fact that the Ottoman Empire was turning into an economic semi-colony of the European countries, both because of commercial treaties and because of the huge amount of debt it owed, before the First World War. Despite the lack of a past of formal colonization, these conditions and their effects make it valid to consider modern Turkey as part of the postcolonial literature.

After the Independence War and declaration of the Turkish Republic in 1923, modernization efforts become more systematized, manifested in a series of comprehensive reforms on all aspects of life from administrative structure to clothing style.⁸ The modernization project in a non-Western context involves a political will to “Westernize,” and the history of modernization in Turkey is one of the “most radical examples of such a voluntary cultural shift,” manifesting in frequent use of the terms “Westernization” and “Europeanization” by the nineteenth and twentieth century reformers (Göle 1997, 83). Within ten years, the alphabet, the calendar system, the legal system and education system changed completely and drastically. A great faith in science, rationality and reason was exhibited in all these changes. Atatürk, who is the national hero, founder of the republic and creator of the official ideology of the Turkish Republic, stated on many occasions that, “Science is the most reliable guide in life” (“Quotes from Atatürk” 2008). This positivist ideology, borrowed mainly from the French example, and having its roots in the intellectual heritage of the Tanzimat era, had some practical benefits beyond the reformers’ belief in it. First of all, its universalistic claims meant that it is a model applicable everywhere, and attainable by anyone who follows this path. Second, its emphasis on “order and progress” made it a useful tool for social control (Göle 1997, 84), where the state managed lives of its citizens for the greater good. The latter point is especially important for understanding the relations between the institutionalization of Turkish medicine and Turkish modernization, which will be discussed below.

In part Turkey went through a period parallel to a postcolonial nation trying to modernize in order to be independent and autonomous because of a conviction of the reforming elite that this was the only right path to go. There has been a real threat of colonization, and there are elements of it happening in different time periods like economic exploitation or direct occupation, yet the relation is still not that of a real

⁸ The Republic of Turkey was proclaimed in 1923, and the period after that date is commonly referred to as “Cumhuriyet Dönemi,” which is translated as “The Republican Period.” The person most associated with the Republic, and the reforms in its wake is Mustafa Kemal Atatürk, and “Kemalism,” the official ideology of the Turkish state, is named after him and is based upon principles that he advanced.

colonizer and colonized. This dynamic is described as “defensive modernization” by some authors (Kazamias 1966; Turan 2002), a term that includes the simultaneous desire among elites to shape the country according to the Western example in hopes that it would become like a Western country, and to protect unique and independent aspects of Turkish identity. This created an ambivalent relationship with modernization and “the West.” Struggles with this ambivalence can be seen in different aspects of the modernization project, such as the political structure, creation of gendered “citizens,” and the responsibilities of a paternalistic state toward its citizens like education and healthcare.

As part of the project of modernization and democratization of the country, there were attempts to switch to a multiparty system during the single party regime of *Cumhuriyet Halk Partisi* (Republican People’s Party) (RPP) during first twenty years of the republic. After several unsuccessful attempts, *Demokrat Parti* (Democratic Party) (DP) was established in 1946 and won the 1950 elections with a significant majority of the votes (Eroğul 1987, Lewis 2002, Zürcher 1998). DP’s coming to power brought several important changes, together with a break from the progressive elite-driven political apparatus acting on behalf of and for the sake of the nation since the Young Turk era. Their political discourse emphasized rights of the individual and private enterprise, and their populism involved embracing the more conservative views of the rural population as opposed to the modern/Western values of the Kemalist elite; while they favored a radically pro-West foreign policy and an economic policy that favored commercial and rural land-owning bourgeoisie (Ahmad 1993, Eroğul 1987, Lewis 2002, Shaw and Shaw 1977). Eroğul defined the DP period as one of increased economic liberalism and decreased political liberalism, and described the overall situation of in the country in 1954 as such:

Turkey was one of the most loyal friends of the West; rabid anticommunism was rampant internally as well as externally; Atatürk’s policy of ‘militant secularism’ had been set aside; the population was pleased with the general revitalization brought about by economic liberalization, which has not yet caused inflation and shortages, and with the curtailment of the bureaucracy’s power; the opposition had been either eradicated, or appeased by the confiscation of its assets; Menderes’

personal power was on the rise within the DP; and intraparty democracy was being rapidly smothered (Eroğul 1987, 111).

In the following five years, DP rule became more and more oppressive against opposition and the period ended in 1960 with a military coup backed by students and intellectuals. In 1961 a new constitution was passed, which established a second chamber (The Senate) to the parliament in addition to the Grand National Assembly with the aim of counterbalancing its power; founded a constitutional court and broadened the civil and political liberties to an unprecedented level (Keyder 1987, Shaw and Shaw 1977, Zürcher 1995). The more liberal nature of the 1961 constitution contributed to the rise of left-wing politics in Turkey during the 1960s and the 1970s, countered by ultranationalist and Islamist currents. The military gave an ultimatum to the government in 1971, asking for a stronger government to carry out the Kemalist reforms and end the violence in campuses and on the streets between left and right political groups (Ahmad 1993, Zürcher 1995). This memorandum was followed by a period of martial law and military courts, resulting in the imprisonment of lots of student activists, academics and intellectuals and suspension of the freedom of press; and the economic reform program that it promoted favored big industrial capital at the face of the growing labor movement (Ahmad 1993, Keyder 1987). In 1980 another military coup took place, declaring curbing of the violence between the left and right wing groups and bringing order to the country as its aim. The following junta regime and the 1982 constitution aspired to depoliticize the urban youth, by “crushing every manifestation of dissent from the left” and, to a lesser extent, the extreme right, although the ideology of the latter has been adopted in the Turkish-Islamic synthesis (Ahmad 1993).

The last two decades of the twentieth century were the breaking point in the Turkish modernization project, as a number of transformations prepared the shift to “globalization.” On the economic front, the 1980s witnessed the rise of neoliberal economic policies that supported privatization, the rules of the free market, and a smaller state sector, developments in line with the IMF policies, and the plan of situating Turkey in the global economy (Keyder 1999). The imposition of this regime made the country more open to foreign investment and trade, and growing industrialization took place in sectors that demanded cheap labor like textiles. The changes brought increased economic

disparity, with a general decrease in the income of the working classes like state employees, workers and farmers, and an increase in the income of capital owners (Algan, 2003).

The socio-cultural effects are discussed mostly along the lines of the rise of Islamic politics, its reasons and new, post-modern Islamic identities (Göle 1996; Gülalp 2001; Keyman 2000). Gülalp defined the social base of political Islam as “a vertical bloc comprising segments of different socio-economic classes...united in their common opposition to Kemalism and their expression of political will through the assertion of an Islamic identity” (2001, 444). The rise of Islamist politics is also linked to the 1980 military coup that strengthened the Turko-Islamic ideology in efforts of countering the left that had arisen in the 1970s. Rapid urbanization brought the more “traditional” rural population to the cities, which resulted in new definitions of tradition and Islam, and prepared the population base for the rise of Islamist politics that defined themselves with the discourse of economic equality and difference from the “center” (i.e. urban, secular, modern elites of Kemalism), offering the alternative for people living in the “periphery.”

The effects and nature of rapid urbanization are not limited to Islamic policies; and have been quite extensively studied, especially in relation to the squatter housing, urban poverty and creation of urban “zones” of class and lifestyle. Ahmet İçduygu summarized urbanization in Turkey as “...rapid rural-urban migration driven, characterized by a rapid growth, the early stages of the demographic transition, the growth of large metropolises, the lack of basic infrastructure, and the resulting negative impact on human welfare in the cities, such as poverty, unemployment, informal economy, deficiency of housing,” and stated that although it cannot be separated from the larger history of modernity, global factors are also present in the dynamics and mechanisms of urbanization in Turkey today (İçduygu 2004, 942). Keyder, on the other hand, focused on the example of Istanbul to show how the dynamics of globalization disrupted the mechanisms of integration for immigrants, resulting in an “excluded” urban population: structural adjustments of the 1980s decreased formal employment opportunities, commodification of land reduced the possibility of building shantytowns, new economic structures created employment for the new middle classes and women in the service sector but left the unskilled males unemployed (2005).

Further developments related to globalization that caused “fragments of culture” (Kandiyoti and Saktanber 2002) include the “NGO-ization” of civil society (Petchesky 2003), which brought a proliferation of feminist, environmental, and education-oriented NGOs working on social issues that were seen as less dangerous than the politics of the past two decades defined on the left-right axis. These new actors in the political arena with diverse interests and global points of reference created alternative meanings of modernity and deepened the legitimacy crisis of the strong state tradition (Keyman and İçduygu 2003). The Turkish modernization project, once seen as a successful example in the Muslim world, was already criticized by Marxists based on the economic and class structures it created starting with the 1970s. In the 1980s and more so in the 1990s, Islamists, feminists and some other scholars advocating the liberalization of the economy joined the critiques, arguing that the project had patriarchal and antidemocratic characteristics (Bozdoğan and Kasaba 1997).

Bozdoğan and Kasaba stated that as global trends affect the country, the official modernization project remains inadequate “both as a source of inspiration and as a mechanism of control in economics, politics, and cultural production” (1997, 5). However, the issues of Westernization, being modern, and being “civilized” remain culturally salient in Turkey of today, and modernization is a point of reference even for those who define themselves against it. Along these lines, Keyman argued that globalization with its multiple processes functions as the “world historical context in which state-society relations of post-1980 Turkish modernization is embedded,” because of its “potential for undermining the national/territorial constitution of social action” (2000). I believe it is possible to stretch Keyman’s “post-1980 Turkish modernization” statement beyond just the state-society relations and argue for the continuity of the Turkish modernization project on multiple spheres, although transformed by the impact of globalization.

Jung and Piccoli discussed the strengths and weaknesses of the analytical approaches taken in the classic literature on Turkish modernization in the face of postmodern debates concerning modernity. For example, they criticized Bernard Lewis’ *The Emergence of Modern Turkey* (2002) for being part of a tradition of Kemalist dogmas, which “interpret Turkish history with the antithesis of old and new, and while

the Ottoman Empire was ‘traditional’, The Turkish Republic is perceived as modern” (Jung and Piccoli 2001, 12). Eric Zürcher also criticized the narrative in some classical books for talking about late Ottoman reforms as the precursors of modern Turkey in a way that gives Ottoman history a teleological character, turning it almost “into ‘prehistory’ of the republic” (Zürcher 1999, 3). Like Jung and Piccoli, he argued that Lewis essentialized Turkish identity as an inherent entity present in the Ottoman times, waiting to be cleansed and “submerged” through the linear process of the modernization project; and recited three aspects that made Lewis’ book obsolete forty years after it was written: First of all, *The Emergence of Modern Turkey* is an intellectual history, concerning itself mostly with the ideology of the elite, not paying much attention to the social realities. Second, it has a problematic approach to the level of continuum between the Ottoman reform movements and the Turkish Republic, in the way that he sees a break in the national resistance movement in Anatolia and developments before that, disregarding that it is the same circle of Young Turks involved in both movements. As the last and most important point, he criticized the modernization paradigm of Lewis that “sees the history of Turkey in dialectical terms as the struggle of an enlightened elite, which is open to the ideas of the West (the Tanzimat bureaucrats, the Young Ottomans, Young Turks and Kemalists) with representatives of traditional, mostly religious, values” (9-10). Zürcher suggested that starting with the 1980s, historical writing began to recognize the complexities of Turkish modernization and go beyond the black and white descriptions of forty years ago. Part of my insistence on seeing the historical and socio-cultural continuities between “modern” and the so-called “post-modern” stems from a desire to avoid a similar mistake that Jung and Piccoli criticized in Lewis. I have the same concern for being limited to the dichotomies of modern and traditional when talking about menopause and HRT in Turkey.

2.2 Turkish Modernization and Gender

The role of gender as a social and symbolic construct has been explored within other postcolonial modernization projects (Briggs 2002; Chatterjee 1989; Fanon 1967; Paxson 2004; Said 1978; Stoler 1995). The literature on Turkey suggests that women, and specifically, women’s bodies, became symbolic carriers of Turkish modernization

(Abadan Unat 1981; Arat 1997; Durakbaşı and İlyasoğlu 2001; Kandiyoti 2003; Göle 1996/1997; Gürboğa 1996; White 2003). Like all revolutions, the Turkish revolution occurred at the symbolic level, and “women in Republican era constituted one of the basic layers of the symbolization process” (Gürboğa 1996, 38). The individual ideals installed by the modernization project were transmitted through the figure of the emancipated woman, and emancipation was equated with Westernization (Durakbaşı and İlyasoğlu 2001; Göle 1997; Toprak 1981). Furthermore, alternatives to the modernization project, like the Islamist discourse, used women’s role and status to define themselves against it (Arat 2005, 8).

What happened after that first generation in terms of women’s status and identity can be partly tracked via the history of women’s movements in Turkey, which can be divided into five periods according to Zeynep Şahin (Şahin 2004). The first three periods were the preparatory period, which coincided with the Tanzimat era; the Constitutional Monarchy Period, when the first indigenous women’s feminism emerged; and “state feminism,” which began with the proclamation of Republic in 1923 and ended in 1935 when the Turkish Women’s Union closed. Şahin called the fourth period between 1935 and 1980 the “recession period,” a time of abeyance during which women were less visible in the public arena. The last period, referred to as the second wave of Turkish feminism, started with the 1980s and gained momentum in the 1990s “with the impact of globalization and involvement with the participation of Muslim women in the public sphere” (3).

Aside from the women’s movements, literature on women’s identity and status focused on the impacts of political and socio-economic changes like the shift from a one party era to a multi party era, urbanization, migration, and globalization. Ferhunde Özbay, writing in 1990, classified the academic studies on Turkish women in five periods: the 1920s and the 1930s, were identified with a focus on Kemalist reforms and mostly comparisons of legal issues before and after the reforms; the 1940s and the 1950s were the years of village monographs by sociologists and anthropologists; the 1960s and the 1970s were dominated by fertility and family planning surveys; the 1970s witnessed a variety of approaches to the woman question (Kemalist, Islamists and Marxists); and finally, in the 1980s feminist studies officially emerged (Özbay 1990). Similarly, Nüket

Sirman categorized debates around the position of women in society into three critical historical moments: the period of Ottoman reforms; early years of Turkish Republic, and after the military coup of 1980 (Sirman 1989). Furthermore, she theorized about the other political ideologies feminism had to share the same political space with, and explained its relation to these ideologies as such:

In this respect, it has had to carve a space for itself by engaging in debates with two other ideologies that attempt to capture the same political space: left-wing ideologies propounding a class-based political struggle and Islamic discourses. Both Islam and the left in Turkey today have their own recipes for the ‘liberation of women from capitalist oppression’ (Sirman 1989, 2).

This section will follow a historical perspective on the changes in women’s identity and status starting from the foundation of the republic, and stressing the different identities that were formed in different times. I am aware that talking about “woman’s identity” as an unchanging, uniform phenomenon—even when specific to a certain era—is essentialist, reductionist and disregarding of the class-based, religious, and ethnic dimensions of identities. Using dichotomies like modern-traditional carries similar dangers. My attempt to talk about “woman’s identity” in relation to the modern-traditional (religious) spectrum of the modernization project is not a claim to put all Turkish women into the same stereotypical box. However, defining/examining these stereotypes is useful for an analysis of the perceptions of the “modern woman.” One of the arguments of this dissertation is that decisions and beliefs about HRT are partially affected by the way women perceive the stereotype of a modern Turkish woman, and their desire to fit into this stereotype or escape from it. Hence, tracing the historical and cultural story of “modern woman” in Turkey is important for this project.

2.2.1 First Wave Feminism and Tanzimat (1839-1923)

As with the case of general modernization efforts in Turkey, a focus on women and issues related to women in the discussions of tradition and modern can be traced to the end of the nineteenth century. Women’s clothing and veiling practices and polygamy were the important and controversial themes in the modernization/Westernization debates in this era, followed by the education of girls (Şeni 1995). From the first moments of the

discussions of modernization, women's clothing, that is to what extent and how a woman's body should be covered in public, has been the symbol for both supporters and opponents of modernization. This was the beginning of a trend that continues even today, with the headscarf debates. The concerns of this era follow the example of the broader feminist literature on modernization and women in the Middle East (Abu-Lughod 1998; Ahmed 1992; Lewis 2004; Mernissi 2003; Moghadam 1993).

The first wave of Ottoman-Turkish feminism arose in the second constitutional period, carried on through women's associations, journals and magazines. The issues on the agenda for the Turkish feminists of the nineteenth century were the right of education, work, and participation to public life for women and contestation of the traditional role of women as wives and mothers. The movement was "sensitive, on the one hand, to the aspirations of the modernizing bureaucratic elites of the time; on the other, to the nationalist movement developing in face of the crisis of the declining empire; and finally, to the Western feminist movement, which had become visible in many countries with the actions of the suffragettes" (Tekeli 1995, 11). This mix of influences went on to affect the women's identity and the discussions in feminist movements to come in the following years.

2.2.2 Republican Period (1923-1950)

Following the foundation of Turkish Republic in October 29, 1923, a serious project to modernize the country started and it was implemented in a series of reforms. Increasing women's presence in the public realm was one of the important projects of the ruling elite in the republican period (Arat 1997; Durakbaşı and İlyasoğlu 2001; Göle 1996; Kandiyoti 2003; Moghadam 1993; White 2003). The stress on women's rights, and the encouragement for women to be educated and become professionals were all vital parts of the modernization project. Women were given the right to vote in national elections in 1934, before many other "Western" countries, and the secular civil code that was accepted in 1926 abolished some of the unequal practices under the previous Islamic law like polygamy, unilateral divorce, inequalities in inheritance, custody over children and being witnesses for women (Arat 2005, 15). Nevertheless, these reforms were not without inner political conflicts. Actually, women's status was the subject of very heated

controversies in the first National Assembly during the debates on the 1924 constitution (Tekeli 1981, 296). The revolutionary minority that proposed women be regarded as “citizens” not only believed in women’s rights, but saw it as a strategy against the Ottoman legacy:

If the basis of the Ottoman state was religious authority, and if on the other hand women were “the” social category which was most deeply oppressed by this authority, then the importance of the role that the women’s rights movement would play within the struggle of the revolutionaries against the hegemony of the religious authorities was quite evident (Tekeli 1981, 296-297).

Pursuing the question of “what did these men want for themselves,” Deniz Kandiyoti analyzed another side of the issue of male revolutionary reformers emancipating women, with reference to the psyche of male children in the segregated societies of the Middle East like the Ottoman Empire (Kandiyoti 1994). She described the position of reformers as young sons rejecting the authority and life style of their authoritarian fathers who were seen as oppressing their mothers by the sons. In an effort to situate masculinity in the historical and cultural context of a sex-segregated society, Kandiyoti elaborated on the subordinate masculinity of the young boys, experienced in the ambivalence of temporarily living in the secluded world of women and being raised to take part in the aggressive world of men; which resulted in the pro-feminist sentiments of reformist elites as a rejection of their fathers’ domestic arrangements. Although there were undeniably many other structural reasons for the reforms, Kandiyoti’s theory brings an interesting perspective to the issue of gender identities in the early Republican Turkey.

There were also symbolic “firsts” in the period of single party era in the 1930s towards the visibility and presence of the “modern” woman of the republic, like the first beauty contest organized by the newspaper Cumhuriyet in 1929, and the first woman pilot, Sabiha Gökçen. The first beauty contest in 1929 had a “liberating” aspect for repositioning of women’s bodies in a cultural context where “the ability to show one’s self without fear of harm or dishonor was deeply radical” (Shissler 2004, 107) There were the additional elements of nationalism and the projection of a positive “modern” national image in the selection of beauty queens and their attendance to the international beauty contests (112), as well as aiming to “undermine the prudery of the urban lower

middle class and build a sense of confidence among its women” (Ahmad 1993, 87-88). Sheer physical visibility was not the only aim of the Republican reforms; there was also the effort to make women’s capabilities and their ability to perform “masculine” jobs visible. Sabiha Gökçen, who became the first Turkish woman pilot and first woman military pilot in the world shortly after she graduated in 1937, is a good example of a woman that would set example to others in this sense. She was Atatürk’s adopted daughter and was encouraged by him in her career choice.



Figure 1: Sabiha Gökçen in front of her plane⁹

However, all of these developments were happening in a top-down fashion, initiated by the male Republican elite rather than being demanded by women themselves and in contrast to the grassroots movement of the previous era. Although it can be argued that some important reforms like the suffrage and the change in Civil Code were inspired

⁹ Image taken from: http://www.fotoajans.com/turk_unlu/s/turk_unlu_s-i0011.htm

by the demands of the Tanzimat feminism, it should also be noted that the existing women's activism was curbed by the Republican elites when it went beyond what is designed for women or started to be "autonomous" (Arat 2005, 17; Tekeli 1995, 12). For example, Nezihe Muhittin, a prominent feminist activist of the time, was denied permission to establish a "Women's People's Party" in 1923 with the argument that women did not yet have voting rights. The women's federation she was allowed to found instead of the party was also closed (Arat 2005, 17; Baykan 1999; Cindoğlu et al. 2007).

Women were expected to be good citizens, contributing to the prosperity of the nation by being productive in economic life; by being carriers of the reforms through their "Western" appearance and lifestyles; and in the early years of the republic, to produce children as a part of their duty to the war-torn country. White defined the ideal Republican woman as a "citizen woman," who is "urban and urbane, socially progressive, but also uncomplaining and dutiful at home" (White 2003, 146). Kemalism synthesized the "project of civilization and the ideology of nationalism in the new image of women" (Göle 1996, 70). To illustrate the ideal woman of the era better, I will quote Nezihe Muhittin's description of Nakiye Hanım, her uncle's daughter, whom she admired a lot and called as someone having lived the modern woman identity that Muhittin herself has always dreamed of. After praising her for being so altruistic and modest that she distributed the wealth she inherited to the poor and unhappy, and remarking that she had only one dress, and if she had two she used to give it away to someone that needed, Muhittin described Nakiye Hanım's characteristics as such:

She used to send her writings that were as neat as a college educated man to the newspapers and her friends under the pseudonym Zekiye. This young girl, whose brain was as mature as an idealist man's, was a flawless housewife. [She was] clean, industrious; sewed and cooked well, struggled to teach how to read and write even to the servants at home, took care of the sick with heart and soul, sewed for those who could not do it for themselves and helped the poor (Muhittin 1931, 77, in Baykan and Ötüş-Baskett 1999).

Marriage and children were included in citizenship duties. In the early 1930s the parliament was debating a "singleness tax," which would have taxed the unmarried to provide support for women with six or more children, and the government was awarding medals to women with five and ten children (Shissler 2004, 112). Although women were

encouraged to take part in public life and economic activities, motherhood was their “patriotic duty,” and it was to be performed according to the “scientific” norms of Fordist home economics that “taught women modern child rearing, household techniques, principles of hygiene, and Western fashion” (White 2003, 154). Muhittin defined motherhood as “the most sacred and the first duty of Turkish woman in the twentieth century of civilization” in one of her speeches that she also put in her book (Muhittin 1931, 155, in Baykan and Ötüş-Baskett 1999).

The idea of being a good and “modern” housewife was combined with the stress on education, and vocational and technical schools with the names of Girls’ Institutes and *Akşam Kız Sanat Okulları* (Evening Art Schools for Girls), were opened for the purpose of helping women become educated homemakers (Arat 2005, 18). Ferhunde Özbay defined the practice of *kabul günü* (Reception Days) as “schools of modernization,” which signified the enthusiasm women showed about the construction of a new society through changes in their role by being “modern” housewives. Reception Days were gatherings in homes during the day when men were out to work, where women discussed manners, fashion, child-rearing practices and relations among spouses in an official atmosphere (Özbay 1999, 561). Thus did a generation of women take up the double burden of work and homemaking for the love of their country, setting the stage for the continuation of that pattern for the generations to come by normalizing that lifestyle.

The attempts of the Turkish State in the early republican period to increase the population by pronatalist policies was replaced by state-sponsored birth control campaigns as the fertility rate in the 1960-1970s increased. As a result of all these factors, the total fertility rate declined from 7.0 children in the 1940 to 2.6 children in the late 1990s (Özbay 1999, 557). What has changed significantly over time is the state discourse on the number of children. Among the lyrics of a popular national march composed for the tenth anniversary of the republic, there is a line saying: “We created fifteen millions of young people of all ages in ten years.”¹⁰ This has changed into the slogan of “Make

¹⁰ The original of this line is “On yılda onbeş milyon genç yarattık her yaştan,” translation mine.

children not as many as you can, but as many as you can look after”¹¹ in the population control campaigns of the 1980s.

Symbolic expectations alone cannot explain such massive change in sex roles and gender identities, and structural explanations have been advanced. Nermin Abadan-Unat referred to rapid modernization as a causal factor in shifting women’s status and roles, defining other contributing factors in the early years of the Turkish Republic as: “the impact of the national liberation war, the decrease in women’s seclusion and exclusion from public life, systematic educational efforts as a part of a comprehensive Western-oriented modernization program, the shift towards a capitalist economic system, the introduction of new technologies leading to a growth in the industrial and service sectors, the elaboration of national development plans, and the persistence of cultural dualism” (1981, 2). All of these factors (with the exception of war) occurred within the framework of the modernization project, having indirect effects on women’s roles even when they were not directly intended for that purpose.

Encouragement for women’s presence in public had reasons beyond symbolic explanations as well. Part of what is described above as the “impact of national liberation war” was the scarcity of male population, which had an effect on the propagation of the education of women and their participation in non-agricultural production. This period witnessed the growth of an urban intellectual class that enjoyed a high status due to their education, comprised of mostly bureaucrats and loyal to the republican ideology (Özbay 1995, 99). A significant number of these intellectuals and professionals were women: the number of women doctors, lawyers and academics exceeded the respective counterparts in the Western countries.¹² Ayşe Öncü explained this trend, which is anomalous both in contrast to the situation in the Western countries, and against the high rates of illiteracy and labor force participation for women with class inequalities. She argued that alternative explanations for the high number of women in the “classical” professions are access opportunities of upper and upper-middle class women to professional education

¹¹ “Yapabildiğin kadar değil bakabildiğin kadar çocuk,” translation mine.

¹² Yeşim Arat reported that a quarter of medical school graduates were women in the 1960s, followed by about one-fifth of the lawyers in Turkey in the 1970s and about one third of academics (Arat 2005, 19).

and the elite recruitment patterns in rapid expansion conditions of the growing professions, making women's liberation in Turkey an issue of class as well as that of gender:

...under conditions of rapid expansion, the elite recruitment patterns into most prestigious and highly remunerated professions are maintained by the admission of women from the upper classes. Women from elite backgrounds are much more acceptable and less threatening than upwardly mobile men from humbler backgrounds who are likely to be more competitive and achievement oriented (Öncü 1981, 189).

However it should also be kept in mind that these developments were happening in the urban centers, which had a considerably small population compared to the rural areas in these years. Despite the ideals of the republican ideology and the rhetoric that the peasants are the “masters of the nation,” status differentiation between urban and rural, and educated and uneducated women was huge (Özbay 1995, 100). The discourse that was developed about women was centered on the educated, urban professional women as the “visible” side of Turkish women. As Arat stated:

In the homogenizing mission of the project of modernity, differences among women were also glossed over. Educated women professionals, mostly women of the middle class, spoke in the name of other women with ease, without regard to differences in ethnicity, religious proclivities, or class. Those women who happened to be different would be integrated into the project of modernity through education and proper exposure to Kemalist ideals (Arat 2005, 18).

This statement explains the vast literature on modernization and women in Turkey, focused mostly on the middle class, urban professional women. There is little written on the other “invisible” women of the same era. They remain, as Clarke and Montini defined for women as consumers of RU486, invisible and implicated actors of the Turkish modernization project (1993, 64)

Binnaz Toprak criticized this view on women's liberation by the republican elite and the modernization project where modernization was equal to Westernization. She drew attention to the difference between “emancipation” and “liberation,” saying that emancipation was a legal issue which was a prerequisite for liberation, yet changes in legal structure did not necessarily mean social change:

For example, the enfranchisement of women is not very meaningful in a country where women are subservient to the men in their families. Indeed, as a recent survey of Turkish voters shows, within-family voting en bloc for the same party is a common patterns among the Turkish electorate (Toprak 1981, 282).

Şirin Tekeli's study results confirmed a similar tendency in political decision making for Turkish women: according to her data, married couples voted or abstained together, and the party who made the decision was the husband (Tekeli 1981, 308). Toprak, being one of the scholars who work on politics, gender and Islam in Turkey, further argued that any assessment of women's roles in Turkish society should take into account the interplay between secular law and Islamic traditions, for it is possible to understand "the ambiguous position of the emancipated but unliberated Turkish woman" only by considering "the amalgam of tradition and change in the process of modernization" (Toprak 1981, 283).

In spite of all of its problems, the Republican reforms opened domains to women that it was impossible for them to enter before, and women of this era embraced the Kemalist ideology together with the "modern Turkish woman" identity. For this generation, working and being a professional had a meaning beyond making a living. One of the women in this generation, Hamide Topçuoğlu, explained it as " [It was] to be of use, to fulfill a service, to show success. Atatürk liberated woman by making her responsible" (quoted in Arat 2005, 17). Increased presence of women in the public sphere also caused a shift in the definition of gender identities. In the pre-1950 period, women who worked as civil servants or teachers had a high social status due to their education. It was almost that the fact that they were educated and were working made them less "women" in the eyes of the society. Özbay defined these women as "Kemalist women try to look like men, both in behavior and attire" (Özbay 1995, 100). In a country making the transition from a gender-segregated society to a "modern" one, downplaying their femininity was also a way of negotiating private and public realms for some women.

2.2.3 In between (1950-1980)

During the period between the 1950s and the mid 1970s Turkish feminism was considered to be in the doldrums by most scholars (Şahin 2004, Tekeli 1995). There were

women's associations and organizations, but these were "oriented towards philanthropic goals, and they did not have much political objective" (Cindoğlu et al. 2007, 468). Şirin Tekeli stated that in this period most women's associations were founded with the aim of protecting the status quo, where women's acquired rights were dependent on the secular state against the danger of going back to the Islamic tradition. For the urban, professional and educated Kemalist women, the oppressed were peasant women, for they lacked the education and were unaware of their legal rights (Tekeli 1995, 12).¹³ Elsewhere, in her analysis of Turkish women in politics, Tekeli argued that the symbolic role of women's political representation lost its importance with the move to a multi-party democracy after Second World War, leading to a dramatic decrease in the number of women deputies after the one-party era (1981, 300). In this new (multi-party) regime, women candidates lost the privilege of being elected almost automatically, competition between parties turned out to be disadvantageous for women, and the conservative ideology of the Democrat Party affected women politicians negatively. On the same subject of women parliamentarians, Yeşim Arat-Pamuk argued that men play a critical role in drawing women into politics, and that the few women that are elected to political office are introduced to politics by their fathers and/or husbands, and were supported by them (Arat-Pamuk 1990, 30).¹⁴ This situation can be considered as a continuum of the nature of Kemalist reforms, where women are "given" the power and privileges by the males. On the same issue, Tekeli suggested that women involved in politics are subject to different criteria than men in the same position.

...women who are acting against the well established cultural norms of the society are expected to be "exceptional". Exceptionality and over-qualification are the conditions for those women who get involved in politics to be tolerated for their audacity and insolence (Tekeli 1981, 306).

The absence of a strong Turkish feminism during the 1960s and the 1970s, an especially lively time for Western feminism, can be partially explained by the influence

¹³ The belief and emphasis on education as the road to salvation, and especially salvation of women is still a prominent theme in the secular, Kemalist organizations in Turkey.

¹⁴ Yeşim Arat-Pamuk reports that the proportion of women parliamentarians was 4.5 % at its highest, and since 1960 it ranged between 1 and 2% (Arat-Pamuk 1990, 29).

of left-wing politics in Turkey (Sirman 1989). A combination of the 1960 constitution and the effects of the '68 movement resulted in the rise of a strong leftist activism especially among the university youth. The leftist politics of this era was mainly defined along a Marxist-Leninist ideology, anti-American sentiments (especially against the establishment of US military bases in Turkey), and the desire for national independence as opposed to Western (especially American) imperialism. In this political environment, gender and identity politics were seen as secondary to the “main struggle” against imperialism and fascism, and the inequality between sexes was attributed to the general inequality of the capitalist system, to be automatically overcome through class struggle.

Following this line, another identity that emerged in the 1960s and the 1970s was that of “leftist woman,” politically active women who were perceived as “comrades,” and sometimes referred to as *bacı* (sister) by the male activists to emphasize the non-sexual character of their identity (Berktaş 1995, Şahin 2004). The general discourse of the Turkish Left before the 1980s on women was that the oppression of women was due to the socioeconomic backwardness and the dominant feudal relations of the country (Berktaş 1995). Tekeli defines the Marxist analysis of the oppression of women as “fundamentally anti-feminist,” saying that the peasant women as the oppressed group of the previous period of state feminism replaced by the working-class proletarian women, and the only way to end this oppression is to fight against class exploitation (Tekeli 1995, 13). Fatmagül Berktaş referred to the argument of women’s greater tendency to “go bourgeois” that was used as a legitimization to exercise jurisdiction over their dress and behavior, as well as their being an “invitation to the vice,” which resulted in the invention of the term *bacı*. She compares this attitude of “woman is closer to the devil” to the understanding of woman in Islam:

The rustic and folksy-sounding word *bacı*, drawn from provincial speech, denoted and unsexed, depersonalized kind of ‘woman comrade’. Through the slogan ‘The people are my only love and all women are my sisters’, male militants tried to protect themselves against women’s potential for introducing discord (*fitna* in Islam) into revolutionary unity and solidarity. This entire notion was remarkably similar to Islamic ideology’s exclusion and negation of personal erotic love for the sake of maintaining the inner cohesion of the community of believers, but nobody seems to have been struck by the parallels, then as now (Berktaş 1995, 252).

In the period after 1980, the “woman question” came to be accepted by the Turkish Left, — albeit accompanied by a defensive attitude— and addressed by setting up independent women’s organizations (Berktaş 1995). At the same time, some of these politically active women of the 1960s and the 1970s constituted the core of second wave feminism after the 1980s. The political environment in which second wave feminism appeared, in the period when the 1980 military coup banned all political activity and crushed left-wing movements, caused accusations that feminism was “the child of the military coup” (Tekeli 1995, 13).¹⁵

2.2.4 Feminists, the Rebellious Daughters and the post-1980 Era

Although the first generation of elite women in the Republican period (who were sometimes called “daughters of the Republic”) were usually content with their position and thankful to the Republic for the changes it brought (Arat 2005, Durakbaşı and İlyasoğlu 2001), this identity of the Kemalist “modern woman” and the period of “state feminism” was criticized by groups ranging from Marxists to feminists to Islamicists in the 1980s. Second wave feminists argued that the Kemalist reforms did not aim at women’s liberation, but instead made women the “enlightened mothers of the nation” who took on the role of breeding and educating the nation (Durakbaşı and İlyasoğlu 2001), and they defined Turkish women as “emancipated but unliberated” (Kandiyoti 1987). They claimed that the instrumentalist nature of reforms undermined women’s individuality, and demanded respect for their individual rights, including expression of their sexuality and protection from sexual harassment and domestic violence (Arat 2005, 20). These issues were the important agenda items of second wave feminism in Turkey. In fact, the first feminist demonstration that happened in 1987 (and the first street demonstration that could happen after the 1980 coup) was against domestic violence, where about 3000 women demonstrated against wife-beating (Tekeli 1995, 14).

¹⁵ Although there is hardly any literature on the issue, there were also a number of women in the 1960-70s who belonged to the rightist camp, who called themselves “Greywolves” (*Bozkurtlar*) or “Idealists” (*Ülkücüler*). The word used for the women active in this ultranationalist camp was *Aşena*, the mythical female wolf that showed ancient Turks the way out of their homeland in Central Asia.

These women were mostly the daughters of the (educated) first generation, and they took the opportunities that reforms brought as given, focusing instead on the shortcomings of the system (Arat 2005, 20). This second wave of feminism in Turkey corresponded to the highly apolitical post-military-coup era, where almost all political activity was repressed by the government. One argument is that the politically active — leftist— women of the 1970s were the carriers of the second wave feminism, with their experience in activism. Feminist movements were to some extent tolerated in the post-coup period, for they were not seen as “threatening” as left wing-right wing politics. The fact that feminism could develop in the apolitical atmosphere of 1980 coup led to the accusation of feminist movement being the product of the coup, especially by some of the leftist movements. Feminists who used to take part in leftist movements prior to the coup were accused of betraying the cause and feminism itself (along with all identity politics), which was seen as helping the ideology of the coup by diverting attention from the real struggle. As Sirman put it:

The emergence of the feminist discourse in the early 1980s was in fact seen by many sections of the left as a piece of opportunism, a voicing of opinion when other ‘more serious’ voices had been forcefully silenced (1989, 8).

The example of the 1990 Constitutional Court case, where a local court applied to the Constitutional Court for the change of Article 438 of Penal Code and was rejected, and the discussions that followed in the public after rejection, show the issues still prevalent for feminism in the 1990s. The article in question stated, “sentences for the rape or abduction of a professional prostitute could be reduced by two-thirds” (Saktanber 1995, 164). This example also shows the expectations from women of being “virtuous,” and those that are not virtuous enough could be punished.

During this period as well as before, small towns constitute a world different from both rural and urban lifestyles. Mübeccel Kıray argued that there are three distinctively different types of women in Turkish small towns: poorer women who work on the farms and gardens surrounding the town; wives of civil servants and professionals who came from outside; and a third and the largest group that fell in between these two: “wives, mothers and the grown-up daughters of the traders, artisans, shopkeepers, fishermen and people who make up the town” (Kıray 1981, 259). Commenting on her case study

performed in Ereğli, she stated that women were the determinants of consumption in small towns, and “coordinator of delicate relations” between husbands, sons, daughters and others (273).

Almost all of these periods witnessed the emergence of new hybrid identities of women, as the social, economical and political environment changed. Şahin mentioned women who lived in shanty towns (*gecekondu*)¹⁶, a phenomenon of urbanization, as one of these identities: women who lived in the outskirts of the city without becoming part of it, and who labored at unskilled industrial jobs or as domestics in the houses of upper class neighborhoods, employed by middle class professional women (Şahin 2004, 19). Tansı Şenyapılı is another scholar who wrote about *gecekondu* women, with stress on the socio-economic background that places the *gecekondu* women in the context of “her own class or group affiliation” (Şenyapılı 1981, 197). Şenyapılı defined the characteristics of the *gecekondu* women as part of the peripheral labor force that is unskilled, untrained, uneducated and inexperienced; forming primary social contacts with other *gecekondu* women; getting married around the age of 18-20 and giving birth to their first child at the age of 22 on average; leading a regular family life in nuclear families that are reducing in size; being exposed to a mass culture (TV and photo-comics) that stimulates consumption with emphasis on vertical mobility through marriage (1981). Although the image of upward mobility through marriage is not a realistic one because of the social space segregation between classes, it facilitates consumption, which is a channel of integration to the city, through gender identities:

In order to make a match which will provide vertical class mobility, a woman should be beautiful (beauty is only achieved by the use of cosmetics, and by closely following the current fashion), she should be clean and fastidious (achieved through detergents, household gadgets), and she should be obedient. She should remain in the background and never compete with her husband intellectually. The indication of vertical

¹⁶ The word for shantytowns in urban areas in the 1970s and the 1980s was *gecekondu*, which literally meant “made in one night” to signify the hasty (and often illegal) building of houses. This word was replaced by *varoş* in the 1990s, which is a word that includes more references to danger and otherness.

mobility is luxurious consumption. Girls may work, yet only in specially feminized jobs and the aim is to be able to make a match of the type explained above (Şenyapılı 1981, 206-207).

Even though it would be too simplistic to see all gender identity dynamics through the lens of consumption and hopes of vertical class mobility through marriage, it is true that in the 1970s this Cinderella-like myth constituted an important part of the popular culture. These were also the times when a second generation of *gecekondu* dwellers was born and raised, who are the children of immigrants that came to the cities in the 1950s. Their experiences and expectations were quite different from their parents', which led to the formation of a new culture. While the first generation compared their life standards with their former lives in the rural area and found their present conditions more favorable, the second generation who was born in the city and was, on the average, more exposed to the middle class urban life through education, popular media or work relations, and they aspired for better standards of living. This created a certain *varoş* culture, composed of frustration of the young generation and its different reflections.

2.2.4.1 Labor and Class Relations

In numerous studies on women in Turkey, it is stated that contributing to production, whether in the form of formal employment of educated urban middle class women, agricultural production of rural women, or piecemeal informal contracted work done by women in their own homes, did not decrease the expectation that women would be responsible for the housework and childcare. This expectation is a structural similarity across many national and cultural contexts, but the particular ways it is pronounced and experienced in Turkey are going to be explained below. In some cases, it is possible that women's working decreased the amount of men's workload, when the latter remained unemployed, as observed in Günseli Berik's article on carpet weavers (Berik 1995).

Similarly, household technologies that entered the middle-class houses starting with the 1950s resulted in a change in the division of labor among women, rather than decrease the workload significantly or have it shared with men. Parallel to Ruth Schwartz Cowan's study on the change in housework and household technologies in American history, for example, the introduction of washing machines erased the custom of paying for another woman to do the laundry, shifting the management and performance of the

task to middle class women (Cowan 1999, Özbay 1995, 107-108). Although modern household appliances and the accompanying shifts in the design of flats in the same era benefited the middle and upper middle class women's lives, it did not relieve women of the responsibility for managing the housework (Özbay 1999, 565).

One strategy of dealing with the double burden with the increase in women employed outside is delegating "reproductive" work to other women. This led to an age and class based division of labor between the women. The generational aspect of this situation is that older women became increasingly the ones responsible for the household tasks and childrearing responsibilities. They were the ones promoted to the "manager" status in the traditional framework. Once again, the discourse around this division of labor is that of family ties: sons and daughters need their mothers in a world of increased responsibilities. Özbay argued that the cooperation between women (mothers and daughters or mothers and daughters-in-law) in childcare did not mean the loss of power for the older women. On the contrary, childcare is "a prerequisite for the establishment of relations of domination with the younger women," and relations of domination among women are constantly reproduced by the increased number of activities undertaken by women in management of family relations (Özbay 1995, 109).¹⁷

The class-based part of the story was the creation of a non-contracted, non-insured class of women day laborers doing the housework (mostly cleaning) for middle and upper middle class working women, especially in the cities. Şenyapılı explained the emergence of this new class –and gender– based labor relations with the raise of marginal sector for the unskilled and illiterate *gecekondu* women starting with the late 1950s (1981, 207). Although Şenyapılı argued that as the employment opportunities for male *gecekondu* labor increased, *gecekondu* women retreated to domestic spaces. Further socio-economic developments in the following years allowed the continuation of this relationship. For example, the stagnation in the industrial sector after the 1980s had

¹⁷ This responsibility of childcare and assistance to children is a theme that came up frequently in my fieldwork data as an important part of menopausal women's daily life, and was sometimes cited as a reason to seek medical help for menopausal complaints.

negative effects on urban employment, especially for unskilled laborers. Stagnation and unemployment in industry was combined with the decrease of jobs available in public sector, which was the most important source of employment for women. All of these developments led unskilled urban women to switch from formal to informal sector jobs like babysitting, cleaning, or selling the products they made at home. Şenyapılı defined the position of day laborer women as “clear-cut exploitation,” working in a heavy, dirty job where the terms of work are never publicly or legally determined except for some oral contract and work security is nonexistent (207). Although the women in question are working outside their houses, and engaging in a paid-labor relationship defined by the understanding of modernity, the employer-employee relationship is still described in a traditional framework of family ties, but this time imagined ones. The day-laborers usually call the women they are working for *abla* (elder sister), and there is a paternalistic relation between them based on one-sided favors and “generosity” on the side of the employer and loyalty on the part of the employee (Kalaycıoğlu and Rittersberger-Tilic 2001, 155).

In her overview article on urban change in the 1980s and women’s roles, Deniz Kandiyoti grouped urban women into three groups based on class: low-income urban women (who are mostly rural to urban immigrants living in shanty towns), lower-middle class and “traditional” middle class women (mostly married to the small entrepreneurs), and educated middle and upper class women (Kandiyoti 1982). She concluded that low-income women retreated into domesticity and treated their work as temporary in cases when they had to enter the workforce (even when their income constituted the substantial part of family income for extended times), sharing the household tasks with daughters and daughters-in-law in a framework where intergenerational continuity of socialization in the domestic/nurturant role of women is considerable. The lower-middle class women were referred to as the most secluded and least likely to enter employment (especially in small towns), which resulted in their being pushed further away from the decisions over consumption. In the case of professional women, the strains of combining domestic and work-related responsibilities were not deflected onto men but instead were shared among other women who act as “buffers” like maids, nannies, poorer relatives or mothers. Kandiyoti further argued that the male role remained the most unaffected by the

structural changes, and almost all women, including the professionals, defined their roles predominantly in domestic terms.¹⁸

This picture that Kandiyoti presented in the 1980s changed somewhat in the 1990s, with further shifts in low-income women's participation in workforce into the informal and service sectors, in mostly invisible ways. Jenny B. White examined women's participation in the labor market in a globalizing economy in the urban Turkey of the 1990s in her book *Money Makes Us Relatives*, based on her fieldwork done in the late 1980s in the squatter districts of Istanbul. She argued that in the cultural context of the Turkish working-class gender structure "gender, identity, and obligation are drawn together in a finely grained description of small-scale piecework production" (1994, 18). Although women contribute to the local and global economy with their labor, their contributions are devalued as being skills that are "naturally" part of being a woman (like knitting), and their work is defined as helping their family, which is already an emotional obligation that does not need to be paid (Folbre 2001).

It is possible to combine Günseli Berik's article with Jenny White's study, and argue that globalization and/or commodification/capitalism makes women's labor even more invisible, giving them work to do but having it being controlled by male intermediaries, mostly within family ties. All of these contribute to the double burden.

¹⁸ Kandiyoti referred to a study that she performed with mother-daughter pairs in Istanbul in 1978, and says that the "mothers", who were the first generation of the Republican era, responded to the question of how they defined "success" as being "a good mother and wife" (32.9%); "socially active and useful to the community along with being an accomplished housewife" (23.2%); "the ability to combine a career with household duties" (25.6%). Only 12.2% stressed "being self-sufficient and self-fulfilled" (Kandiyoti 1982, 114). At this point should also be noted that in a former article where she presented the data of her aforementioned study, she argued that the mothers' generation represented a special phase of social transition, with high education and employment levels yet traditional ways of marriage and "success" definitions, showing that big social transformations they experienced did not change the traditional expectations rooted in their socialization too much. The same tendency, however, was not observed in the daughters' answers suggesting that they may have different sex role expectations than their mothers even though they shared the same social worlds (Kandiyoti 1981, 257-258).

The situation depends on the centrality of family, discourse of family values, and women's identity as a "good woman," "good citizen," and "good daughter."

In this context paid work in the public domain is transformed into an activity performed in the private domain and defined as part of the familial duties of womanhood. Thus, the forces of globalization makes use of and contribute to the maintenance of family values and gender identities, despite the rhetoric of modernization and being more connected to the world. While consumption gets connected and "global," production of goods and services is limited to the local, and only selectively connected to the market through a gendered mechanism of traditional values. In fact, it would be inaccurate to define the relations between women as producers and the market as "traditional," for they are more characteristic of a transitory situation between rural and urban life (or traditional and modern) than a strictly traditional framework. Another side of this issue is that it is family and kinship that enables people to get over unemployment and economic crises and survive in Turkish context. Family and kinship networks are important in every level of life, including origin-based ones (*hemşerilik*).

Managing the familial relations and informal networks has been another responsibility of women. Reproduction of the informal ties between relatives or extended family and neighbors is important for these networks provide the family in times of need, as well as serving as a base of power for women independent of their own household (Özbay 1995). An example of these intricate "diplomatic duties" of women is Nükhet Sirman's case study conducted in a village in Western Turkey on the networking activities of women in marriage negotiations, and alliance-forming efforts of young brides who start to live in their husband's household (Sirman 1995). Mechanism of the networks that women form are threefold: on the one hand, they help secure the place of the household in the larger community of relatives, neighbors or the village; on the other hand, they describe women's social identities both within the community and the household, and give them a power within the household to the extent that their activities advance the status of the household as a whole.

With the rise of Islamist politics in the 1990s, the figure of a new "Muslim" woman identity also emerged: image of a woman who both lives according to the rules of Islam, and exists in the public sphere, is veiled, and is sometimes even politically active

(Arat 2005; Göle 1996). The Islamic movement of the 1990s in general, and the emergence of the politically active Muslim woman identity are defined as postmodern developments, in the sense that they are reactions to modernization, and at the same time they use “modern” means/tools in constructing their responses (Gülalp 2001). There is much written on Islamist women in Turkey, especially after the 1990s (Acar 1995; Arat 2005; Göle 1996/1997; Kandiyoti 2003; Saktanber 2002). The broadness of this literature is mostly due to the conflict between the modern woman identity of the Republic and the desire of a group of women to accept and in some instances fight for a lifestyle that the reforms tried to undermine for the benefit of women. Some of the themes were the unintended consequences of Islamic women’s political activism (Arat 1995), the way Kemalism, modernism and Islam is seen by these women (Acar 1995; Göle 1996); and in general, an attempt to understand the meaning and the consequences of women furthering and defending a life style that is understood as oppressive and limited for women, despite the years of reforms for women’s rights. As Arat put it, the broader object of this literature is “the conflictual relationship between secularism and Islam in a liberal democracy...through the experiences of the people who live by them” (Arat 2005, 1).

As in the efforts of furthering modernization, women had important symbolic value in this political movement that aimed to further an alternative sociopolitical system. This focus on women for the Islamist movement can be explained by the sensitivity of the Islamic religion towards women’s rights and functions in society since its inception, and the historic place of the issue of women held in the confrontation of secularity of Kemalist reformism and Islam (Acar 1995, 47-48). The discourse of Islamic movement regarding women has been that the modernism and secularism that Kemalist reforms brought about are the reasons for women’s exploitation in Turkey (Acar 1995, 48). Instead of the Western understanding of gender equality, which is criticized for putting a greater burden on women, Islamists have a notion of equality before God on the Judgment Day and complementarity of the sexes in this world (53). According to this “equal but different” argument, women are burdened by being forced to work in jobs that do not fit their natural inclinations. Although the criticisms of Islamist women with regard to exploitation and Westernization paralleled the feminist criticisms of “capitalist usurpation of women’s needs and labor,” Arat argued that their attitude toward feminism

varied from rejecting feminism as a part of “Western” outlook and blaming feminists for being elitists, to a more sympathetic position (Arat 2005, 22-23). In terms of the effects of Islamist activities on women that engage in them, Arat argued that these activities have some unintended consequences such as providing a venue for politicization and a consciousness about individual rights, which might lead to the questioning of Islamic ideology in the long run (Arat 1995). Focusing on the motivations of the Islamist movement in Turkey, Moghadam explained women’s involvement in this movement as “part of the search for respectability and redefinition of status,” including the search for upward social mobility made possible by the “network politics” aspect of Islamist movements (1993, 141).

The most prominent issue around Islamist women’s identity and modernization was (and has been) the headscarf debate, which started roughly in the early 1980s. The “headscarf” in question is different from the traditional way that women covered their heads: the Islamist women wore larger headscarves covering all of the hair as well as the shoulders, whereas the traditional scarves were smaller in size and loosely tied under the chin, usually allowing hair to show in front (Arat 2005, 23). The increasing visibility of covered women in public alarmed the state, leading to a statute that required female employees and students to dress without head covers, and the ban of headscarves in the universities in the 1982. In 1984, in response to the protests of Islamist groups and women with headscarves, *Yüksek Öğretim Kurumu* (Council of Higher Education) allowed *türban*, a scarf tied at the back covering only the hair, to be worn in universities. However, secular groups reacted to this decision, Kenan Evren, president of the time, intervened, and in 1989 the use of *türban* in universities was also banned (24). Islamist women demanding to attend universities with headscarves argued that it was their basic liberty, and that they were discriminated against because of their religious beliefs, which is against the constitution (25). During the long course of this debate, which went on through the 1990s, some secular feminists stood on the side of the covered women, for they were discriminated against not only based on their religion, but also their gender; for Islamist men did not have any difficulty in continuing their education.

One important example that many scholars studied with regard to the Islamist women identity was the political activism of the “Ladies’ Commissions” of the Refah

Party (Welfare Party) in the 1995 elections (Arat 2005). Before the elections, the Ladies' Commissions organized rallies and house meetings, went from door to door to explain the politics of the party and operationalized the personal networks they already had. They played an important role in the party's success in 1995 elections, yet after the elections they ceased to be visible: it was the male elite of the party that held the positions after the elections, and activist women retreated to the "private realm." Arat defined women's organization and activism in Refah Party as an "unprecedented phenomenon," because the number of women members and the role they played preceded any other party in Turkey (8). According to Arat's argument, the success of these women "as a result of crossing the boundaries between the private and the political, secular and religious, democratic and authoritarian, and individualistic and communitarian, " and their failure was due to the boundaries they could not cross, like the glass ceiling between them and the men in the party (10).

No matter which identity we are talking about, the consequence to the specific situation in which Turkish women found themselves from the 1930s onward was "hybridity" in the form of a blend of Western perceptions/stereotypes of femininity and national/traditional identities to differing degrees, in order to respond to all of the religious, secular, and social-structural demands mentioned above. Apart from other realms, these hybrid figures were also available discursive resources for Turkish modernization and modern medicine.

2.3 Turkish Modernization and Medicine

Before the nineteenth century, Turkish medicine "remained faithful to Galen and Avicenna, as Ottoman science to Aristotle, Ptolemy, and their commentators" with some interest in European medicine in the form of documents written by Jewish refugees from Europe in the sixteenth century and some scarce medical works written in Turkish suggesting "an acquaintance with European writings" during the seventeenth century (Lewis 2002, 53). The first Turkish modern medical institution can be dated as early as 1827, with the foundation of *Tıbhane*, the first modern medical school in Istanbul, in line with the reform program of Sultan Mahmud II. In 1832 a military surgery school, *Cerrahhane*, was opened and in 1938 it united with *Tıbhane*, forming the Imperial School

of Medicine (*Mekteb-i Tibbiye Adliye-i Şahane*). In 1866 a civilian medical school was opened as part of the military medical school. Like the reform program itself, medical education was modeled after the European—more specifically French—example, and successful students were sent to France and Germany to further their studies. There was a heavy French influence in the general intellectual climate of the school, which manifested itself in discussions on biological materialism, Enlightenment philosophy and positivism; and debates on whether the language of education should be French or Turkish (Mardin 1996, 240; Shaw and Shaw 1977; Terzioğlu 1998, Zürcher 1998). Following the general idea of learning and implementing Western science to develop Turkish society, medical education contributed to the formation of a political as well as professional identity:

Most of the Muslim Ottoman students entered the medical faculty not only to learn medical knowledge and fulfill a crucial need for doctors in the country, but also to pursue a mission to contribute to the development of modern Turkish science and national reformation and modernization projects both in theoretical and practical terms (Terzioğlu 1998, 19).

Western-style education determined the mindset of the Ottoman elites, including doctors who thought it was their mission to intervene in the country, as well as their patients' bodies, to save them. At times, this “salvationist” responsibility manifested itself in active engagement in politics, as in the case of Young Turk movement that included some doctors and medical students like Adnan Adıvar and İbrahim Temo; and the formation of Committee of Union of Progress (CUP) at the end of nineteenth century. The symbolic interaction between Turkish modernization and medicine can be traced through metaphors, such as the definition of the Ottoman Empire as “the Sick Man” through the last years of the empire by European countries.¹⁹ The overlap between medical and political elites that drove the reforms, and the effects of the positivist ideology of the modernization project that made the elite responsible for shaping/healing the nation (and their patients) created parallel ideological and institutional structures of medical paternalism and state paternalism. Starting from the Young Turk era, the state

19 Yeşim Yasin drew attention to the real “medical” reason behind this metaphor in her unpublished master's thesis, pointing out a series of epidemics like typhoid fever, typhus, dysentery, leprosy, malaria, tuberculosis, smallpox and cholera in Ottoman Empire during the course of nineteenth century (Yasin 2007, 42).

elite was interested in a language of “healing the nation.” In his analysis of the Young Turk revolution Hanioglu pointed to the sources that informed the Young Turks:

All the theories that Young Turks developed and took particular interest in, such as biological materialism, positivism, Social Darwinism, and Gustave Le Bon’s elitism, defended an enlightenment from above and opposed the idea of a supposed equality among fellow citizens (Hanioglu 2001, 313).

Despite his problematic relationship with medical students because of their affiliations with Young Turks as mentioned earlier in this chapter, the reign of Abdülhamit II was a time of medical institutionalization and professionalization. He opened a children’s hospital and founded *Darülaceze*, which is a special institution for babies and the elderly who do not have anyone to take care of them. Apart from his efforts, the smallpox and cholera epidemics and long-lasting wars in the nineteenth century contributed to the developments in health sector, like the foundation of two large-scale hospitals in Istanbul, Çapa and Cerrahpaşa. The Crimean War, fought between 1854 and 1856, was especially important for the establishment of modern nursing, for Florence Nightingale came to Istanbul during this war and contributed to the opening of a nursing school named after her. For other professional developments in nineteenth century, the first professional journal, *Vekayii-Tıbbiye* was issued in 1849 in the military medical school; the first professional organization *Cemiyet-i Tıbbiye-i Osmaniye* was founded in 1866 in the civil medical school; and the equivalent of Red Cross, *Hilaliahmer*, was founded in 1868 (Terzioğlu 1998, 29-31).

During the early years of the Turkish Republic, the development of a state-based health care system was one of the important aspects of the Kemalist modernization project, and “sustained particular formulations of subjectivity and citizenship that were defined in opposition to a set of cultural practices and modes of religious-political authority represented by the ‘traditional medicines’” (Dole 2004, 255). This opposition to “traditional medicines” was in line with the vital position of (Western) science, technology and medicine for the Turkish modernization project, and it underlines the cultural and political authority of Western medical practices in Turkey. In addition to its science-oriented element, Kemalist ideology also had a nationalist character, “which envisioned a broader, more concrete project of a major transformation in various sectors

in the newly defined ‘Turkish society’, where a new identity of “Turkishness” was described” (Terzioğlu 1998, 32). The nationalist and scientific-progressive Kemalist modernization project took a functionalist approach towards the occupational groups (including but not limited to the health professions), all of which should “have sense of duty of serving the welfare of their country” as Atatürk himself stated (33). This approach fit the professional identity of doctors that has been developed since nineteenth century, and carried on to today.

The Turkish National Ministry of Health (named Ministry for Medical and Social Service at the time) was established on May 2, 1920, and was one of the first ministries having been formed: literally days after the opening of first Great National Assembly of Turkey, even before the promulgation of the Turkish Republic in 1923. Primary health issues during the first ten years of the Republic were preventing infectious diseases, decreasing infant mortality and increasing the population, as well as dealing with infrastructural problems like establishing the rules and regulations of a new system, increasing the number of medical staff and extending the medical organization of the state. There was a tremendous increase in the geographical range of healthcare and the number of doctors compared to the Ottoman times during this period. In 1923, an Obligatory Service Law (or Law of Rotation) was passed for the doctors, and those who were sent to less developed areas, especially Eastern Turkey, were provided with incentives. The campaigns against widespread diseases like malaria, syphilis, tuberculosis and trachoma started around 1925 as part of the project of creating a healthy nation (Özpekcan 2001, 105; Terzioğlu 1998, 35-36).

The Public Health Law that was passed in 1930 called for health councils on the provincial and municipal levels and set the standards for sanitation (Shaw and Shaw 1977). The early 1930s was also a time when there were discussions about the quality of university education, including medical schools, was good enough, and a reform project was started in 1933 in the leadership of Dr. Refik Saydam, minister of education of the time. Part of this reform program was to replace some of the professors brought up under the Ottoman system with German professors of Jewish origin who had to leave their country; which created a nationalist reaction among some of the students and other

professors and caused conflicts in medical knowledge and teaching methods (Terzioğlu 1998, 41-43).

The 1940s and especially the 1950s brought a gradual shift from state-led preventive health projects to encouraging private medical practice, although the share of private sector still remained in a ratio of one-fifth of the general healthcare facilities until the 1980s. This shift was partly due to the number of doctors joining military camps as army doctors in the mass mobilization during the Second World War, and partly as a result of the economic policies of the DP government that came to power in 1950. Some structural developments of the era are the founding of *Türk Tıp Kurumu* (Turkish Medical Institution) in 1940, as the largest scale professional organization to the date, and the establishment of a faculty of medicine in Ankara in 1945, with the aim of serving Anatolia, which was mostly neglected during the Ottoman times. In addition to these, a regulation was passed to define the criteria between specialists and general practitioners in 1950 (Terzioğlu 1998, 44-47).

The healthcare system was reorganized after the military coup of 1960, with the establishment of a network of small health clinics throughout the country that increased state control over medicine and rationalization (Dole 2004, 260). Establishment of these new clinics was implemented by the 1961 socialization law, which was a response to the decreased importance given to public health issues during the 1950s. The law had the aim of prioritizing the most disadvantaged parts in terms of access to healthcare with the idea that universal healthcare is the duty of the state, and several pilot provinces were selected to test the plan in the East and Southeast of the country (Terzioğlu 1998, 48-49). In 1965, *Sosyal Sigortalar Kurumu* (SSK) (Institution of Social Security) was founded to cover the health insurance needs of the workers (54). Despite the impressive changes that the 1961 plan brought, there remained (and still remains) a discrepancy in the quality of healthcare between urban and rural areas, and between private clinics and public hospitals or clinics.

Terzioğlu argued that the 1960s reform programs are different from those during the 1930s because they had greater cooperation from the medical students and their professors, and despite that higher degree of collaboration between the state and universities, the 1960s saw the shaping of strong and oppositional political movements among medical students and doctors (52). The rise of political activism in medical

schools is in line with the developments of the 1960s and the 1970s with increased politicization and political polarization in the universities. Based on her analysis of Turkish doctors' self-narratives, Terzioğlu also pointed to the role of professional medical organizations in this process of politicization, where “the chambers of medicine developed a more sharply political discourse which was not limited to the problems and the inequalities in the health sector,” (54) and compared this period to the situation of doctors involved in the Turkish nationalist movement between 1850 and 1900.

After the 1980 coup, along with leftist groups, doctors were blamed by the president of the military regime for criticizing the government and organizing to “bring about anarchy and destruction” despite the generosity of the state in providing educational opportunities for them. In a period of systematic torture allegations against the military regime, many doctors refused to cooperate and give false reports on the health conditions of prisoners, which increased the tension between the government and doctors. This tension resulted in the promulgation of a new obligatory duty law in 1983, requiring two years of compulsory service in the disadvantaged areas of the country for the medical school graduates (Terzioğlu 1998, 56-57).

In line with the economic development and privatization policies of the 1980s, while the share of budget for health sector decreased significantly, new hospitals and faculties of medicine were opened and the capacity of the old faculties was doubled. Without the infrastructural changes necessary to make these efforts efficient, these developments led to a decline in the quality of medical education and public healthcare. With the increased prestige of finance and management related jobs in the new economy, demand for medical schools went down and being a doctor became a less prestigious career (59). The neoliberal policies of the 1980s promoted privatization in healthcare, resulting in a drastic increase in the number of private hospitals, clinics, labs, and private health insurance companies and making the already existing double-standard in healthcare more prevalent. When these developments were combined with the shift in demand for medicine as a career, more people from lower socio-economic backgrounds started to enter the profession and career patterns of the new graduates started to change as academic career became a less preferred path as opposed to working in a private hospital. Compared to the previous generation of idealistic doctors coming from an elite

background, the new generation of medical students was a more heterogeneous and less politicized group aiming to graduate as soon as possible and getting a well-paying job rather than serving (or saving) their country. (60). The rise of Islamist ideology in the 1980s and the 1990s also contributed to the heterogenization in the health sector, with the increased number of medical students who had Islamist views and private hospitals that functioned according to Islamic rules (67-68). Both the government intervention in the cadres of medical faculties and hospitals and the increasing privatization of healthcare has been criticized by the professional chambers which opened again starting with the mid 1980s, although they have never been as politically active as the 1970s (65). In terms of institutional developments, in 1984 an examination of specialization in medicine (*Tıpta Uzmanlık Sınavı* - TUS) was instituted for last year medical students who wished to specialize in a certain field rather than stay as a general practitioner (61). In 1992, a system called “green card” was implemented, which is a card issued to people who are too poor to afford any kind of healthcare and have no other social security; however the implementation of the system proved to be problematic due to the vagueness of criteria and the political corruption involved in issuing of cards (64).

Currently, there are three different types of medical institutions in Turkey: 1) public hospitals, including networks of small health clinics, 2) research (university) hospitals, and 3) private hospitals. Most types of public health insurance are not valid for private hospitals, and only a small percentage of population can afford private health insurance. Public hospitals are usually overcrowded, as are most research hospitals. Specialists are usually either affiliated with a research hospital, or work for private hospitals for financial reasons, or sometimes do both. Most also have their own private clinics. Medicine is an organized profession in Turkey, as demonstrated by the *Türk Tabipler Birliği* (Turkish Physician’s Association). Aside from being the biggest medical professional association in Turkey, it is highly influential and has a public image of representing the “progressive” side of politics. The Association sometimes goes against current politics in the name of defending scientific values, the sanctity of human life, or Hippocratic principles, in issues like environmental effects of a possible nuclear plant or reporting that some detainees have been tortured. The public image of Turkish doctors today is still that of the vanguard of modernization.

2.3.1 Women and Medicine

The non-medical resources on women and medicine in Turkey are quite limited and the literature mostly focuses on the birth control/family planning aspect of women's health. Here I will cite only some examples that reveal the way Turkish medicine perceives women's identity, and the way women and medicine are related both as patients and caregivers.

The book entitled *Türk Kadını* (Turkish Woman) by Nezihe Muhittin, one of the prevalent Turkish feminists in the 1920s and the 1930s, contains some insights into the question of how modern medicine is pertained to the “new woman” identity that she talks about as an example for Turkish women (Muhittin 1931, in Baykan and Ötüş-Baskett 1999). Muhittin criticized the tendency of the new woman to dress, think and live like men, stressing the necessity to address social needs by improving the “real characteristics” of women. She continued by referring to some traditional practices that she found dangerous:

Leaving aside the ability to clean and bandage her child that cut [his/her] hand, that fell down and hurt [his/her] head and foot in a scientific way before the doctor arrives, I am sure that the number of those [women] that were blinded by the old era of superstitions who infect the wound by putting cobwebs or mud on it is high enough to scare us not only in villages but even in most places in cities (Muhittin 1931, 71, in Baykan and Ötüş-Baskett 1999).

She then quoted an interview that she had with Hanife Kadın, a village woman, as an example of the attitude towards medicine in the villages and the extent of ignorance. In these quotes it is possible to see the emphasis on the responsibility of women in healing the minor incidents and doing it in a “scientific” way. The caregiving responsibilities of women are furthered in Muhittin's story on how the most elite women of the country volunteered to be nurses during the Balkan Wars (Muhittin 1931, 101, in Baykan and Ötüş-Baskett 1999); as well as her statement that “The most important role expected from the woman of future is the salvation of our country, and its material and spiritual health” (Muhittin 1931, 124, in Baykan and Ötüş-Baskett 1999).

In terms of women's health in Turkey, Muhittin cited the name of Besim Ömer Paşa –calling him “the first male feminist,” who studied women's health, founded the

Red Crescent²⁰ Women's Center and wrote books with titles like "Giving Birth," "Scientific Marriage," "Child Congress," "About Caregiving," "Red Crescent Conferences," "Women's Diseases," "Danger of Tuberculosis," and "Infertility" (Muhittin 1931, 102, in Baykan and Ötüş-Baskett 1999). Especially the titles of these books give us an idea about the important women's health issues of the time.

In her discussion on religion and Turkish women, Binnaz Toprak gave the example below to show that ambivalent attitudes toward sex differences can still find public expression 40 years after Kemalist reforms:

For example, none other than a Prime Minister of the Turkish Republic, Professor Sadi Irmak, stated in a press conference during his term of office in 1974 that speaking as a medical authority, it is biologically natural for married men to be polygamous provided that their wives do not find out about it (Toprak 1981, 290).

Toprak's comment on this statement is that although it does not make sense from a medical point of view, it makes sense "as a prototypical attitude of formally accepting women's rights but tacitly supporting the allegedly intrinsic inequality of women" (Toprak 1981, 290). Beyond the issue of publicly supporting inequality, I find this statement also an interesting example of the way medicine was and is used to legitimize "intrinsic" inequalities, which is an issue taken up by feminist science studies literature (Hubbard 1995; Lowe and Hubbard 1983; Keller and Longino 1996).

Sabahat Tezcan's article reporting on a series of local studies done in Sincan, Yenikent and Etimesgut (all districts of Ankara) in the 1970s is an example of fieldwork done on women's health in Turkey. According to the data from these studies, Tezcan summarized the underlying reason for the health problems of married women at fertile ages as such: "the absence or inadequacy of pre-natal care; undiagnosed or untreated conditions during pregnancy; having a delivery or abortion without the assistance of trained health personnel and under unsanitary conditions; short intervals between pregnancies; and starting work shortly after a delivery or an abortion" (Tezcan 1981, 99). It should be noted that this article was published before the 1983 legal changes that allow abortion in the first ten weeks of pregnancy, and was written at a time when abortion was

²⁰ Red Crescent is the equivalent of Red Cross in Turkey.

only legal in the case of threat to maternal health or of delivery of a malformed child. Tezcan stated that this condition led to widely practiced illegal abortions, which further deteriorated the health conditions of Turkish women (Tezcan 1981, 100-101, Türkiye’de Kadın Bilgi Ağı 2007). This change in abortion law signifies the attitude of the state about the fertility rate as well as being an improvement for women. In a more recent study done on the rates of abortion before and after the legal regulation of induced abortion, Işıl Maral et al. (2007) did a questionnaire with 2455 women in Ankara, and concluded that the rate of abortions increased after the passing of 1983 law.

In the same volume with Tezcan, Ayşe Baysal reported common nutritional problems of Turkish women and their underlying causes. According to the data she presents from studies done in the late 1970s, the most important nutritional problems are iron deficiency anemia,²¹ endemic goiter mainly because of iodine deficiency, dental caries, vitamin deficiencies, and being underweight (especially when pregnant or lactating) or overweight (Baysal 1981, 109). Baysal attributed these problems to food consumption habits, like high carbohydrate and low protein intake.

A more recent example is Dilek Cindoğlu’s article entitled “Virginity Tests and Artificial Virginity in Modern Turkish Medicine” (1997), where she addressed the relation between modern Turkish medicine and the two medical procedures that mainly stem from patriarchal expectations about women’s virginity: virginity tests and virginity surgery. Based on interviews with ob/gyn practitioners, she concluded that medicine plays an important role in controlling women’s bodies, and even though virginity repair surgeries can be seen as women’s increased control over their own bodies in a patriarchal society that force them to abstain from sexual intercourse before marriage, it is far from their emancipation from patriarchal control. Rather, the author described the procedure as “a strategy to gain position in a patriarchal society,” and “to combat the patriarchal expectations of the family and society without comprising their desire for a premarital sexual relationship” (Cindoğlu 1997, 260).

²¹ Baysal reported that according to the results of the National Nutrition-Health and Food Consumption survey done in 1977, approximately half of preschool children, pregnant and lactating women were anemic, in comparison to very few anemic adult males (Baysal 1981, 109).

2.4 Conclusions

Modernization such as Turkey has undergone in the last two hundred years, is a multi-faceted phenomenon, which evokes very different reactions. Many of these reactions, even if they are advertised as “Islamist” or traditional, do not necessarily signify rejection of the modernizing process. They may even be the form in which modernization can most successfully penetrate an Islamic society (Zürcher 1999, 12). Jung and Piccoli stated that the term “modernity” denotes a structural discontinuity from the past, and modernization has been an uneven yet global process from the start (2001, 13). Following their claim, I would like to argue the separation between the concept of modernization and the process that is called postmodernization by some, and globalization by others is not that sharp. In *Istanbul*, Keyder asked about the relations between the globalized and its implied “other,” and criticized the way of thinking that treats these as non-changing entities:

Does globalization create an ordered duality where there is a constant stream of defections to the globalized sector and what remains behind diminishes in scope? Or, is it the case that the material transformation engendered by globalization is necessarily limited and self-enclosed, leading to a permanent dividedness between a globalized enclave and its excluded and oppositional hinterland? The duality implied in these questions ignores the way in which globalization changes the nature of the division. The line between the included and the excluded is continuously redrawn (Keyder 1999, 194).

It is possible to follow this continuous redrawing of boundaries between the modern and pre-modern, and post-modern through the gender roles and relations in Turkey during the process of modernization. As noted earlier, this fluid situation creates hybrid identities and varying responses that accommodate modern and tradition at the same time, and affects the way women interact with illness, medicine and doctors. With that background, the approaches to menopause and HRT as a category and a technology that has been constructed with the colors of global pharmaceuticals carry the traces of traditional, modern and global/postmodern with varying degrees. In the arena of menopause, old and new gets mixed, traditional blends in with the modern and the discourses of the modernity project are redefined as part of the marketing strategies of globalized pharma.

3. Menopause: One Period, Many Names

As I was writing this chapter on the different meanings of menopause in cross-cultural and Western medical contexts, I was invited to a musical in Albany, New York by a friend who knows about my research subject. The play, called “Menopause the Musical” with the subtitle “The Hilarious Celebration of Women and the Change,” was based on the conversations of four women from different backgrounds —defined as Professional Woman, Soap Star, Earth Mother and Iowa Housewife in the cast description—meeting at a department store and sharing their experiences of “the change.” As can be guessed from the names, they were the stereotypes of two urban and two rural characters, defined by their concerns for career, beauty and youth, family and spirituality. Their experiences focused mainly on hot flashes and night sweats, and to a lesser extent, on mood swings, aggression, forgetfulness, weight gain, urinary incontinence and sexual problems like husbands not wanting to have sex as often as they did before. The general approach to these issues was humorous, encouraging women to love and accept themselves and their bodies in their “changed” state. The specific anecdotes and complaints boiled down to a common account of women struggling with menopause as a medley of vasomotor symptoms and other bodily disturbances, and as a marker of aging. There was very little mention of drugs, except for one skit where three women mentioned the name of various anti-depressants that their doctors prescribed them and the fourth one, who is the parody of a middle aged hippie (Earth Mother), mentions an herbal extract. The script portrayed a picture of menopause with no HRT, fear of osteoporosis, sadness in the face of loss of fertility, obligation of care for elderly parents or the imperative for yearly mammographies. That Saturday night the theater was full of women, most of whom were above forty. As the four characters of the play made jokes and sang re-lyricized versions of popular songs—like “Stayin’ Awake”—for an hour and a half, they laughed and cheered loudly, with profound joy. The few middle-aged men, most of whom accompanied women, appeared silent. As we were driving home, my friend, who is a Turkish man in his mid twenties, said that the play made him aware of certain things about menopause that he had not known, and admitted that he felt a little uncomfortable and out of place.

Menopause the Musical serves as an exemplary text illustrating US-based cultural understandings of menopause, which have been constructed through the interaction of Western medical discourse, the impact of feminist movements including the women's health movement, and a culture that values independence, individuality and —especially in women— a youthful appearance. However, the cultural meanings that circulate in the United States have been “globalized” through medicalized language of menopause, as well as the values and meanings of femininity, menstruation, aging and health mobilized in popular culture. I will explicate how these circulating meanings are embedded in the Turkish cultural context in the next three chapters. In this chapter I will illustrate this interwoven texture of meanings that are related to menopause in cross-cultural contexts, with an overview of the relevant literature and a brief history of the medicalization of menopause, with an emphasis on the North American scene.

There are several threads that I want to unravel regarding the cultural meanings of menopause. First of these is the notion of “critical points” in a person's life course. A second thread that I follow concerns the cultural and symbolic value of blood and menstruation; the meanings around bleeding, and lack of blood, and more generally, what blood signifies. I will elaborate on these two threads in the first part of this chapter, in which I discuss the concepts of liminality and pollution. Thirdly, I explore the meanings of femininity and the feminine body defined in relation to others of social significance. Women's bodies are defined in relation to those of children, and in most cultures, with their social roles within the family. This thread will be examined in the second part of the chapter. The third section presents the history of how menopause became medicalized in the Western world, and traces social responses to this process of medicalization.

3.1 Liminality and Danger

In his classical study entitled *The Rites of Passage* (1960), Arnold Van Gennep examined ceremonies in different cultures that accompany an individual's life crises. He called these ceremonies “rites of passage,” and argued that there are three major phases through which all rites of passage proceed; that of separation (preliminal rites), transition (liminal rites), and incorporation (postliminal rites) (Gennep 1960). Here, liminality denotes the intermediate stage or period where an individual is in between two social

worlds. There is an element of liminality in certain phases of an individual's life, and these are socially marked by specifically designed ceremonies. First, one is separated from a situation to which they once belonged such as of childhood; then they linger in an "in-between" stage such as adolescence; and finally, they are integrated to the category to which they belong to from that point on, like that of adulthood in this example. Genep examined this process of passage in several different points of life through the book: integration of a stranger to a group, pregnancy and birth, birth and childhood, betrothal and marriage, and funerals.

My study of menopause draws upon Van Genep's concept of "territorial passage." Van Genep explained that "prohibition against entering a given territory is...intrinsically magico-religious" (1960, 16). There is a neutral zone between two (or more) territories which is sacred for the inhabitants of both (or all) sides, and whoever happens to be in the intermediary zone is also considered to be in a special situation. Genep argued "this symbolic and spatial area of transition may be found in more or less pronounced form in all the ceremonies which accompany the passage from one social and magico-religious position to another" (18).²² Like in spatial/territorial passage, a person in a liminal social stage is also attributed special qualities associated with the liminal position itself. Rites of passage are designed to ease this passage and make sure the transition is smooth. Among all these passage points, he mentioned menopause and aging very briefly:

There do not seem to be any rites of menopause, or of the graying of hair, though these both mark the beginning of a new phase of life which is very important among the semicivilized. In general, either old women become identified with the men and therefore participate in their ceremonies, political activities, and so forth, or they acquire a special position within their own sex group, especially as ceremonial leaders. Old age brings increased social standing for the men (Genep 1960, 145).

In her book *Purity and Danger*, Mary Douglas also emphasized the element of power and danger in liminality. Although her main point was to explain the concepts of pollution,

²² Another important scholar who wrote on the issue of liminality is Victor Turner, who borrowed Genep's definition of liminality and expanded his theory (Turner 1967/1969/1974/1982/1987). I chose to refer to Van Genep's description as the first author to coin the term.

purity and taboos, she came to the conclusion that what lies in the core of taboos and beliefs about pollution and purity are the concepts of ambiguity and abnormality (Douglas 1978). She defined dirt as “a matter out of place, the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements” (Douglas 1978, 44). She attributed a chapter on powers and dangers of transitional states in which she elaborated on pregnancy, menstrual blood and puberty rituals as moments of vulnerability that contain powerful and potentially dangerous situations and concepts:

Danger lies in transitional states, simply because transition is neither one state nor the next, it is indefinable. The person who must pass from one to another is himself in danger and emanates danger to others (Douglas 1978, 119).

Douglas pointed to a contradictory aspect of pollution/dirt: Impurity, or more generally anomaly/liminality, which is normally something destructive, can sometimes become creative. Dirt is defined as “formlessness” and thus founds a desire to categorize and order things, to produce a meaningful world. Douglas defined this creative potential as such:

In its last phase, then, dirt shows itself as an apt symbol of creative formlessness. But it is from its first phase that it derives its force. The danger which is risked by boundary transgression is power. (Douglas 1978, 199)

I believe it is possible to interpret both menstruation and menopause in terms of liminality and territorial passage: Menopause is the end of a cyclical life, which was defined by monthly periods of liminality. Menstruation itself is pollution, and it is both powerful and dangerous because of this liminal position of being in between fertility (the possibility of bearing a child), and death (bleeding as a sign of lost probability of pregnancy). It signifies both hope and despair. There is the dualism of chaos and order here: chaos also carries the potential for creation, for fertility.

An example of the chaotic meaning of menstrual blood and the attempt to control this chaotic nature can be seen in the Babylonian myth of creation, the tale of Tiamat and Marduk as told in *The Curse: A Cultural History of Menstruation*. According to the myth, Tiamat is the Mother of All, and the symbol of chaos, who creates monsters with

poisonous blood and unleashes them to the world. She is defeated and her body is split in two by Marduk, her son, who is the ordering principle. This suggests that: "...before he himself can come into power, the male must subdue and divide the body of woman, whose danger lies in her unpredictable fluid" (Delaney, Lupton and Toth 1988, 188). The danger stems from the creating nature of woman, for "...the power to create suggests the power to destroy" (11).

Authors of *The Curse* explored the cultural meanings of menstruation in time, mostly in the Western tradition. Along with providing knowledge or analyzing the issue, the authors had an additional agenda of challenging the "taboo" nature of menstruation, ceasing its cultural construction as "the curse." They elaborated on different aspects of menstruation, like the menstruating woman in popular imagination, menstrual images in literature, menopause and the concepts of cycles and rhythm in men; as well as explaining the taboos about menstruation, relating it to the threatening power of the menstruating women. As for the taboos, the danger is most prevalent for men, since they are the makers of the rules, and the "unruly" situation of menstruation threatens their order. That is why most taboos of menstruation concern sex, cooking and/or food preparation, which are the two prominent ways through which men come into contact with women. (4-10)

According to Delaney, Lupton and Toth, the idea of stages in a woman's life is also present in the phases of Io/the Goddess, which are represented with the colors white, red and black. This cosmology depicts menstruating woman is in the red phase, while the menopausal woman is black:

In these two tales, the colors associated with the Great Goddess are being used to suggest the eternal feminine cycle. Lederer refers to Io, the cow, who changed her color from white to rose to black, and associates her with the new moon (the White Goddess of birth and growth), the full moon (the Red Goddess of love and battle), and the old moon (the Black Goddess of death and divination): virgin, nymph, crone, the three aspects of the Great Goddess. Most heroines of tales are presented to us first in their white, or virgin, state. After they fulfill conditions of seclusion and trial and ride off with the prince, they are associated with the color red, or nubility; and all have a brush with transformation or death, which brings them in touch with the black. (Delaney, Lupton and Toth 1988, 166)

There are different sides, or facets of the “woman,” associated with different periods of her life, and her reproductive history. In a way, every woman has the potential for growth, love, destruction, death and divination. The color black, which depicts the menopausal woman, signifies both death and divination; it is both beyond mundane “life.” Women in this stage acquire a sense of reverence along with the negative feelings of death and destruction. They fit the cultural prototype of the “wise old woman.”

If we define menstruation as a liminal period, menopause is in a way the end of that liminality, ending the chaos and establishing order once the possibility of fertility, which is one of the poles of that ambiguity, is ceased. A post-menopausal woman is no longer dangerous, or periodically polluting. However, menopause itself is also a liminal phase, a moment of passing from fertility to infertility, somewhere in between the red and black phases of the Goddess.

All these theories and arguments cited so far are broad generalizations and categories that must be applied to menopause within specific cultural contexts. Carol Delaney’s essay on menstruation in a Turkish village is an example of this approach. She defined the entire system of menstrual taboos as “...an elaborate denial of the awesome power of women to bring forth life and a response to and prophylactic against the mess, fluidity, and change that are its inherent characteristics...Instead of affirmation there is a fear of the mutability of life and a desire to keep it under bounds and under control” (Delaney, Lupton and Toth 1988, 92). It is possible to see in this statement Douglas’ definition of pollution: in the presence of phenomena that are “out of place” or unstable, there is the effort to put everything in its place, or at least contain the liminality. Menstruation is one specific example of an unstable situation. It is crucial to situate the meanings of menopause within the cultural context in which women experience this period.

3.2 Situated Menopause: Cross-Cultural Analyses

Meanings around menopause are constructed in relation to many different factors. First of all, there are the meanings produced in relation to femininity and reproduction, with menstruation defined as the “opposite” of menopause. Another aspect of the cultural construction of menopause is related to how aging is perceived and experienced

differently according to the gender, class, or culture of the subject in question. It is important to consider all these layers in understanding a woman's experience of menopause, and her response to it. Context becomes important at this point, and one of the mistakes that both medical practitioners and anthropologists sometimes fall into is to treat menopause, or aging in general, as if it is a uniform or "universalistic" experience. Looking at the ways menopause, aging, and other aspects of reproductive life are lived out within different cultures illustrates the variety of experiences within specific institutions.

Although not directly on menopause, Lawrence Cohen's *No Aging in India* is one such study. Starting from the construction of Alzheimer's disease in the North America as the pathological side of being old, which isolates the old person in question and focuses on the particular body; the author contrasted this "disease" with the definition of *seva* (service to, and respect for aged parents as a domestic duty) and "Bad Family" in India when talking about senility, which places old people in an interrelated context of family (Cohen 1998). He emphasized that there are also differences of gender and class in determining what "old" is, and how old person's voices are heard, as well as the efforts of drug companies to create an awareness of Alzheimer's disease in order to penetrate the Indian market, especially by focusing on the concept of memory, which he defined as another important theme in postcolonial India. What makes these concepts and experiences different, first of all, is the relational context in which people define themselves and others, as opposed to the more individualistic approach of European/American culture. Another important aspect is the particularities of postcoloniality in India, and the realities of a modernizing, urbanizing country.

Since the book is primarily on aging and senility, there is little direct reference to menopause. Cohen stated that menopause started to emerge as a medical problem of middle-class Indian women in the 1980s, requiring psychotropic medicine. In that pathology, hysterical aspects are stressed, "implying an opposition of cognitive male versus embodied female age reminiscent of earlier European climacteric language" (Cohen 1998, 208). Referring to Margaret Lock's famous study on menopause in Japan, which will be examined below in detail, he further argued that:

Medicalization, less of the menopause itself than of the postmenopausal body as a tremendous market for hormone therapy, may well change middle-class women's negotiation and experience of the body in middle age, with the more far-reaching consequences Lock has outlined in the case of Japan (Cohen 1998, 209).

Another study on a similar subject was done by Brian du Toit, this time on the climacteric experiences of Indian women living in South Africa (du Toit 1990). After a medical description of climacteric, and social, historical, demographical information on the South African scene and Indian population living there, the author examined the gender identity, lifestyles, life course, health perspectives and approaches to menopause of Indian South African women. He compared data from two groups of women: one in the pre-menopausal stage, and the other in the post-menopausal stage. There was, naturally, an age difference between these two groups as well. As a result of an in-depth analysis of different aspects of these women, he came to the conclusion that menopause, for both groups, was more of a status change rather than a procreative marker. There are generational differences as well, like attitudes about sex, and views on menopause:

For the older category, the role of old woman is accompanied by mature children, grandchildren to spoil, and preparation for death. Age fifty to sixty was seen old, and women became sedentary. Among the younger cohort, age is relative. Better education and jobs outside the home have expanded their vision and given them a new perspective on women's status, opportunities, and roles. According to them, women who have completed their reproductive years are not old, nor they are through with living (du Toit 1990, 290-291).

Here it is clear that generation can also be a variant in views about menopause, along with other changes coming with the generational difference in a modernizing country, or for the migrants coming to a different country than their own; like urbanization, education opportunities, or other changes in lifestyle. I encountered a theme of generational differences in attitudes toward menopause in my fieldwork as well. Similar to the findings in du Toit's study, rapid social change, modernization and urbanization affected the way menopause is perceived in Turkey, as will be discussed further in the next chapter.

Heather Paxson's *Making Modern Mothers* is another cross-cultural study of the mobilization of cultural meanings related to specific aspects of femininity. Although it is

not directly related to aging or menopause, it is useful in showing how meanings of motherhood are constructed in a modernizing country, and how these can be different from the more “Westernized” versions (Paxson 2004). She approached the subject from the point of view of ethics, and analyzed the family planning methods in Greece, and their relation with the role of motherhood. All of these are determined by gender identity, being “Mediterranean,” Orthodox Christianity, efforts to be recognized as part of Europe and the European Union, Greek nationalism, and population policies. Paxson stated that motherhood in Greece is influenced by the state policies against an aging population and a falling population growth rate. There are also the growing pressures of modernity and urbanization, which have raised expectations in ways that make it more difficult to raise children. This situation has brought about a shift from an “ethic of service” (motherhood as a duty) to an ethic of choice (motherhood as an option), and from there to an ethic of well-being (motherhood as a planned, rational choice). Motherhood is seen as the completion of womanhood, even by women who do not have children and do not think of having any, in a culture where gender identity is defined as a performance at which one should perfect. Abortion is a favored way of family planning, and in Greece it does not have the same negative baggage as it does in North America. Here it is possible to see the connection between culture, gender roles, the role of religion and the use of contraceptive technologies.

In the realm of social sciences literature on menopause, no book has been more influential than Margaret Lock’s *Encounters with Aging*, where she compared the medical discourses with women’s discourses about female aging in North America and Japan, aiming to show the permeation of culture by scientific discourse (1993a). According to Lock, there is an overwhelmingly negative discourse on menopause in North America, which emphasizes pathology and decrepitude in ways that stem from the beliefs that regular appearance of women over fifty years of age is an anomaly against nature, and that female life is just about the reproduction of the species (332-334). Aging and menopause are defined as pathological via a medical understanding in which pre-middle age body chemistry is taken as the standard measure of “normal,” and it is assumed that the female body needs outside intervention in order to stay healthy during and after menopause. Lock located debates on HRT, both inside medical circles and between

medical authority and women's circles, within the triangulation of interests among gynecologists, laboratory scientists, and pharmaceutical companies. She argued that older women are assumed to be essentially anomalous:

The universalized oddity of the aging, failing, potentially costly, white, middle-class female body is the target of medicalization, and individual women are required to calculate in terms of risks and benefits how they measure up against her (Lock 1993a, 345).

A different perception of the older women is prevalent in Japan, where the burden of care for the elderly falls upon middle-aged women, because of Japanese family culture and governmental efforts to use that ideology as a kind of welfare policy. Menopause is seen as a disease of urban housewives with too much time on their hands. As opposed to the North American example, aging is not seen as an anomaly or pathology, and the climacterium, which is called "konenki" in Japan, is not necessarily seen as related to the end of menses. The discourse on konenki is the account of an "unstable" body, rather than being related to the reproductive function or organs. Both doctors and patients are skeptical about HRT, which is a reflection of the lack of availability of the pill in Japan, and suspicions about its iatrogenetic effects. Lock argues that in both these discourses the subjective experience of the aging, and the economic constraints of women are ignored. Women are reduced to a uniform mass.

Unlike Lock's nuanced and robust analysis of menopause and medicine, one problematic side of some of cross-cultural analyses is a tendency to romanticize non-Western medical practices, and a tendency to jump to conclusions considered valid for anyone just by looking at some examples at hand. Judith Marmor's study on the health seeking behavior of Turkish women in Berlin displayed these tendencies, although the author stated that conventional expectations were not borne out (Marmor 1988). First, there was the assumption that these women will prefer a home delivery; and second there was the assumption that they will be avoiding male doctors because of the traditional-religious concerns. Both of these turned out to be wrong according to the findings of this study, as the following excerpt illustrates:

Although one might expect that Turkish women might be more comfortable with a home delivery, surrounded by female relatives and a familiar environment, one woman had a simple explanation for the easy acceptance of hospitalized delivery: anyone who had ever gone through a

complicated delivery in an Eastern Anatolian village would jump at the chance of modern medical assistance...Physicians are outside the normal realm of male-female relationships. Thus it is acceptable for Turkish women to go to their doctors without being overly worried about their reputations – a legitimate way of escaping from confines of the apartment (Marmor 1988, 92-96).

This quote brings a different perspective to the medicalization arguments that portray patients as victims with no agency at the face of a powerful medical system. The same arguments and counter-arguments can be valid for medicalization of menopause; like the argument that menopausal women on HRT are the victims of a medical system controlling their bodies and the counter-argument that the decision to take or reject HRT is more complicated than just buying into the dominant medical paradigm. I will elaborate on different approaches to HRT in feminist literature later on in this chapter, which ranges from seeing HRT as yet another tool for medicalizing women's lives for the benefit of their husbands and profit of pharmaceutical companies to welcoming it as a helpful technology liberating women from the confines of their own biology.

3.3 Medicalization

The term medicalization has numerous definitions, and the one employed in this dissertation is borrowed from Maren Klawiter

As a concept, medicalization refers to the process through which phenomena are literally “made medical”, usually by applying a medical “frame” or definition to a particular problem. Medicalization thus includes the “extension of medical jurisdiction” and the “expansion of medical boundaries”, as well as the processes of medical naming and diagnosis. Medicalization can occur at different levels and within different arenas: the conceptual, institutional, and the interactional. At the conceptual level, medicalization consists of the use of a medical model or vocabulary to identify or define a problem, even in the absence of the involvement of medical professionals and organizations. At the institutional level, medicalization refers to the involvement of medical personnel, organizations, and institutions in the legitimation, definition, or treatment of a particular problem. At the interactional level, medicalization refers to the interpersonal interactions and processes through which conditions are constituted as medical, usually via the physician-patient relationships (Klawiter 2002, 311-312).

This rather lengthy definition allows me to talk about different faces of medicalization, different conceptual, institutional, and interactional levels of it, and different arenas in which medicalization takes place. I especially focus on the conceptual level of medicalization in this dissertation according to Klawiter's definition, and elaborate on the ways in which menopause came to be understood as a period of time requiring increased and sustained medical supervision. As one of the first authors writing on medicalization, Ivan Illich showed how certain phases of life (including menopause) were defined as "age[s] of risk," and argued that stages of life have always been ritualized, yet their medicalization is new (Illich 1976, 78). The medicalization of menopause provides a particularly clear example of the medicalization of a stage of life. There has also developed a complementary literature on how female body has been the target of medicalization to a greater extent than the male body. Reproductive processes of women's bodies, like pregnancy, childbirth and menstruation, have been particularly prone to medicalization. Examples include the development of contraceptives for women, construction of premenstrual syndrome (PMS) and postabortion syndrome, increased number and acceptance of hospital births, and most recently, the arguments around "female sexual dysfunction" (Figert 1996; Tiefer 2004).

The concept of "risk" is a key one for the medicalization of menopause. Throughout the process of medicalization, the language of risk is used by different groups for different arguments, from defining menopause as a time of risk to portraying menopausal women at the risk of long term and serious health problems like osteoporosis and heart disease, to weighing the risks of undergoing the treatment with its potential benefits for individual women.²³

It is a common argument in the Western medical and popular literature that menopause came to be a problem—or was even brought into being in the first place—because of life expectancy increases in the twentieth century, which allowed women to

²³ I will return to the theories on risk and the implications of this concept for menopause in the concluding part of this chapter.

live beyond their reproductive years.²⁴ Elizabeth Watkins, another scholar who wrote on the history of HRT, traced this argument to E. Kost Shelton, who was a “clinical professor of medicine at UCLA and director emeritus of the Endocrine Clinic of Los Angeles General Hospital” (2007, 44):

To build his case that estrogen-starved women represented a new and pressing problem in America, Shelton distorted the meaning of the change in life expectancy from 1900 to 1950. By stating that “women now live a quarter of a century longer than in the year 1900” (life expectancy was 48.7 years for females born in 1900 and 72.4 for those born in 1950), he implied that very few women lived past the age of menopause at the turn of the century. In fact, many women did survive well into their seventies and even eighties; the average age of life expectancy took into account females who died in infancy and during childbirth (Watkins 2007, 46).

The definition of female life after reproduction as an “anomaly,” and the acceptance of male aging as less problematic, covertly implies that the central aim of woman’s existence is reproduction (Lock 1993a, xxvii; Martin 1987). Though it is tempting to explain the medicalization of menopause by resorting to the explanation of misogyny, the picture is more complex. One of the best summaries of the medicalization of menopause in the North American context comes from Margaret Lock:

A potent fear of aging, coupled with a quest for immortal youthfulness and sexual desire, seems to be driving the medicalization of menopause. Commercialized and linked to the puritanical heritage of North America with its insistence on individual responsibility for a disciplined body and continued good health, this urge biases our interpretation of demography and reproductive biology and causes us to believe that we can improve on nature’s poor design: thus we arrive at the present impasse (Lock 1993a, 367).

²⁴ A more current explanation on the subject seeks the meaning of menopause in evolutionary survival mechanisms, arguing that menopause allows females of the human species to take care of their daughters’ offspring after a certain age, increasing the babies’ chance of survival (Hawkes et al. 1998). Yet another theory argues that menopause serves the function of decreasing reproductive competition between generations of women living in the same family, like mothers and daughters (Cant and Johnstone 2008).

It is useful to take a look at how the meanings of femininity, menopause, aging, and of aging women changed along with the developments in the production and marketing of hormones. Focusing on the pharmaceutical interest in marketing hormones enables us to go beyond the simpler explanations of misogyny and see macro-structural factors that shape meaning attribution both within the Western medical culture where the practice originated and across cultures where it traveled.

The construction of menopause as an abnormal condition has had a relatively short history in Western medical knowledge. It is related to cultural and historical understandings of women's body, as well as the changes in the structure of the medical world and development of pharmaceutical technologies. Nineteenth century ideas of menopausal woman as gaining masculine characteristics, having better mental and physical health, and as no longer engaged in sexual activity gave way to twentieth century ideas in which menopausal women were considered unfortunate to have lost their femininity and their sexuality. By the end of twentieth century the discourse had changed yet again to centering on the deterioration of health and fitness, with sexuality and femininity becoming secondary issues (Sybylla 1997, 205; Leysen 1996).

In her history of menopause in United States in the twentieth century, Judith Houck distinguished between three main eras "defined by developments in the treatments of menopause and shifts in the public lives of women" (Houck 2006, 5). The first era fell between the years of 1897 and 1937, starting with the publication of the first book to focus exclusively on menopause by an American physician, Andrew Currier. It was characterized by the attempts of organotherapy, and crude, expensive and relatively inefficient hormones, as well as medical attitudes that saw menopause as a natural shift rather than a medical condition that called for intervention. The era ended with the invention of DES in 1938, which made estrogen treatment cheaper and much more effective. Although the medical theory (in the form of published medical literature) did not change too much, medical practice began to include prescription of hormones and sedatives to menopausal women, who sometimes asked for these themselves. The last era started with Robert Wilson's *Feminine Forever* in 1962 and it stretches into the present. Although there have been some fluctuations in the perceived efficacy, legitimacy, and necessity of HRT, it was established in this era as an accepted "cure" for menopause

(Houck 2006, 5-7). Elizabeth Watkins defined its story as “rise and fall, and rise again and fall again of estrogen and its promise to stave off the effects of aging” (Watkins 2007, 2). She described the period between the 1890s to the 1960s as the first rise, followed by the first fall in 1975 with the findings on endometrial cancer, the advent of the women’s health movement and its effect on FDA; the second rise in the 1980s with addition of progesterone to estrogen and the stress on HRT’s protection against osteoporosis; and the second fall in 2002 with WHI study results.

Houck (2006) and Watkins (2007) are the two main sources that form the framework of my historical narrative of medicalization of menopause and HRT. Accepting Houck’s general classification, and following Watkins’ categorization of rises and falls, I have a more layered structure, based on the aforementioned “fluctuations” in the popularity of HRT in the medical world and in the popular understanding of it. I especially want to focus on the important “watersheds” in the history of HRT, where the medical world itself divided over the risks and benefits of HRT. Accordingly, my first era begins with the first occurrence of the word “menopause” in the medical literature in 1821, and ends in 1938. The second era corresponds to Houck’s categorization of 1938-1962. However, I would divide her last era, from 1962 to the present into four parts. The first part ends in 1976 with the FDA regulation to include patient leaflets into estrogen products. The second part corresponds to the discussions of the link between endometrial cancer and estrogens that took place from 1976 to 1980. The third part comprises the second rise for HRT in the 1980s and 1990s. Finally, the fourth part marks a period in which doubts about the usefulness of HRT and concerns about its risks have been raised since the turn of the twenty-first century. Combining Houck’s focus on the shifts in public lives of women parallel to the development of HRT and medicalization of menopause with Watkins’ emphasis on fluctuations in the history of HRT gives a more complete picture of historical struggles and discussions around HRT and their interactions with women’s lives. This periodization enables us to focus more on the conflictual nature of HRT and medicalization of menopause, in addition to a more nuanced late history emphasizing the importance of WHI study. I find this more detailed approach to the recent history of HRT in line with the general framework of the

dissertation and the fieldwork data, in which most participants stressed the WHI study results as a watershed moment.

3.3.1 Different Treatments of Menopause (1821-1938)

The very first use of the term *menopause* is attributed to Gardanne, a French physician, who used the word in 1821 to refer to the cessation of menses. From the mid nineteenth century onward it was referred to as the “dodging time,” describing several years before and after the first menstruation in France and England (Leysen 1996, 176; Lock 1993a, 308-309). When it comes to the Anglo-Saxon world, Edward J. Tilt appeared to be the leading authority regarding menopause at the end of the nineteenth century, with his 1857 book entitled *The Change of Life in Health and Disease: A Practical Treatise on the Nervous and Other Affections Incidental to Women at the Decline of Life* going into four editions (Houck 2006; Lock 1993a). Tilt warned about the “perilous passage” through which women navigate, also noting that their health and physical looks improved afterwards. He described hot flashes and increased perspiration, the most common symptoms of menopause, as “salutary” effects of menopause that relieved *congestion* (Lock 1993a, 311). Together, hot flashes and perspiration acted as *safety valves*, for the system needs “compensating discharges...until health could be permanently re-established by striking new balances...” (Tilt, quoted in Martin 2001, 31). The underlying “hydraulic” metaphors used to describe menopause are noteworthy, and are in line with the development of industrial metaphors of “body as a machine” in medical culture of the time. The idea of “striking a new balance” was compatible with the nineteenth century view that the post-menopausal period was one of “increased vigor, optimism, and even of physical beauty” (Martin 2001, 35).

Although menopause itself was not seen as a danger itself during this era, it could still be a “critical time” if healthy habits were not followed in the years before menopause, and it also could mask the dangerous pathologies that came with age. Thus, women were encouraged to visit the doctor at menopause, for treatment of possible pathologies. Those who did were usually given advice on healthy habits that was essentially the same regardless of age, sex or complaint, and information about menopause to alleviate the anxiety caused by the idea of menopause, which was believed

to be the reason for most of the complaints (Houck 2006, 17-21). There were no comments in the nineteenth century literature about women mourning the loss of their reproductive powers in menopause, and the idea gave way to an even “kinder” view of menopause in the 1890s (Lock 1993a, 313, Houck 2006, 17). Tilt’s contemporary, Andrew Currier, condemned Tilt for implying that menopause is difficult and dangerous. Currier’s 1897 book *The Menopause*, compared menopause to puberty, and insisted that having a hard time in menopause was exceptional. He defined symptoms like hot flashes as neither salutary nor pathological, but just “common” (Lock 1993a, 314-315).

The approach to menopause in this era can be placed in the context of Western society in which scientific knowledge was gaining more and more legitimacy. The science of the times placed women closer to nature, together with children and nonwhite races, in a continuum of nature and culture where adult white men constituted the “most cultured” (Merchant 1980; Scheibinger 1989). It should also be noted that there was a class element here too, with middle and upper class women seen as more prone to having difficulties in menopause while the working class and peasant women thought to have fewer issues (Lock 1993a).

The nineteenth century approach to menopause as a dangerous but still manageable period gave way to increased use of medication in the twentieth century. This change can partly be attributed to the birth of organotherapy (ovarian therapy), which can be deemed the precursor of modern HRT, in the early twentieth century (Houck 2006, 21). It started with the late nineteenth century idea that the internal secretions of some organs, as well as their anatomical structure, were significant. The first trials were done on male subjects who were injected testicular extracts for the purposes of rejuvenation (Lock 1993a, 327; Oudshoorn 1994, 18). Until the 1930s, the practice of organotherapy involved treatment of menopausal complaints like vasomotor symptoms by freshly ground or dried animal ovaries, or, as a more advanced technique, administration of ovarian extracts. In the medical world still carrying the belief that menopause was not a dangerous period requiring treatment, the attempts of organotherapy were received with skepticism. Patent medicine was the venue that offered treatments in the form of suppositories, pills and tonics during this time, as alternatives to institutionalized medicine and the “ethical” pharmaceutical industry (Houck 2006, 22-

25). In terms of the medicalization model, the 1930s and the 1940s was the period during which menopause was first framed as a medical problem through a theoretical framework and scientific methodology that explained the role of estrogens in menopause constructed by biomedical researchers, availability of cheap hormones (starting with DES), and adoption of the theories and tools of sex endocrinologists by some gynecologists with the belief that it would make their discipline more scientific, and thus, safer (Bell, cited by Leysen 1996, 176).

Although my main focus is on the parallel between medicalization of menopause and the development of hormones, the “mental” aspect of menopausal complaints is too important to neglect. Psychological and psychoanalytical explanations of menopausal complaints and endocrinological models were supported by the same cultural anxieties in their early years. In time endocrinological models became more accepted, partly because they could respond better to the changing social environment and the development of the hormone industry. Freud himself described puberty and in women, menopause, as the times when certain instincts were reinforced. Although he did not go into detail about menopause, he suggested that women were vulnerable to neuroses in menopause because it could bring about an “enfeeblement of the ego” (Lock 1993a, 334). Freud’s disciple Helene Deutsch was the first one to theorize the symbolic losses associated with the end of menstruation, and to call the menopausal woman “the third sex,” followed by Eric Erikson, who focused on the loss of a sense of a vital inner potential (Lock 1993a, 334-336; Leysen 1996, 177). Most psychoanalysts considered menopause especially difficult for single women and women who had never had children (Lock 1993a, 334-336). It is interesting that between 1897 and the 1920s, women who were thought to be especially prone to mental problems in menopause were fragile, delicate women of the upper and middle class, married women with children, thus fitting the feminine ideal of the time. This “risk category” shifted to “single, sexually aberrant, and masculine women” by the 1920s, reflecting the growing anxieties associated with the age as mentioned above (Houck 2006, 44). Changes in the degree to which menopause was thought to be “mental” varied with changing constructions of risk and vulnerability.

In the chapter focused on the mental aspects of menopause, Houck explained the relation between psychoanalysis and endocrinology in terms of the effects of social

change on physicians and their perceptions of menopausal women. She described the popularity of Freudian theories in America as one of the trends contributing to the general anxiety of “the masculinizing of American women” in the late teens and the 1920s (Houck 2006, 46). Houck further commented on the relation between psychoanalytical theories and menopause, saying that physicians deployed Freudian theories intensely against menopausal women only in the 1920s in the United States, for this was the time that Freud’s ideas resonated with larger cultural anxieties (52). Interestingly, this readiness on physicians’ part to accept psychoanalytic theories coincided with the increasing prevalence of an endocrinological or hormonal model that explained nervous symptoms of menopause by hormonal changes in the 1920s, “partly because it provided a possible treatment” (43).

Robyn Gardner’s argument that the invention and development of the hormonal body has been contemporaneous with the development of psychoanalysis supports the argument of shift from the psychological realm to the hormonal body. Gardner argued that both endocrinology and psychoanalysis were based on similar concerns, informed by the racial and biological anxieties of the late nineteenth century in which the body of the aging woman became the locus of several stigmas involving and interrelating old age, women, non-white races and children. She explained the rise of psychoanalysis particularly in the United States with its emphasis upon “nurture,” which made interest in nature (or, biology) less acceptable after the Second World War. However, psychoanalysis stayed limited to the textual, while biochemistry combined “two kinds of revelation: those of complex script and clear picture,” and it was the latter, biochemistry, that was becoming more visually accessible thanks to technologies like computer enhanced images, PET scans and MRI in ways that made the endocrinology more effective in a world of spectacle (Gardner 1997, 144). Though the scope and time frame of Gardner’s study is much wider than the focus of this dissertation, it is useful to explain the mechanism behind the shift from psychoanalytical to hormonal arguments around menopause.

By the end of the 1970s, most psychiatrists asserted that no psychiatric syndrome is directly associated with menopause (Lock 1993a, 339). This shift is meaningful, for it coincided with the establishment of HRT as the accepted treatment for menopause, and

the prevalence of endocrinological explanations for menopausal symptoms rather than psychological ones. As menopause ceased to be a disease of the mind for medicine, it became a disease of the body (Coney 1994, 69). In either case, menopause was defined as a socially acceptable phenomenon belonging to the realm of medicine, necessary to be managed scientifically even when it is considered as a natural phase.

3.3.2 Birth of Hormones (1938-1962)

The history of HRT started in the 1920s, when Edgar Allen and Edward Doisey managed to isolate and crystallize a form of estrogen that they called “estrone,” from the urine of the pregnant women (Coney 1994, 183-184). The problem with this product was that it was difficult to obtain, so scientists in America and Europe started seeking cheaper and more available alternatives. In 1928, the German pharmaceutical company Schering developed Progynon, which was an injectable form of estrogen from human placentas and the first drug the company marketed for climacteric complaints. This was followed by Progynova in 1933, and ethynlestradiol in 1938, a powerful synthetic oral estrogen mainly used in oral contraceptives (Coney 1994, 184; Schering Group 2006). Organon, the Dutch pharmaceutical company, was promoting the treatment of menopause as one of the major indications for female sex hormone therapy as early as the late 1920s, and it chose menopause as the major medical indication for its yearly advertisement campaign in 1938 (Oudshoorn 1994, 93-95). Meanwhile, Ayerst started marketing Emmenin, the first orally active estrogen, in the United States in 1934, which was derived from the urine of pregnant Canadian women (Houck 2006, 22; Li 2003, 103; Seaman 2003, 20). Another important development was DES, diethylstilbestrol, which is a synthetic form of estrogen developed in 1938 by Charles Dodds. Although it was later used mainly on pregnant women to prevent miscarriage and became infamous for the health problems it caused in the children of these women, its first use was for the menopausal symptoms. Its advantages were that it was cheap, twenty times more effective than Emmenin, and widely available; yet it caused intolerable nausea in many women (Houck 2006, 59; Li 2003, 103). The real development, however, was Premarin, developed by Ayerst Laboratories in 1942 from pregnant mares’ urine, and named accordingly (Coney, 1994,

184; Li 2003, 103). Houck described the development of HRT market after DES and Premarin as such:

...[H]ormone treatments were not new to this era, but their visibility increased markedly with the development of conjugated and synthetic estrogen. Drug companies began aggressively advertising estrogen replacement therapies (ERT) to doctors in medical journals and through drug salesmen, known as detail men. Women's magazines featured articles on the medical marvels of female hormones (2006, 59).

Premarin became not only the top selling menopausal treatment but also one of the top selling prescription drugs in the United States and Canada, by the end of the twentieth century (Li 2003, 101).

The characteristics of the medical encounter between doctors and menopausal patients between 1938 and 1962 can be summarized as one in which HRT gained a central role in the treatment of menopause. In a sense, HRT became one of the non-human actors of the menopause field. In the absence of medical consensus about which kind of estrogen was best or whether ERT should be used at all, women were disinclined to seek medical care just because they were entering menopause (Houck 2006, 58-59). The medical literature of the era promoted a three-tiered treatment regimen, starting with education and reassurance, continuing with sedatives if necessary, and prescribing hormones as a last resort (Houck 2006, 67). In the light of the above discussion on psychoanalysis and menopause, it is possible to say that this was a period in between the "mental menopause" model and that of "physical menopause." Despite that attitude in the medical literature, some physicians in the 1950s started to argue for a more liberal use of HRT. Their enthusiasm was joined by the popular literature and sometimes, by women's husbands. These proponents shared the view that treating women with hormones was an obligation; that natural or universal processes were not necessarily desirable, and that HRT had cosmetic benefits that mitigated against the loss of femininity (Houck 2006, 79-83). However, the positive view about HRT still did not mean that menopause was seen as a horrible time or as a disease. On the contrary, the emphasis was on the liberation of menopausal women from childbearing responsibilities (87-89). According to a study done on middle class menopausal American women in the 1950s, most of the women insisted that menopause is a natural event requiring little attention, and it is best to not

dwell on oneself during that period, and “keep busy.” Use of hormones in this picture was a way of denying or ignoring menopause, rather than believing in its importance (133-151).

Houck challenged Susan Bell’s argument that references to “symptoms” and a “menopausal syndrome” denoted a medicalized disease model as early as the 1940s and 1950s:

In contrast, the evidence suggests that some physicians self-consciously used the language of “symptoms” to separate the physiological process of menopause from its occasionally unpleasant manifestations. This allowed physicians to argue that while severe menopausal symptoms might warrant medical intervention, menopause itself remained a natural transition (2006, 60-61).

Houck claimed this separation had several consequences and meanings: First, it put women at the center of the decision to treat menopause; second, it reflected a resistance on the physicians’ part to label female aging as pathological; and finally, it validated medicine’s presence in the lives of healthy women, not just the diseased ones (77-78). Despite the fact that the physicians in question resisted labeling menopause as pathological, I would still argue that validation of medicine’s presence in healthy women’s lives constitutes another step in the social (or to follow Klawiter, conceptual) process of medicalization, regardless of the definition of menopause as a natural transition or not –which is a point that I will return when discussing the developments in the 2000s.

The attitude towards hormones as the logical treatment for menopause can be seen as part of an ideology that demonstrates a strong belief in scientific progress, and is based on the Enlightenment ideas of “science against nature,” as examined by many feminist critics of science like Carolyn Merchant (1980, 2003), Nancy Tuana (1993), and Londa Scheibinger (1989, 1993). The so-called “therapeutic revolution” (or “pharmaceutical revolution”) that started with the development of penicillin in the 1930s and the 1940s led the belief that “physicians and the drug therapies they controlled could cure disease with a bottle of pills” (Coney 1994, 183; Houck 2006, 83). Ayerst, the producer of Premarin, took advantage of this cultural climate in its promotion strategies in the 1930s and 1940s to back their product with the authority of science by emphasizing their connection to

J.B. Collip, who was a leading biochemist and hormone researcher at McGill University, and his laboratory (Li 2003, 103). The post- World War II cultural climate contributed both to the fetishization and gendering of science and technology, creating a new ideal of masculine attainment in building “a new problem-free world, a modern technological paradise, a world of plenty,” and “hardheaded, ultrarational, efficient, scientific technoman needed an Other who was soft, emotional, “dumb,” passive, and sexually appealing” (Sybylla 1997, 210). This gendered relation of technology where man is the “producer” and woman is the “consumer” would be further reflected on the HRT scene in the following decade.

Medical intervention lay within a “progressive” framework well illustrated by this quote from Kost Shelton, Professor of Medicine at the University of California, who was quoted earlier in this chapter with his views on increased life expectancy:

The very person who argues that menopause is a natural phenomenon fights nature everyday. He pasteurizes his milk, boils his instruments, vaccinates his stock and his children...makes new elements and splits the atom (Houck 2006, 80).

A similar comparison between HRT and other “modern solutions” can be observed in one of the popular magazine articles, a Good Housekeeping article from 1967, also cited by Houck:

If you couldn’t read the fine print, you’d get glasses.... And you’ve probably tried rinses for your hair. Take female hormones in the same way—a restoration of what used to be (Houck 2006, 175).

Despite the developments in pharmaceutical interventions and the cultural climate change, during the 1940s and 1950s, gynecology books still saw menopause as a phase of life not requiring medication, but this view started to change in the mid 1960s. Further medicalization of menopause happened partly as a result of Ayerst’s successful promotion campaign for Premarin, also supported by Robert Wilson and his *Feminine Forever* (Li 2003, 104-105; Martin 1997, 242).

3.3.3 Feminine Forever and the Golden Years of HRT (1962-1975)

In the 1960s, hormone replacement was advanced as the magic solution to the “estrogen deficiency” that women were experiencing. During this period a convergence

between conceptual, institutional, and interactional factors brought about the medicalization of menopause (Leysen 1996, 177). Robert Wilson is one of the most influential characters (and undoubtedly the most famous one) in the medicalization of menopause and the establishment of HRT as its “cure.” His fame began with an article he co-authored with his wife, Thelma Wilson, which was published in 1963 by the *Journal of American Geriatrics Society*. The article was entitled “The Fate of the Nontreated Postmenopausal Woman: A Plea for the Maintenance of Adequate Estrogen from Puberty to Grave.” It defined the menopausal woman as a castrate (Lock 1993a, 346). Wilson further detailed his position in his 1966 book *Feminine Forever*, which sold 100,000 copies in the first seven months of publication, and was funded mostly by the Ayerst company (Coney 1994, 70). Although not attributed solely to Wilson’s efforts, prescription rates for ERT quadrupled between 1962 and 1975 (Houck 2006, 6). The number of prescriptions per capita increased 130% between 1950 and 1972 (Kaufert and McKinlay 1985, 114).

Wilson’s main argument in *Feminine Forever* was that menopause is a deficiency disease with drastic consequences for women’s health, sexuality, well-being, identity and relations with those around them, and that it can (and, actually, should) be cured by estrogen replacement therapy. He equated menopause to castration, in which lack of estrogen turned a woman into a “eunuch” (Wilson 1966, 40). The way Wilson described the endocrine system and the metaphors he deployed can be put in conversation with Emily Martin’s *Woman in the Body* (1987) and *Flexible Bodies* (1994), as well as Donna Haraway’s article “The Biopolitics of Postmodern Bodies: Determinations of Self in Immune System Discourse” (Haraway 1993). Wilson referred to the endocrine system as a corporation, talking about the head commander issuing orders, and the “ranks” that do or do not follow orders (Wilson 1966, 73-76). Especially interesting was the part in which he drew a parallel between the pituitary and an irascible man, and between estrogen and a calm and tactful woman:

To summarize the role of estrogen in the pituitary control center in the brain, I should like to quote a simile I once heard at a popular medical lecture. The speaker compared the pituitary to an irascible man who controls his entire family with strict discipline. But if something goes wrong, he is likely to fly into a rage and smash up the whole house.

Estrogen, on the other hand, is like a calm, tactful woman who smooths his irascible temper and keeps him from going to extremes (Wilson 1966, 77).

In *Woman in the Body*, Martin gave examples of medical metaphors that likened the human body to a small business, a factory, an industrial society or a machine. Regarding the working of female hormonal system, the image is that of a “hierarchical” feedback loop where hypothalamus is in the dominant position controlling the reproductive organs. In this system, menopause is described as the breaking down of authority, where ovaries become “unresponsive” to stimulation (Martin 1987, 42). In Wilson’s quote above, not only there is the reproduction of a hierarchical social system, there is also a gendered hierarchy. Martin demonstrated that a similar hierarchy of gender and class was reflected upon different type of immune cells in *Flexible Bodies*, where macrophages associated with the female gender and seen as performing a lower function while T-cells are masculinized and put in a higher position of “orchestrating” the other immune cells (Martin 1994, 55-59).

Haraway also talked about metaphors of immune system in “The Biopolitics of Postmodern Bodies” that include constructions of self and the other, symbolic and material “difference,” complexity and harmony. She cited Golub and Gershon’s “immunological orchestra” drawings, which start with a highly hierarchical “orchestra” conducted by the Generator of Diversity (G.O.D.) in the diagram corresponding to 1968; and becoming increasingly “postmodern” with multiple sites of control and increased complexity in the 1982 diagram (Haraway 1993). Wilson’s descriptions corresponded to the earlier, linear and hierarchical understanding of immune system, and in general, human body. They made sense in the cultural context of the time, but as the socio-cultural perceptions and descriptions changed, they became less acceptable.²⁵

After the popularity of Wilson’s *Feminine Forever*, another physician, David Reuben, published *Everything You Wanted to Know About Sex* (1969), which became a best-seller and claimed that menopause signaled the end of a woman’s useful life and brought her closer to being a man. Reuben’s book was followed by a barrage of articles

²⁵ See (Martin, 1994) for an analysis of the theories of complex systems and the idea of the body as a complex system.

in women's magazines like Harper's Bazaar on the wonders of estrogen therapy (Houck 2006, 173; Naughton et al. 2005, 162). Although Wilson argued for a wide array of negative effects at the lack of estrogen, his biggest emphasis was on the loss of sexuality rather than "secondary" effects like weaker bones, coronary disease, and high blood pressure. He described the "primary effects" in quite graphic language:

As for the primary effects, they are quite simple. Deprived of its natural fluids by the general desiccation of tissues, the entire genital system dries up. The breasts become flabby and shrink, and the vagina becomes stiff and unyielding. The brittleness often causes chronic inflammation and skin cracks that become infected and make sexual intercourse impossible (Wilson 1966, 42).

Houck placed Wilson's emphasis on sexuality in the broader context of the "sexual revolution" of the 1960s in United States. Growing popular acceptance of sexual activity outside marriage, use of the birth control pill and questioning of traditional family values by both mainstream and counterculture trends led to a visibility of female sexuality, portrayed in the popular culture with the image of younger women that left some older women less secure about their looks and "value" (Houck 2006, 160-161). Against this cultural backdrop, Wilson's book was created and received, and according to Houck this was the source of its strength:

He connected menopause with the aged female body at a moment when an aged body accounted for women's alienation from the many opportunities and obligations of the female and the feminine body. By emphasizing an older women's loss of femininity and sexual allure, Wilson portrayed her as unwanted commodity in an increasingly competitive sexual marketplace (Houck 2006, 162).

Despite the fact that he was harshly criticized for the misogynist language and attitude of his book by many feminists, Wilson deployed the feminist stance as the basis for his arguments. He blamed his colleagues for neglecting women's needs, and argued, "This medical attitude...is dictated by a fairly common type of male indifference to anything exclusively female, except as it affects men" (Wilson 1966, 17). Yet the foundation for this "feminist" attitude was his belief in the women's right to remain "feminine" and sexual:

Women, after all, have the right to remain women. They should not have to live as sexual neuters for half of their lives. The treatment and cure of

menopause thus becomes a social and moral obligation. At this point in history, medical science can no longer evade the responsibility of helping women remain feminine for life (Wilson 1966, 25).

Wilson's use of feminist arguments can be connected to the co-optation of feminism by advertisers in the 1970s to sell various products (Houck 2006, 164). Feminists were divided over Wilson and ERT more generally. Some like Belle Canon, Wendy Cooper, and Paula Weideger, found a powerful weapon for women's liberation in the disease model of menopause, following "a feminist tradition of belief in biomedical technology" as argued by, for example, Shulamith Firestone. Their attitude aligned with a feminist tradition that refused to see nature as inherently beneficial for women, and turned to technology for solutions that would allow women to "escape from the tyranny of their biology" (215). Wilson was on common grounds with the women's health movement in demanding respect and attention to women's problems from the medical community. His book also aligned with the tendencies of the previous two decades that value education and reassuring of women who may have wrong beliefs about menopause by explaining them the physiological changes going on in menopause. He devoted two chapters to explaining hormones and female reproductive system, together with diagrams and figures. However, he clearly did not share the non-interventionist attitude of the previous era.

Popular responses to Wilson's book and some others like it did not really correspond with the response of the medical world. Most physicians still hesitated to call menopause a disease, even when they accepted the notion of "estrogen deficiency." Discussions of the era revolved mostly around the necessity of long-term hormone therapy as a restorative and preventive medicine, rather than discussions on the nature of menopause, and medical views were quite diverse (Houck 2006, 166-172). When it came to evaluating Wilson's influence on medicalization of menopause and the increased use of HRT, Houck argued that his role has been exaggerated by many scholars. His main contribution and that of his followers was to shift the conversation about menopause from one that is located in the larger frame of social circumstances and personal lives of women to a discussion about treatment (154). The shift is not insignificant. The loss of a social analysis and the gradual normalization of medical intervention in menopause was

yet another step in the medicalization of menopause and the establishment of hormonal treatments for its cure.

3.3.4 First Doubts (1975-1980)

Between 1963 and 1973, estrogen became one of the top five prescription drugs in the United States, with annual sales approximating 70 million dollars (Li 2003, 105). In 1973 it was estimated that “51 percent of women had taken estrogen for at least three months and that the median use was ten years” (Kaufert and McKinlay 1985, 114). However, studies began to be published about a possible link between estrogen and cancer in the early 1970s. The most significant publications of this kind were two articles indicating a link between postmenopausal ERT and endometrial cancer published in the *New England Journal of Medicine*, the first by a group of researchers at Washington University led by Donald Smith, and the second by Harry Ziel and William Finkle of Kaiser-Permanente Medical Center, by the end of 1975. Ziel/Finkel study found a fourteen times higher likelihood of endometrial cancer after seven years of ERT use. These two studies constituted the best evidence of the time that ERT posed cancer risk in humans, and they led to an FDA regulation requiring estrogen manufacturers to include a package insert about the risks in 1976 (Coney 1994, 128, 196-197; Houck 2006, 181; Li 2003, 106; Watkins 2007, 94). The link between estrogen and cancer had been identified as early as the 1930s and 1940s in animal studies, and in 1947 Saul Gusberg, a Columbia University gynecologist, linked estrogen use to cancer of the endometrium. Still, this link was not found to be persuasive by most of the physicians in the 1940s and 1950s (Houck 2006, 76).

The immediate impact of these studies and the FDA regulation was not drastic in terms of changing the discourse: physicians still thought the benefits outweighed the risks. Although the initial enthusiasm was curbed in the popular media, articles in women’s magazines still assured women of the safety of hormones (Houck 2006, 183-184). In their study of papers published in *New England Journal of Medicine* and the *Journal of American Medical Association*, Kaufert and McKinlay state that by the end of 1976 there were papers linking estrogen therapy with “gallbladder disease, endometrial and breast cancers and with higher levels of the risk factors for coronary disease, but not

with myocardial infarction,” followed by both careful reviews of these papers and attacks on this research and defense of ERT (Kaufert and McKinlay 1985, 119-120).

Despite the slower change it caused in the discourse, the effect of medical debates and FDA regulation on the drug sales was more serious. There was an 18% decrease in estrogen sales in 1975-76 and an additional 10% decline in 1976-1977. By 1980, prescriptions had fallen to 15 million from a previous number of 28 million in 1975 (Houck 2006, 186; Kaufert and McKinlay 1985, 125; Li 2003, 106). Pharmaceutical companies, primarily Ayerst, published articles in the industry-controlled press and trying to reach clinicians and convince them of the safety of estrogen. The Pharmaceutical Manufacturer’s Association took legal action against the FDA regulation, arguing that mandatory patient information was an unconstitutional constraint on free speech, and that it would reduce sales and thereby reduce profits (Kaufert and McKinlay 1985, 126). Clinicians united with the pharmaceutical companies in the effort against patient inserts: The American College of Obstetrics and Gynecology, American Cancer Society, American College of Internal Medicine and a number of state and county medical societies joined the Pharmaceutical Manufacturer’s Association in their legal action, arguing that the release of information to patients challenged the physician’s authority to decide what to disclose to a patient and how to balance risks and benefits, and that it would “confuse the patients” (Hoberman 2005, 130-131; Kaufert and McKinlay 1985, 126; Ronald 2006, 50).

These developments created a new climate for patient-physician relations. Kaufert and McKinlay argued that two main principles of the physician-patient relationship changed: the principle that the physician should be trusted to act in the best interest of the patient, and the principle that physician has the right to control the relationship because of his or her exclusive possession of medical knowledge. In an environment where patients have access to information available to physicians—including the possibly harmful effects of the treatment—physicians were advised to inform and consult the patient in the decision, for “the notion of the ‘passive,’ ‘compliant’ patient was becoming a legal liability” (Kaufert and McKinlay 1985, 131-132).

One primary factor that changed the patient-physician relationship and the attitudes toward HRT in the 1970s was the second wave of feminism and the

strengthening of the women's health movement (Morgen 2002). Some feminists started questioning the necessity and possible harms of HRT, within a framework critical of the medicalization of women's bodies. Starting in the 1970s feminist researchers like Dr. Madeleine Goodman and Karen Frey began doing their own studies on menopause and concluded that the number of women experiencing serious menopausal symptoms was drastically lower than the figures indicated in medical research. Only about 25% reported symptoms to Goodman and Frey (Fausto-Sterling 1999, 173).

Wilson's *Feminine Forever* and the increased use of HRT roughly coincided with the second wave of feminism. Houck drew attention to the dilemmas that HRT and medicalization of menopause caused for the women's movement, listing several questions they raised:

Should feminists shun the "medicalization" of their normal physiological processes or should they demand even more medical attention? What were the social costs of regarding menopause as a "deficiency disease" requiring pharmaceutical intervention? Were menopausal symptoms caused by defective physiology or a sexist society? Did medical technology help or hinder the cause of women's liberation? (Houck 2006, 209)

The only common ground between differing viewpoints was the stress on women's control over decisions concerning their bodies and health, as part of gaining control over their lives (Houck 2006, 210).

Reproductive issues were among the earliest concerns of the women's health movement. Discussions on ERT/HRT and menopause came later, due in part to the ages of women involved in the movement (Houck 2006, 211; Kaufert and McKinlay 1985, 133). One important example in this regard is the coverage menopause and HRT had in various editions of *Our Bodies Ourselves*, the famous self-help women's health guide by Boston Women's Health Course Collective. In the first edition of *Our Bodies Ourselves*, which came out in 1971, menopause was mentioned in one sentence (Houck 2006, 216). In the 1973 edition, negative stereotypes of menopausal women were condemned, and medical profession was criticized for not doing adequate research on menopause. ERT was accepted as a valuable tool, yet it was posed as a drug that carried potential risks that should be discussed with physicians (216-217). The chapter on menopause was still not as extensive as other chapters, and recognizing their lack of information on this matter, in

1974 the Collective sent out a questionnaire to five hundred women about menopause (Watkins 2007, 90-91). The 1976 edition of the book was more skeptical of ERT, in the light of all discussions around ERT and cancer risk, advising women to be cautious (Houck 2006, 221). In 1987, the Collective decided “the second half of life deserved a book of its own,” and published *Ourselves, Growing Older: Women Aging with Knowledge and Power* (Watkins 2007, 187). In the chapter devoted to menopause, the authors had a critical approach to portrayal of menopause as a disease, rejecting call the changes women experience in menopause as “symptoms,” and calling them signs instead. Scientists were encouraged to do more research on the mechanism of hot flashes, and women were recommended non-medical remedies for issues like osteoporosis or vaginal dryness. Skepticism towards HRT remained (188-189). Finally, in 2005, the Collective published a whole volume dedicated to menopause: *Our Bodies Ourselves: Menopause* (Boston Women’s Health Collective 2005).

Houck argued that the women’s movement –especially the women’s health movement—affected women’s experiences of menopause in multiple ways.

First, feminism encouraged women to take control of their bodies and their health care decisions. As a result, some menopausal women demanded both respectful treatment and specific therapies from their physicians. If their demands were not met, they took their business elsewhere. Second, prompted by the feminist critique of patriarchy, women began to articulate their dissatisfaction with their medical providers in terms of misogyny and male chauvinism. Third, women rejected the “suffer in silence” approach to menopause advocated by their mothers and grandmothers and turned to one another for support. And finally, realizing that their reaction to menopause was influenced by their limited social options, some women saw women’s liberation itself as the cure for menopausal difficulties (2006, 223).

After the cancer discussions of 1975, the number of feminists that argued against seeking a pharmaceutical solution for a natural process increased. Nevertheless, some feminists still encouraged short-term estrogen use for women who experienced severe symptoms. One important contribution of feminists was to carry the menopause discussion from one just about treatment options to one that situates menopausal difficulties within a broader social context and argues for a change in women’s social roles as a route to improving the lives of menopausal women (Houck 2006, 222).

Taken together, Wilson's claims, FDA regulation, cancer discussions, the women's health movement, and a cultural era that problematized getting older had contradictory effects on postmenopausal women. Although reactions ranged from actively searching for a physician to prescribe hormones to refusing them for fear of cancer to believing that menopause is not that bothersome, there were some characteristics that made the 1960s and the 1970s different from the previous decades. One important difference was that women became more inclined to accept menopausal complaints and search for cures for them instead of arguing that it will go away as long as you keep busy. This popular acceptance came as a result of both Wilson's arguments and the empowerment that came with the consciousness-raising efforts of the women's health movement, which enabled women to talk about their complaints and demand attention for them. Another difference, partly tied to the former one, was the change in women's relations with their physicians. Physicians came to be trusted less, and in a sense became more "replaceable" if they did not correspond to the patient's needs. Despite the rhetoric of menopause as a deficiency disease, women came to see menopause as more of a nuisance than a disease, and fought being "hot and bothered" rather than seeking to be "feminine forever" (Houck 2006, 188-208).

3.3.5 Newfound Reasons for HRT (1980s-1990s)

The trend of decreasing HRT prescriptions reversed in the 1980s, rising from 13.6 million in 1982 to 31.7 million in 1992 (Houck 2006, 230). This change can be explained by several factors, including the aging of the baby-boom generation; standardization of combined hormone therapies (progesterone plus estrogen) to counter the risk of endometrial cancer from estrogen only versions; and increased arguments for HRT as preventive treatment for osteoporosis and heart disease (Barrett-Connor et al. 2005, 115-116; Houck 2006, 230, Seaman 2003, 171).

A series of clinical trials starting from the 1970s showed a link between the prevention of osteoporosis and HRT, coupled with an increasing number of medical papers appearing on medical journals on the issue. This made HRT a "preventive drug," that can be prescribed to post-menopausal women as well as the menopausal ones—for the remainder of their lives (Coney 1994, 128; Li 2003, 106-107; Lock 1993a, xxxiii). In

1989 Premarin, Wyeth's best-selling HRT drug, was approved by FDA as a preventive drug for osteoporosis (Li 2003, 107). The preventive character of HRT was furthered in the 1980s by the findings that showed a "dramatic reduction in coronary heart disease," like the famous Nurses' Health Study (Barrett-Connor et al. 2005, 116). This study, which began in 1976, was one of the largest observational studies on HRT, with the participation of 121,964 nurses who answered a questionnaire that has been mailed to them on a biannual basis (Stampfer et al. 1985). Annual sales of estrogen rose to 460 million dollars in 1990 (Lock 1993a, 350). With the risk-benefit ratio (of breast and uterine cancer vs. reduced hip fractures and heart disease), as described in a meta-analysis of observational studies of postmenopausal HRT in 1992, HRT came to be recommended for all women. Between 1995 and 1999, the annual number of filled HRT prescription increased from 58 million to 90 million (Barrett-Connor et al. 2005, 116). Prevention of heart disease in women has been the focus of attention in the 1990s with regards to the effects of HRT, joined by the prevention of Alzheimer's disease. The situation has resulted in the decreasing age of "potential subjects" of HRT, which included perimenopausal women by the mid to late 1990s (Li 2003, 109).

In 1996 Wyeth-Ayerst started a campaign called "Living Smart" that targeted women over 35, with the aim of "increasing visibility and increase usage of Premarin as a preventive and prescriptive treatment for osteoporosis" (Li 2003, 110). The increasing success of Wyeth-Ayerst in promoting Premarin was challenged by an FDA demand to withdraw a TV ad in 1999, for violation of DTC advertising code by making "broad and ambiguous health claims for Premarin" (110). Another important shift in the language of promoting HRT was the emphasis on the social and economic costs of the chronic diseases of later life that are arguably possible to prevent by HRT. The analogy used to lobby for the usefulness of hormones was no longer diabetes and insulin, as in the deficiency disease years, but that of compulsory vaccination (115).

3.3.6 Winds of Change, Risk and Prevention (2000s)

Despite years of criticisms, the real watershed for the medical world on the HRT discussion came with the results of several large, placebo-controlled clinical trials in the late 1990s and the early 2000s, backed by large-scale observational studies. First, and

even before the clinical trials, the follow-up studies of the observational Nurses' Health Study concluded that postmenopausal estrogen use causes a significant increase in the breast cancer risk, and addition of progestins does not change that effect (Colditz et al. 1995). Then came the results for the first of the big clinical studies, HERS (Heart and Estrogen/Progestin Replacement Study) which included 2736 participants with heart disease and an intact uterus and aimed to study the relation between combined hormone therapy with coronary heart disease. The 1998 findings revealed that the estrogen-progestin combination did not reduce the number of coronary events as it had been argued. Worse, it increased the risk of blood clots and gallbladder disease (Barrett-Connor et al. 2005; Houck 2006, 233, Hulley et al. 1998). HERS was followed by the Million Women Study and the Women's Health Initiative study.

The Million Women Study was an observational study performed in the United Kingdom on more than one million women between 1996 and 2001, with the aim to investigate the relation between HRT use and breast cancer incidence and mortality. The results indicated increased risk in incidence and fatal breast cancer among women on HRT, especially in the combined (estrogen-progestagen) form of HRT. The study also showed that the relative risk of breast cancer increases with the duration of use of HRT. The researchers also reported no significant difference between the oral, transdermal or implanted delivery (Million Women Study Collaborators 2003). In the commentary written by Toine Lagro-Janssen, Walter W. Rosser and Chris van Weel in the same issue of *Lancet* where the Million Women Study results were published, the story of HRT was described as "a lesson for medicine to exercise extreme caution in promoting hormonal therapy, and, in general, a lesson of how not to introduce new developments" (Lagro-Janssen et al. 2003, 142).

The Women's Health Initiative (WHI) study was the largest hormone study done on healthy women with the support of U.S. National Institute of Health, and its magnitude has been reflected in its effects on the HRT debate, and the reactions the study received. The study had two main arms, one studying the effects of estrogen in women that underwent hysterectomy, and the other involving the use of estrogen plus progesterone on women with intact uterus. The second (combined therapy) arm, which started with 16,608 participants, was halted in July 2002, three years before planned,

once the risks of HRT outweighed the benefits. Women taking combined hormone therapy had a 26% increased risk of breast cancer; a 29% increase in the risk of coronary heart disease; a 41% percent risk increase in strokes; and a 113% increase in the pulmonary embolism risk (Barrett-Connor et al. 2005, 126; Worcester 2004, 56). The WHI study caused changes in the public image of HRT, women's adoption patterns, doctors' prescription policies, and even the dosage of hormones produced by the pharmaceutical companies. These results caused a 50% drop in HRT prescriptions, more so (66%) for EPT prescriptions than those for ET (33%) (Barrett-Connor et al. 2005, 116).

The estrogen-only leg of the WHI trial including women who had undergone a hysterectomy was also terminated earlier than it was planned, in March of 2004, because of the increased risk of stroke in the trial group and low likelihood for future cardiac benefit (Barrett-Connor et al. 2005; Houck 2006, 234; Naughton et al. 2005, 166). The results of the study are summarized below:

The use of CEE increases the risk of stroke, decreases the risk of hip fracture, and does not affect CHD incidence in postmenopausal women with prior hysterectomy over an average of 6.8 years. A possible reduction in breast cancer risk requires further investigation. The burden of incident disease events was equivalent in the CEE and the placebo groups, indicating no overall benefit. Thus, CEE should not be recommended for chronic disease prevention in postmenopausal women (The Women's Health Initiative Steering Committee 2004, 1701).

Especially the last sentence of the quote above is important, for it challenged the preventive effect of HRT that has been the legitimization for its prescription since the 1980s, despite the risks. This suggestion heightened the discussions around saliency of HRT use as a prophylactic measure for osteoporosis or CVD in postmenopausal women.

In September 2005, WHI researchers published yet another result of the study based on the estrogen-only group. This time, participants were surveyed on the effects of estrogen on their life quality. No significant improvements were found in general health, physical functioning, pain, vitality, role functioning, mental health, depressive symptoms, cognitive function or sexual satisfaction at the end of one year. Results did not change for a subgroup followed after three years (Brunner et al. 2005). Some physicians attributed these results to the age of participants, most of whom were already past the stage of

menopause when troublesome symptoms like hot flashes occur. Brunner, the lead author of the article, commented it is true that estrogen reduced hot flashes in a younger subgroup of participants, but they still did not report a better quality of life than the placebo group (Tanner 2005).

Being the biggest and the most influential study done on HRT so far, WHI received a number of criticisms, as summarized below:

...WHI used only one HT drug regimen; the results are not applicable to women who go on short term hormone therapy at the time of menopause for symptom relief; stopping the trials early reduced the precision of the estimates of the long-term effects of treatment on the primary and secondary outcomes; the absolute numbers of participants who suffered adverse events was very small, although the results were statistically significant; and women themselves will be unlikely to forego using HRT, because it makes them feel better and improves their quality of life. (Naughton et al. 2005, 167)

The methodology of the study became the focus of criticism. Some critiques, like Ostrzenski and Ostrzenska argued that the study design and execution brought into question the validity of the results, concluding that the WHI trial should be completely redesigned and redone in order to determine the safety and effectiveness of HRT. In addition to the common criticisms summarized above, they criticized the study for using a combination of hormones and alternative remedies like calcium and vitamin supplements, thus obscuring the interpretation of the risk/benefit effect of Prempro. They also drew attention to the high dropout rates, a high percentage of participants with preexisting illnesses, and disproportionately low proportion of women from minority groups. More importantly, participants' age was higher than the median age of menopause which Ostrzenski and Ostrzenska thought skewed results due to the absence of postmenopausal symptoms among older women. Finally, they argued there was contamination between the Prempro and Premarin groups due to non-randomized reassignment of some participants (Ostrzenski and Ostrzenska 2005).

In response to Ostrzenski and Ostrzenska's criticism of participants' preexisting illnesses, WHI researchers defended the study on the grounds that WHI participants were in fact healthier than the general United States women of that age. Against the age-related criticisms, they stated that over 12% of participants were of median age for United States

and subgroup analyses did not indicate significant interactions between age and outcomes. They further argued the study had adequate statistical power despite dropout rates, minority group participation was higher than the previous hormone trials and the reassignment of participants did not create a substantial difference in findings, as can be observed in comparisons with analyses done without the reassigned participants (Cochrane et al. 2005). In the presentations in EMAS conference and in my private conversations with the physicians in Turkey, the most commonly cited criticisms of the study was participant age and the usage of a standard dose and type of HRT that was not tailored for the individual. Another criticism was not about the conduct of the WHI study but the way it was published: Some physicians argued that it was “leaked” to the media prematurely; that is, before the results were debated in a closed circle of professionals.

In 2006, new results from WHI trial were published, and debate continued as to their validity, even as new studies were being done on the risks and benefits of HRT. Today there is consensus in the medical world over the effectiveness of HRT in treating vasomotor symptoms and vaginal atrophy. These are the two indications for which the FDA approved HRT. Some other symptoms like mood swings, sleep disturbances, and depression are either shown to be unchanged in clinical trials, or their improvement is attributed largely to improvement in vasomotor symptoms. Both estrogen only and combined therapies have the same level of effectiveness on vasomotor symptoms, regardless of the method used (transdermal or oral), while intravaginal application of estrogen proved to be more effective than systemic use in the case of vaginal dryness. The results about HRT’s effectiveness on preventing weight gain and urinary complaints are not consistent, and there is no substantial evidence showing improvement of sexual satisfaction or libido with HRT (Barret-Connor et al. 2005).

There are varying and sometimes conflicting views on the preventive use of HRT. Both arms of the WHI trial, as well as some other trials showed a decrease in the risk of fractures for women on HRT. There is also consensus about HRT increasing bone density; however, it has to be used continuously to maintain that effect (Barrett-Connor et al. 2005, 124-125). Women’s health groups have been arguing for a while that use of hormones to prevent osteoporosis is questionable, since the real danger of osteoporosis is the risk of fractures, yet “not all women with fractures have osteoporosis and not all

women with osteoporosis have fractures” (Lock 1993a, 355). Risk of fractures depends on a number of factors some of which are not related to bone density, like body size, balance, drug use causing drowsiness, amount of body fat that can act as padding and environmental factors like the layout of furniture. Moreover, hormones are not the only treatment (or prevention) available for osteoporosis. Indeed, the FDA has taken a cautious stance in approving HRT for the prevention of osteoporosis.

The preventive role of HRT in heart disease is even more debatable, with the results of HERS and WHI trials. The explanation for HERS was either HRT is not effective in protecting women who already have coronary diseases, or that progestin cancels the preventive effects of estrogen (Barrett-Connor et al. 2005). Yet there is a recent argument about the timing of HRT: if it can be started at the critical time of the very onset of menopause it may have preventive effects on heart disease, but it will not be useful if this period is missed. This “window of opportunity” argument became especially prevalent after publication of new data from in-depth studies of the WHI cohort in 2006 (Hsia et al. 2006, Mendelsohn and Karas 2007). The importance of timing for the vascular effects of estrogen was a point very much emphasized during the presentations of the EMAS conference as well, and stressed in the TSMO workshops for ob/gyn practitioners.

Observational studies and clinical trials give inconsistent results for the effect of HRT on colorectal cancer or ovarian cancer. Although observational studies showed that there are cognitive benefits of taking HRT, clinical studies like HERS and WHI had contrary results, which might be attributed to micro infarcts or other vascular brain disease consistent with the findings on stroke in these trials (Barrett-Connor et al. 2005)

As for the negative side, HRT is associated with a number of risks, some of which are more established than others. Several studies, including the WHI trial, have shown a relation between HRT and the risk of stroke that is in line with the effects of hormones used in the birth control pills. Observational studies on HRT use and breast cancer are inconsistent, mostly showing an increase in breast cancer for women on HRT. The positive relation between HRT and breast cancer is also seen in the progestin-estrogen arm of WHI trial, but not in the estrogen only arm. This difference is attributed to the effect of progestin, and the increase that combined hormone therapy causes in breast

density. There is consensus on the effect of estrogen on increasing endometrial cancer, and that this increase can be countered by progestin; as well as the positive relation between HRT and venous thromboembolic events (Barrett-Connor et al. 2005).

In April 2007, a group of researchers published an analysis of National Cancer Institute's epidemiological registries on breast cancer, pointing out to a drop in breast cancer rates since 2002. Researchers commented, "the decrease in breast-cancer incidence seems to be temporally related to the first report of the Women's Health Initiative and the ensuing drop in the use of hormone-replacement therapy among postmenopausal women in the United States" (Ravdin et al. 2007). In March 2008, results from a three-year follow-up of WHI was published, analyzing breast cancer and cardiovascular health risks for the HRT arm of the study that was stopped early. According to results, cardiovascular disease risk decreased after stopping to take HRT for women who were in the experiment group, but the risk of breast cancer remained increased (Heiss et al. 2008).

Medical trend related to HRT use after the WHI study is to prescribe the lowest possible dose for the shortest possible time, in line with the FDA recommendation. However, there is no negative or positive evidence showing that a lower dose will decrease the adverse outcomes; this is just a logical inference from the known data (Naughton et al. 2005, 168; NAMS 2007). The general idea is that the longest time to prescribe hormones should be five years, in the light of findings that women who were on HRT for a longer time had increased risks. The importance of starting hormone therapy as early as possible and the possibility of reduced risks with different routes of administration like transdermal patches or topical treatments are the other ongoing discussions in the field (Hsia et al. 2006, The IMS Executive Committee 2005, Mendelsohn & Karas 2007, NAMS 2007, Rossouw et al. 2007, Skouby et al. 2005). As debates continue in medical world, feminist responses have also varied with regards to HRT. In an article written before the results of WHI trial, Celia Roberts sought to see HRT in a different light than simple medicalization of the female body with misogynist intentions.²⁶

²⁶ I will return to this question and attempt to answer it at the end of Chapter 8.

How might bodies be theorized in a way that allows for the possibility of HRT's 'working' without exaggerating or underestimating the roles of either the social or the biological in such an event? (2002, 40)

In response to some feminist's approach to HRT as a misogynistic and oppressive tool of medicine and representing menopause as a "natural" and desirable period, some other feminist authors like Kwok Wei Leng, Deborah Lupton and Jennifer Harding argued that glorifying natural aging and menopause reinforces the nature/culture dichotomy upon which the medical model is based (Roberts 2002, 46). In the technology-nature dichotomy produced in the classical feminist literature on menopause, the "resisting menopausal body" became a proper and privileged position in a totalizing narrative where accepting HRT is equal with being a passive victim (Leng 1997). The particular feminist approach that places women along a continuum of empowerment between two positions of passive victim of medicalization and well informed active feminist has been criticized for reproducing portrayals of postmenopausal woman as "in need of a detailed knowledge of the risks she faces in order to control her destiny" (Harding 1997, 138). While agreeing on the power of Harding's argument, Celia Roberts criticized her model for offering "an even more complex version of knowledge promotion as the best avenue for women's decision-making regarding HRT" that replaces the standard medical knowledge and language with a more "preferred" type of knowledge and understanding (Roberts 2002, 46).

Not only must women understand the medical side of HRT, they must become aware of the historically and socially constructed nature of HRT and biomedicine in general, and be able to apply deconstructive thinking to their own lives. There is still a sense here of a valorized feminist position from which informed and correct decisions could be made about HRT. This position is gained with extensive (feminist) knowledge (47).

However, in her criticism of both medical and feminist discourses, Harding also pointed to different subject positions "from which women may seek to negotiate or reject clinical verdicts and procedures" and "the subject positions excluded by a focus on the clinic and resistance to medical control" (Harding 1997, 144). This neglect that Harding pointed out aligns with other general criticisms of the Foucauldian medicalization framework:

One major problem is the tendency of Foucault and those using his work to neglect examination of the ways that hegemonic medical discourses and

practices are variously taken up, negotiated or transformed by members of the lay population in their quest to maximise their health status and avoid physical distress and pain. (Lupton 1997, 118-119)

Inspired and supported by social science, feminist studies, statistics and medical and popular literature cited above, the pilot study I conducted in the Troy, New York area in 2005 gave crucial insight about the perceptions of menopause and HRT in the early years of 2000s in the United States. In an effort to discover the various ways in which HRT is taken up and negotiated in different contexts, I turned to the actual practices of using and prescribing HRT after the WHI study in the United States in the smaller example of Troy.

The way physicians interviewed in the study referred to menopause still carried negative connotations even though they did not define their overall approach to menopause being negative. They still used terms like “estrogen deprivation,” “ovarian failure,” and “dramatic decreases” in hormone production. This finding is in line with the theories of Emily Martin on the way medical literature portrays the woman in the body (Martin 1987). On the other hand, menopausal women and healthcare professionals who define themselves as supporting a more “natural” or “holistic” approach to medicine employed more positive expressions when describing menopause, like the end of bleeding, not worrying for birth control, and a new (and good) stage of life.

The way menopausal women were portrayed in the narratives of physicians can be referred to under several headings. The most prevalent of these was the picture of “women with problems and increased risks.” This view gave credit and legitimacy to women’s complaints, and made use of the “risk language” mentioned above. Especially if these women came with symptoms that disturb them, the idea was that it is not right to “deny them of hormones.” Some women may think that they need hormones even if they are not experiencing severe symptoms because of the increased risks of bone loss and heart disease coming with menopause. Usually, the idea of “menopause as a stage of life that requires medical help” correlated with the willingness of healthcare workers to support HRT, and showed that the idea of preventive medicine is quite prevalent.

The impact of consumer culture also shaped how physicians described menopausal women. One of my informants defined them as “healthcare consumers” who should be informed by their physicians but to make their own decisions. Almost all said

that they informed the consumer/patient and supported them whatever their decision. However, all stressed the importance of being under medical control, coming to yearly evaluations, etc. and some complained about women who behave as “unruly subjects,” who believe in or choose to follow the advice from friends, family, media, or the primary healthcare professionals. The idea of informed healthcare consumers making responsible choices sometimes appeared to be more about protecting the physician from liability rather than a genuine respect for the patient’s will and her ability to make the right decision.

Another point was that symptoms of menopause and the increased risks coming with menopause could be decreased by healthy life style habits, which portrayed women as responsible for their own health at this period. This was an attitude that attributes more agency to women, yet women were again sometimes blamed for not having healthy life styles and looking for a quick fix with hormones instead.

Another way in which consumer culture shaped responses to menopause had to do with the way in which personal responsibility had become central to discourses of health and health care. The portrayal of individual women as responsible for their own health was an attribution of both increased agency, or consumer “empowerment,” and blame when women did not develop “healthy” life styles and looked for a quick hormonal fix instead. The pictures that women themselves presented supported the idea of importance of maintaining healthy habits, yet they often expressed unwillingness rather than desire to take drugs, which may partly be attributed to the publicity of side effects of hormones.

In terms of the variety of positions in the medical community regarding menopause and HRT, the study suggested that tensions within the medical community regarding HRT use extended beyond the clinical versus basic research divide elucidated by Kaufert and McKinlay (1985). Some of the participants showed frustration at the cessation of WHI study, and also pointed to a difference in points of view between ob/gyn specialists and general practitioners, blaming the latter for misleading women for their lack of information on HRT. These findings support Lock’s description of the second North American Conference on Menopause that took place in Montreal in 1991: in-house fighting among the medical profession, where gynecologists blamed surgeons

for not understanding the importance of menopause and clinicians from all branches voicing inadequately answered questions about risks and benefits (Lock 1993a, 357-358).

The importance of the WHI study as a watershed was also mentioned by all the healthcare professionals. They stated that the study caused great controversy in the medical field, scared women who are on HRT, and drove pharmaceutical companies to produce pills in much lower doses than before.

3.4 Conclusion

Medicalization of menopause is a modern phenomenon that can be analyzed within the framework of medicalization of stages of life (Illich 1976). In a broader sense, and within the STS literature, medicalization of menopause can be tied to the idea of technological legislation, technological somnambulism, and the study of how technological systems are becoming a force that shape and at times rule our lives. Outside the canonical STS literature, Ivan Illich is one of the authors who examined large technological systems. In *Medical Nemesis* Illich stated that he did not have reformist intentions when he targeted the medical establishment, but was instead using “medicine as a paradigm for any mega-technique that promises to transform the *conditio humana*” (Illich 1976, ii). He took medicine to be an example of large technological systems that shape human lives, along with the other examples like education or transportation.²⁷

If we look at the Western medical discourse, preventive medicine, risk-benefit analysis, successful aging and consumerism are several important concepts to discuss in relation to the point that medicalization of menopause came today. In an editorial on the halting of WHI trial in 2002, David Sackett, a Canadian epidemiologist commented on the arrogance of preventive medicine:

Preventive medicine displays all three elements of arrogance. First it is aggressively assertive, pursuing asymptomatic individuals and telling

²⁷ Langdon Winner, while accepting the value of Illich’s approach, criticized this focusing on a potential hazard to illustrate “oppressive social structures of the modern life” as having the potential to be a “conceptual Trojan horse.” See (Winner 1986, 141-142) for his argument on Illich and for a broader framework of “a process of technological change disciplined by the political wisdom of democracy” (Winner 1986, 55).

them what they must do to remain healthy...Second, preventive medicine is presumptuous, confident that the interventions it espouses will, on average, do more good than harm to those accept and adhere to them. Finally, preventive medicine is overbearing, attacking those who question the value of its recommendations (Sackett, quoted in Seaman 2003, 55).

Illich defined the medicalization of prevention as a symptom of social iatrogenesis that transforms “personal responsibility for my future into my management by some agency” (Illich 1976, 89). Notions of responsibility have changed since Illich wrote about preventive medicine. Now preventive medicine appears as responsibility of your future managed by you, with your “informed” decision. The presumptuousness of protective medicine that Sackett described was somewhat curbed after the WHI trial with arrogant assertiveness transmuted into sharing the decision making. This denotes an exemplary shift from medical paternalism to a more consumer oriented, “empowerment” approach that accompanies the transfer of responsibility together with decision making to the patient. Even though this approach sounds like an improvement in terms of giving more agency to the patients, there certainly is a moralistic undertone in this concept of shared or transferred responsibility. There is an irony in the expectation that women will be responsible to make the “right decision” when the medical community itself is not in agreement about the what is “right.”²⁸

²⁸ *Menopause Guidebook*, published by the North American Menopause Society is an example of the efforts for increasing awareness and making “informed consumers” out of menopausal women (NAMS 2003). The guidebook starts with a chapter called “menopause basics,” in which terminology and definitions about menopause are introduced. Then a chapter on perimenopausal changes comes, including subtitles: reduced fertility, changes in menstrual periods, hot flashes, sleep disturbances, psychological symptoms, vulvovaginal symptoms, and changes in sexual function, urinary concerns, and other health changes. This chapter is followed by another one on postmenopausal health, including heart disease, osteoporosis and cancer as subtitles. The last two chapters elaborate on menopause treatments, which are listed as: lifestyle changes, nonprescription remedies, prescription therapies, and complementary and alternative medicine; and it is stressed that different women have different needs, and menopause is “a time of new beginnings.” (NAMS 2003, 58) There is a semi-medical language throughout the book, explaining the period in medical terms, yet not being universalizing or dictating what the best

This shift from traditional medical paternalism to a new kind of relationship between the doctors and patients framed by a consumerist ideology is described by Jill Fisher in the context of the privatization of clinical trials (2005). Fisher defined the transformed relation with the concept of “pharmaceutical paternalism.”

As part of the historical process of the transformation of the healthcare system by trends in neoliberalism and the consumerism it fosters, pharmaceutical paternalism is characterized by industry interests attenuating the traditional ethic of care associated with medical paternalism with the pursuit of corporate profit, thereby casting both physicians and patients as consumers of pharmaceutical products (Fisher 2005, 18).

This new approach of “patient as customer” who is empowered by information rather than overwhelmed by it comes partly out of the fact that preventive medicine in the case of HRT does not only prevent but also carries the potential to harm. In this context, another example for comparison with HRT would be the approval of tamoxifen as a “risk reducing” drug for breast cancer (Wooddell 2004). Despite the scientific controversy over its effects, tamoxifen was approved by FDA in 1998, which is a situation Wooddell calls the “medicalization of prevention” (3).

In this environment, the language of risk-benefit analysis became especially important. In *Risk Society*, Ulrich Beck argued that the individual, overt, obvious, observable and palpable nature of risk in traditional and early modern societies became global, impersonal and unobservable in the modern society (Beck 1992; Turner 1995, 222-223). Despite possible criticisms of this theory, the impersonal characteristic of risk is very much prevalent in the discussions of HRT and menopause, as well as many other domains of risk. In the STS literature, as well as sociology, the concept of risk is often examined in relation to environment and science, like Brian Wynne’s 1996 study on the hill sheep-farmers of the Lake District in England after their exposure to radioactive fallout from the Chernobyl accident. Similarly, Langdon Winner analyzed the meaning and the potential consequences of employing the language of risk, as opposed to using

choice in terms of treatments is. Facts and figures, as well as the individualistic, rational approach are rather context specific (i.e., valid for an industrialized, Anglo-Saxon environment), which is understandable considering the publisher.

concepts like “danger” or “hazard” (1986). He said that once we start talking about “assessing risks,” how we define the problem and the possible solutions become complicated:

Our task now becomes that of studying, weighing, comparing, and judging circumstances about which no simple consensus is available. Both of the commonsense assumptions upon which the concern for “hazards” and “dangers” rely are abruptly suspended...Evidence that “the experts disagree” adds further perplexity and a need to be careful before drawing conclusions (Winner 1986, 143-144).

Employing the language of risk, Winner argues, brings a conservative element to the argument, where conservatism is defined as the continuation of the *status quo*, and “the burden of proof rests upon those who seek to change long-existing patterns” (Winner 1986, 149). Speaking about risks where there is no possible benefit from a situation, like environmental pollution, obscures the argument and shapes it so that thinking about a totally different way of shaping a technology becomes impossible.

A more relevant literature example for menopause and medical risks is *Risk*, where Deborah Lupton discussed different perspectives on risk, focusing on the theories of Mary Douglas, Anthony Giddens, Ulrich Beck, and Michel Foucault (Lupton 1999). She argued that risk appeared in modern times as a result of the need for control over one’s life:

In contemporary western societies, where control over one’s life has become increasingly viewed as important, the concept of ‘risk’ is now widely used to explain deviations from the norm, misfortune and frightening events. This concept assumes human responsibility and that ‘something can be done’ to prevent misfortune. Feelings of insecurity are common, just as they were in pre-modern times, but we now harbour somewhat different fears, different targets and causes for our anxiety (Lupton 1999, 3).

After laying out how the meaning of risk has changed over time, Lupton turned to the cognitive science, sociocultural and social constructionist theories of risk, and then described the purity and danger theory of Douglas, reflexive modernization and risk society ideas of Giddens and Beck, and the relations between risk and the governmentality concept of Foucault. Several points in her discussions and explanations are important for the purposes of how understanding of risk is used in preventive

medicine and medicalization of menopause. One of them is the idea of the “forensic theory of danger” that she borrowed from Douglas, which is “how people, as members of certain social groups or communities, explain misfortune by looking back to what might have caused it” (Lupton 1999, 46). One type of explanation for misfortune, she argued, is moralistic and relates to a sin committed, like someone died because they broke a taboo, and purification rituals are called for. Another explanation is that which attributes a misfortune to the work of individual adversaries. A third explanation blames the misfortune on an outside enemy, who must be punished.

In contemporary secularized societies, ‘The concept of risk emerges as a key idea...because of its uses as a forensic resource’ (Douglas 1992: 24). Risk has largely replaced older ideas about the cause of misfortune (Lupton 1999, 46).

This “forensic” understanding of risk, when combined with the language of empowerment and the idea of complex systems, created a situation where an individual “feels responsible for everything and powerless at the same time,” which Martin terms as “empowered powerlessness” (Martin 1994).

Imagine a person who has learned to feel at least partially responsible for her own health, who feels that personal habits like eating and exercise are things that directly effect her health and are entirely within her control. Now imagine such a person gradually coming to believe that wider and wider circles of her existence—her family relationships, community activities, work situation—are also directly related to personal health (Martin 1994, 122).

Increased use of the language of risk and cost-benefit analysis in medicine is part of a relatively recent trend that transcends HRT and menopause. In her article on tamoxifen and breast cancer, Klawiter defined the two most important developments contributing to the change of (post)modern medicine as the medicalization of risk and the pharmaceuticalization of medicine (Klawiter 2002). Both developments are relevant for HRT and the definition of menopause as a period of risk by the end of twentieth century in Western medical discourse. Klawiter argued that the “governing logic of risk” is the spirit of postmodernity in wealthy post-industrial societies, so there is no escape from it. However, risk reduction does not necessarily mean pharmaceutical interventions to individual bodies at risk; instead, a more meaningful focus might be the creation of a less

toxic global environment that will keep more people healthier. The argument of an environmental solution also holds true for menopause and HRT, and can be supplemented by the feminist argument of changing “the social” environment rather than holding women responsible for menopausal problems. In a sense, that would be going back to a previous understanding of risk, health and environment, if we follow Lupton’s argument that there has been a shift in the focus of epidemiological risk strategies in the twentieth century, from altering environmental conditions like hygiene and sanitary conditions in the city to individuals’ lifestyle choices. Lupton defines this as “an example of ‘government at a distance,’ for it relies upon voluntary participation in technologies of self-surveillance and a sense of self-responsibility rather than direct intervention” (Lupton 1999, 97).

Similar to the arguments of Klawiter and Lupton on a “newer” form of medicalization involving more personal responsibility over risk, Adele Clarke et al. developed the concept of “biomedicalization” to describe the next step of medicalization in a globalized world (Clarke et al. 2003). They defined the shift from medicalization to biomedicalization as “a shift from enhanced control over nature (i.e., the world around us) to the harnessing and transformation of the internal nature (i.e., biological processes of human and nonhuman life forms), often transforming ‘life itself’” (164). One aspect of biomedicalization is the increased importance of risk factors, and the focus on health, as “a matter ongoing moral self-transformation” rather than illnesses or disabilities (172). This kind of self-surveillance creates a paradox in medicalization:

Health is paradoxically both more biomedicalized through such processes as surveillance, screening, and routine measurements of health indicators done in the home, and seemingly less medicalized as the key site of responsibility shifts from the professional physician/provider to include collaboration with or reliance upon the individual patient/user/consumer (173).

Medicalization of risk in the case of menopause is the last step in a story where scientific information legitimates the use of HRT. Alison Li’s study on the history of the promotion of Premarin examines how scientific evidence and commercial promotion were interrelated in shaping and reshaping the drug’s profile and public relations. She described the change as such:

In the early period, the image of dispassionate science served as a general source of authority. Later, scientific information was framed in terms of personal empowerment and responsibility. More recently, the model of scientific thinking is introduced through the language of statistics, probability, and risk assessment (Li 2003, 102).

Several problematic issues arise when individual women deploy statistically based risk-benefit analysis to decide whether to use or reject HRT. One of them is the argument of “informed decision making” by the woman herself in the face of conflicting information and possibilities condense in the equation “breast cancer vs. hip fracture.” Another issue is the meaning of “risk” calculated from population-based statistics and probabilities when it comes to individual decisions. This is what Illich defined as “equating statistical man with biologically unique men” (Illich 1976, 97). In this respect, it is the words of Lock that summarize the situation in the best way regarding the menopausal women:

The universalized oddity of the aging, failing, potentially costly, white, middle class female body is the target of medicalization, and individual women are required to calculate in terms of risks and benefits how they measure up against her. (Lock 1993b, 345)

Another aspect of this issue is to determine who will be the yardstick for calculating risk in the statistical sense. Two examples would be the calculation of osteoporosis risk for a menopausal woman and the calculation of risk in hormonal contraceptives. According to WHO, osteoporosis is defined as a state in which the bone mass/volume ratio is lower by a designated amount than that of a healthy young adult of the appropriate sex, which comes down to labeling aging body as automatically pathological (Lock 1993a, xxxiii). Furthermore, it is even more difficult to predict whether or not one will have a fracture because of osteoporosis (Coney 1994, 149). In her study on the development of male contraceptive pill, Oudshoorn drew attention to the gender bias in risk assessment in the development of contraceptives, where different criteria were employed for men and women in calculation of risks:

In the individual risk model for men, the health risks of contraceptives are compared with the conditions of untreated, healthy men. For women, the health risks of contraceptives are calculated against the risk of pregnancy, including maternal mortality and morbidity, health risks related to

abortion, and psychological and social problems related to unwanted pregnancies (Oudshoorn 2003, 109).

As we can see in these examples, the meaning of risk and its level of acceptability take many forms even for the “statistical man” (or woman). As a last example, consider this reversal of the usual medical discourse in looking at risk and benefit figures:

Recent data estimate that the reduction in prescriptions of hormone therapy following the stopping of the WHI Estrogen plus Progestin Trial lead to a 65% reduction in adverse events or 8,000 cardiovascular, coronary heart disease, or breast cancer events related to the use of hormone therapy in 2003. (Naughton et al. 2005, 169; quoting Hersh et al. 2004)

Here, data is presented concerning the lack of using a particular drug instead of using it. All these variations in risk calculation make it even more difficult to make sense of the conflicting data for individual women as the “informed decision makers.”

The language of risk-benefit analysis and preventive medicine is combined with the idea of obligation. Another concept related to this is “successful aging,” or “active aging” as the WHO calls it. The WHO definition of the active aging concept is “the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age” (WHO 2002, cited in Kiyak 2005, 245). One of the supporters of successful aging, Asuman Kiyak, argued that this is a positive view of aging, shifting the focus of gerontology from disease, disability, long term care and survival to “enhancing quality of life, overcoming senescence and age-related changes that can be slowed or prevented from resulting impairments” (Kiyak 2005, 245). Thus, the focus will turn to prevention rather than treatment, and aging people are encouraged to be independent, productive, healthy and socially connected. Although all of these sound much better than the formerly prevailing stereotypes of helpless and useless old people (especially women), there are some problematic aspects of this portrayal as well.

John Hoberman argued that “successful aging” implies a prosperity associated with wealth, class and professional achievement in addition to good health, and quoted David Morris, the medical historian on the image of the people who have aged successfully:

A postmodern revision of aging that began in the 1970s has begun to promote a positive vision of the elderly as 'healthy, sexually active, engaged, productive and self-reliant' (Hoberman 2005, 124).

In addition to the class element, the language of success in relation to aging brings the preventive medicine and one's relation to his/her body to a different level. Being able to protect yourself from the possible diseases that come with aging and still having a "healthy" body and mind at an advanced age becomes more than a wish or desire, but "success." What is not pronounced here though, is what happens when one gets sick, or is not "fit enough" for his/her age. Those who do not abide by the rules of preventive medicine and standards of individual responsibility for one's body can easily be labeled "unsuccessful." Your relation with your own body comes to be measured by notions of success, and the stigma of the aging body is reinforced by the sub-categories of "successful" and "unsuccessful" aging. The body is pitted against the will, and it is the body that is to be disciplined by the will that is at work with the re-definition of old age as a continuum of "productive years." The specter of "unproductive" years always looms within the emphasis on successfully aged bodies, which can be put into the general context of the capitalist state practices that portray social problems on terms of individual responsibility:

Funds for the care of the sick, aged, and unemployed are seen as being in short supply, and there has been a corresponding emphasis upon bodily health and fitness, which have also become questions of virtue and blame (Sybylla 1997, 213).

The general frame of "individual responsibility on health and body" resonates well with the tone of successful aging discussions, where governments are encouraged for providing opportunities for the elderly to "participate as workers and volunteers," and reminded of the "cost-effectiveness of providing preventive health services across the lifespan," in order to "recognize the tremendous resource that is the older population" (Kiyak 2005, 246-247).

Discipline and control of the medicalized body is the responsibility of the individual in the culture of successful aging and informed patient. This is where the obligation of "bodily maintenance" (Lupton 1994, 37) is combined with the patient "empowered" with information. Medical discourse on menopause has changed to

emphasize choice and informed patients in the twenty-first century, which seems to be an improvement from the past and responsive to the feminist criticisms of the 1970s. However, this language of choice, and an independent, fit menopausal body still corresponds to the broad economic (and I should add, medical) interests while adopting the theme of “woman’s decision” developed by the women’s health movement, this time to create fear and guilt (Sybylla 1997, 213-215; van Wingerden 1996, 201).

Houck defined the history of menopause in America as one of women’s efforts to gain control over their own bodies, and went on to ask the meaning of it:

But what happens when some measure of bodily control becomes possible? History has suggested how the *ability* to control one’s body frequently shades into the *obligation* to control one’s body (Houck 2006, 238).

She added to that concern two others: that the individual and medicalized responses to illness prevention and female aging can depoliticize women’s bodies, and the limits of the “empowered patient” in the face of evidence can be confusing even to physicians themselves (Houck 2006, 238-239).

It seems like physicians’ obligation to cure their patients’ “deficiency disease” via pharmaceuticals has shifted to the patients’ obligation to prevent possible illnesses and make their own informed choice with regards to HRT. On the one hand, this shift grants a certain degree of control to women/patients/consumers over their own bodies and decisions, yet it is debatable how realistic this feeling of control is when combined with the rhetoric of –and the rationale behind–successful aging and personal responsibility for managing the effects of aging. Clarke et al. argued that the stress upon self-surveillance and the promotion of “preventive” technologies like total body CAT scans is related to the neoliberal discourse of “being proactive” and “taking charge of one’s health” (2003, 181). The same belief in a proactive approach can be observed when it comes to the medicalization of menopause. The question here is what this proactive approach brings to menopausal women. Can a feeling of empowerment mixed with a moral obligation be a real empowerment? Although it is true that this situation makes women “moral pioneers” (Rapp 2000), there might also be a potential for empowerment for some women. Healthcare related proactive moves which are generally legitimized by the aura of respect around science and medicine can enable women to focus on

themselves and make demands that are otherwise not acceptable within patriarchally organized societies. In this sense, biomedicalization can be a tool for women to use in their negotiations with patriarchy.

The way menopause has been medicalized in the Western world has changed over time, affected by technological developments like the availability of synthetic hormones, negotiated by a number of actors with differing powers and interests, including physicians, researchers, pharmaceutical companies, popular press and menopausal women, and all framed by the historical and cultural context. This chapter summarized these shifts, negotiations, and differing medicalizations by focusing on hormones as the crucial and debated therapy for menopause. Europe and North America (conveniently referred to as “the West” throughout the text) was the context where the technology of HRT emerged, as well as the institutionalization of medicine and the starting point for the sociological concept of medicalization. Often, when technologies move out of the contexts into which they were constructed, they change meanings and in return change the social relations in the environment into which they arrive. Now I will turn to what has been happening with regards to medicine, medicalization and HRT in Turkey in order to discern how these concepts and technologies have been adopted and transformed in a non-Western context, where the boundaries of modern, pre-modern and postmodern are continuously redrawn.

4. Listening to Women's Menopause

On three days each week, the obstetric and gynecology clinic of Çapa Research Hospital devoted one of its examination rooms to menopausal women. On Mondays and Fridays they accepted forty people per day; on Wednesdays thirty, because they have staff meeting in the morning and they could not begin until 10:30 instead of start at 9:00 as they did on the other days. The young residents working in the menopause clinic referred to these women as “patients” just like all the other doctors I have met during the course of nine months I spent in Istanbul.

On one of the short Wednesdays I was sitting on the white benches of hospital corridor, talking to Nuray Kaya, who was a 51 year-old retired teacher and one of the “patients” of the menopause clinic. She was telling me the story of how she came to the menopause clinic for the first time. She said that she already was a patient in the regular ob/gyn clinic because of the irregularities in her menses, and then they switched her to the menopause section:

Around that time they sent me to the menopause section upon these complaints of mine and they had me take hormone tests. According to the test results, they told me that I came close to the level of entering menopause and I became a menopause patient, under their surveillance.

The irregularity in her menses was attributed to a polyp in her uterus and she had a series of unsuccessful medical procedures to remove it. In the end she was told that she did not actually have a polyp. At the time of our interview, she had some menopausal complaints like insomnia and hot flashes but she was not taking hormones because she was concerned about the possible effects that hormones would have on the polyp –if she really had one.

[The doctor] asked me if I wanted [to take] hormones. At that time the doctors were divided into two: some were for prescribing hormones, some were against, and some others left [the decision] to the patients themselves. My doctor left it to me. I told him “one of the professors here said I had a polyp, you said I didn’t, I am having a dilemma now. Even if you say there isn’t a polyp, if there is, [I heard that] the hormone triggers it.” Because of that, I said, I am not going to take hormones. I will get over the stress and disturbances by walking and exercise. Now I am taking walks very regularly and am telling my friends who take hormones to not take them.

Despite her decision to not take HRT and her distrust of doctors who operated on her she referred to herself as a patient, and seemed quite comfortable in accepting the role of a patient, coming to regular check-ups and understanding herself to be under medical surveillance. I ran into others like her, who accepted the authority of medicine but kept a certain level of skepticism, mostly based on their negative experiences with the medical system. Other women I met were more at ease with the medical authority, sometimes stressed the importance of being a conscious patient, going to the doctor regularly at the earliest sign of any disease, and even when there is no disease just to make sure there is not any. Then I met some others, who shivered even with the idea of seeing a gynecologist, and told me about their mothers whose menopause they did not even notice. Stories of menstruation, hot flashes, fears of aging and osteoporosis mixed with stories of how to convince women to come for doctor's visits after menopause, this time told by the doctors I interviewed.

In this chapter I will focus on narratives of women on menopause and HRT. Mostly based on the interviews I had with menopausal women, the chapter will start with the invisibility of menopause in Turkish culture in the past, and its connection to menstruation. After a brief section on the portrayal of menopause in popular literature, I will move into the meanings of HRT for women, their reasons for taking and rejecting it and its alternatives. Finally, I will mention how menopause is constructed vis-à-vis "others" like husbands, families and friends of menopausal women, and conclude with a discussion of how women's voices are absent in the public view of menopause.

4.1 Menopause in Women's Narratives

The visibility of menopause in the public sphere is a relatively new and mostly urban phenomenon in Turkey. According to the narratives of menopausal women, menopause was a hidden subject, not talked about up until about fifteen or twenty years ago. There are also marked urban-rural and class differences in the visibility of menopause as a subject that people talked about. This is not to say that previous generations did not have any menopausal complaints. It is more about not having the language to call it a specific time of life, or a condition. When asked about the

menopause experiences of previous generations, most women I interviewed mentioned not noticing menopausal complaints of their mothers or grandmothers. Some, like Nuray, attributed this to moral understanding of the time of their mothers.

I don't know much about [menopause in previous generations], but I haven't seen my mom saying anything like "oh I ceased to menstruate, I am irritable, I am sweating," or anything like her getting angry at us, or losing her patience. It was already a shame according to our understanding of morals to speak of these things. A mother wouldn't speak to her child about these matters.

A small number of women stated that their mothers had some menopausal issues, but usually they could not specify the troubles. Some of them, following the thread above about mothers not talking to their daughters about these matters, said that their mothers did not speak much about it, but they could tell based on their observations. Some others said that they were too young to know about menopause and did not pay attention to what was going on at the time of their mother's menopause, like Meryem Sarıkaya, a 48 year-old divorcée with three sons who recently quit her job in an office where she was responsible for cleaning, cooking and making tea:

[Menopause] wasn't spoken about much of course, we were such a family that you wouldn't get into these kind of issues at all. Besides, I should have been young and oblivious, I didn't care much. Now one understands it better when it happens to oneself. Apparently [my mother] got like that after she ceased to menstruate. She was burning, but who knows why. We didn't have any idea at all.

Some women realized their mothers were going through menopause through their conversations with older women around them who were not their relatives. One of the stories I was told by Emel Sunar, a retired bank employee in her 60's, is illustrative of this point. Emel's mother, who was taking care of her daughter while she was working, used to take the child's clothes off, saying it was too hot in the house. At the time she thought that was weird, but could not really understand why, until she heard some older women talking about menopause at her workplace and realized that her mother was having hot flashes.

[T]here were [elders] in the bank, they were talking at that time [about menopause]. I said, Mom, you have menopause, don't take off the child's clothes when you feel hot, OK?...I said, that's how it happens apparently; I think you don't have your periods anymore. We didn't use to talk to my

Mom. I didn't know anything, we didn't use to talk about anything with my Mom. We still don't.

Like Emel, Nuray's story of learning about menopause is related to older colleagues who are more open to talking about their menopause. She mentioned learning about menopause at school as a word, and contextualizing it in the experience of some of the teachers in the school she worked complaining about the heat. One possible explanation for the relative ease in talking about menopausal problems among friends and colleagues is the nature of these relationships. Interactions women have in their workplace would be that of equals rather than laden with the roles of parent and child in a family. Another reason can be related to the higher socioeconomic position of their women friends, who are relatively better educated and working at a job compared to their mothers, who were mostly housewives.

The difference in approach between generations on talking about menopause was a common theme in interviews. Generally women said that their relations with their own mothers were burdened with taboos, their relations with grandmothers was even worse, and their relations with their own daughters are much freer. Hanife Toska was one of the women who commented on her grandmother. She was also one of the few women who was born and lived in Istanbul all her life, and was married to a shoemaker who did not let her work despite her desire. She was living in Samatya at the time of the interview, which is a lower middle class neighborhood of Istanbul.

Well, the [previous generations] always had hot flashes. Anyway, is it even possible to talk to the grandmother about these things? But we are like friends with my mom.

The difference in her description of generations might be attributed to the more liberal values of an urban environment she was born into. Along the same lines, Zehra Yalova, a 51 year-old housewife and high-school graduate, repeated the argument about the mother-daughter relations in the previous generations and added that the situation has not changed in some more conservative circles.

Because my mother passed away at the age of 55 we didn't witness [her menopause] much. When my mother passed away I was married, I was not by her side. She had her problems, as I said, insomnia at night, and others, that's the most that I witnessed. Another thing is that in our upbringing the mother didn't tell [about her problems] to the daughter. Because it was

very shameful, it was forbidden, things like these weren't spoken. It was a taboo. Still it is the same in some circles.

The invisibility of menopause parallels the invisibility of menstruation, a similarly unspeakable subject. Some women linked their stories of not knowing anything about their mother's menopause to stories of their own menarche. The following story, told by Şaziye Kurtuluş, a 60 year-old housewife married to an army officer, is a very good illustration of the cultural environment that some of the menopausal women of today were brought up, which probably shaped their understanding of menopause:

Now, my mom, may she rest in peace, these kinds of things were never spoken in our house. I mean, never. Because of that I don't know when she entered menopause, what she did, not at all. But I didn't treat my daughter like that. My elder sister and I grew up like twins, when we had our periods my mom told us not to tell anyone, because it's a big shame, a big sin. I had my period before my elder sister, I was in fifth grade. We were playing, running around. God bless her [my mother's] soul, everything was shameful and sin with us. We grew up with that kind of a discipline. I still appreciate my deceased mother, but it shouldn't be that much. For example, I couldn't tell my sister [that I had my period]. She would run in front of me, or rather walk fast, and I'd try to catch up with her in—excuse me—in rags and stuff, because there wasn't any *orkid*²⁹ in those times. Anyhow, one day my sister had her period, she couldn't tell my mom. Poor thing put tiny little something, after asking her friends. She's not telling me either, you know, since it's a shame for us, a sin. She dropped that little thing at school. I can't forget it ever, oh my dear sister. What could she do? She couldn't tell. We two sisters told each other eventually and took care of it like that. Then, when I was raising my daughter—of course that changes in every generation—she learned about it from her friends. We were like friends with my daughter too, I mean, we're close.

Connections to menstruation came up frequently in the group interviews during tea parties, which can be considered “safe” places for women to talk about issues that would be shameful to talk in public or in mixed company. Following is a dialogue that took part between two women during a tea party where they were telling me about their menopause. The first one, İnci Soylu, is 66 years old and the second, Münevver Coşan, is 70. They are both housewives, living in a lower middle class neighborhood in Istanbul.

²⁹ *Orkid* is the oldest and most famous brand name for sanitary napkins in Turkey, which became the general name for all sanitary napkins -like Kleenex for tissues in the United States.

İnci - Now everything is spoken everywhere. Now I feel ashamed talking to you about these because we were brought up like that, believe me.

Münevver - Yes. I was talking to the postman at the door once, because my elder brother was doing his military service and his letter came in late. My dad got so mad at me for talking to the postman. He didn't beat us or anything, but we were raised with very strict ways in the family. My mom was docile, she used to overlook a lot of things, take us to places we want to go, dress us however we wanted to. But my dad was very conservative, very disciplined.

İnci - I mean, maybe everyone was like that. Maybe it was just my environment, but we didn't speak. These things were shameful, they weren't talked about.

Maral - They didn't talk about periods either, right?

İnci- No, no, what does period mean? We didn't know what it was.

Münevver - My sister wrote it down, left me a note on the table, saying there are rags in the so and so place, take and use them. I sat around wet for two-three days. You don't know what's going on. And I had it [my period] late, I was 14 years old.

As can be seen in these and some previous examples, women who are brought up with strict discipline and taboos of not talking about matters regarding menstruation or sexuality mention their own relations with their daughters, and their attempts at providing a more open environment for them. This shift has resulted in menopause and menstruation being more publicly spoken issues in the next generation.

The fact that most women in these examples referred to matters regarding menstruation and menopause, or reproductive issues in general without mentioning their names illustrates the “taboo” nature of these subjects. While part of this invisibility stemmed from the shame of talking about menopause and menstruation, part of it is due to certain characteristics, or moral values of their mothers that would make them “suffer in silence” without making their complaints visible to their families. Belgin Altan is a 55 year-old retired high school teacher from Manisa. She shared her experience of her mother's menopause.

For example the closest example to me is my mother. My dear mom was a very selfless, forbearing person, she had all sorts of niceties about her, I never felt [that she was in menopause]. She never talked about it...she didn't complain, didn't say anything. But we were four siblings, the period

before us there was a very primitive life, poor mom always worked...So it wouldn't be a lie if I told you that I haven't seen any complaints, any problems that my mom had. But of course there should be some, she didn't reflect it upon us.

Another example would be Banu Hekimoğlu, a 53 year-old nurse from Kayseri, who worked in a hospital in Edirne. She said that her mother never went to the doctor or take drugs despite her complaints:

I remember my mother's menopause, she had very severe hot flashes, they have been continuing still to a recent time actually. My mom is 73 years old now, she entered menopause at the age of 48, she constantly had sweating and hot flashes since then but my mom didn't go to the doctor and took drugs. For a while she suffered, then it went away but she never took drugs, ever.

As in Banu's story, narratives of menopause as being a shameful or invisible issue in past generations is backed up by stories of the non-existence of the habit of going to the gynecologist in the past, or in some cases, doctors in general. This is especially true for those who migrated to Istanbul from rural areas, as Cennet Eliaçık stated. Cennet came to Istanbul from a village of Tokat, married to a textile worker and worked as a day-laborer in the house of a doctor couple for six years, until they moved to Ankara.

I remember my mother's menopause from old times. She was very nervous, hurtful. But she was also very busy, had a lot to do, they didn't know what menopause was in that date. I know very well that my mom didn't know about doctors, menopause, which disease is which. My mom came from the village, had a stroke and only then understood [learned] about going to the doctor.

Yet again, there are a few participants who said they remember their mother's menopause not being problematic at all. Sıdika Acısu, a 62 year-old housewife from Çatalca, talked to her mother about menopause at the time of her own menopause, and the mother's reaction was to dismiss that there could be any problems about this period:

My mom says she didn't understand anything. She was even getting mad at me, saying why are you going to the doctor, we lived through those days too, we didn't understand.

I observed this attitude of dismissal especially in the context of women who said they were too busy to realize what was going on about themselves. In some of the above

quotes, some women who said their mothers did not have menopausal complaints attributed the lack of complaints to the harsh life conditions their mothers endured. There are some other women who I talked to outside of the hospital circles that tell the same sort of stories about their own menopause. As a matter of fact, my own mother is one of them. She told me that it is usually the housewives that complain about menopause because working women like herself are too busy with the double burden of working both at home and outside that they do not have time to notice what is going on. In general, although visibility of menopause increased with the level of education and urbanization, these factors alone cannot explain its medicalization. Menopause of previous generations is characterized by the prevalence of hot flashes, sweating and nervousness/irritability that were observed by daughters, granddaughters or daughter-in-laws, and it was rare to seek for medical remedy for those complaints.

As can be seen in the examples above on taboos of talking about menstruation, menstruation and menopause are related concepts. In Turkey, even before the word menopause was used, there was an acknowledgment of change that comes with the cessation of menses. During my fieldwork most women spoke about menstruation when asked about their menopause, especially the last few menses that they have, which sometimes happen to be very heavy. Apart from the shameful or troublesome aspect of menstruating, there is a more positive side that denotes an idea of purging. Some participants spoke of menstruation as something that brings relief, helps the body get rid of some excess material. Menopause, in relation to that, can cause distress because that purging, or getting rid of excess cannot happen. One problem that comes with it is headaches, according to what Nurdan Gökdemir, a 50 year-old housewife living in Gaziosmanpaşa explained.

In the beginning I was very aggressive, extremely, I was terrorizing everyone at home. Then there are headaches, when I can't have [my period] I have a headache for like three days...Like how you would have your period and be cleaned, feel lighter when you were having your periods, I thought, I have to live [menopause] like that, and I will.

HRT is also sometimes assessed in this context, as a substance that helps you to have your period and relieves the headache. Rukiye Denizli is one of the women who found

such relief in hormones. She is a housewife living in Gaziosmanpaşa like Nurdan, and has a case of premature menopause, having ceased to menstruate at the age of 38.

When you don't have your period you have a headache, a scalding sweat comes, you go crazy, get very aggressive...[The drugs] help, you have your period and get relieved. Your headache goes away.

The meanings of having a headache are beyond the scope of this dissertation. However, they are still worth mentioning for the prevalence of complaints I heard from my participants, and the attribution of a psychosomatic character to women's headaches by some doctors.

Along with the meanings of being a necessary substance countering a loss and a suspected unknown material and following the connection between menstruation and menopause noted above; HRT was also perceived in relation to the menses and/or lack of menses. This more specific meaning showed itself in the accounts of women who talked about "postponing the menopause," or who said that they wanted to menstruate as much as they could, with the help of HRT. It should be noted, however, they usually referred to HRT as a "drug," not as hormones, or hormone replacement. The hormone related element was either ignored or downplayed, or the women were unaware of the components of the drug they are taking. For example, Meryem was telling me that she has to take drugs to go on having her periods:

Thank god [the hot flashes] are passing quick for now. But when I think what if it comes more frequently, I don't know how it will be like. So somehow I'll have to take drugs to make it go away, to be relieved. But now I'm all for having my periods. I say, let me have them as long as I can.

Sometimes women directly referred to drugs as the "lengthening pills" that prolonged the period when a woman is still menstruating, like Şükran Ilgaz, an elementary school graduate housewife living in Güngören did:

Back then I wasn't in a good position financially, I didn't have [social security] either. I told the doctor about that, said I didn't have the means to do the tests. I asked him if there is anything that he can give me without the tests, and he gave me the same period prolonging pills, he said if you haven't entered [menopause] this will prolong [the amount of time you have periods].

Especially when women were on HRT for premature menopause, they defined the pills in relation to menstruation. Güliden Levent entered menopause at the age of 34, and was prescribed HRT:

I'm 38 years old, I entered menopause four years ago, premature menopause. I have been taking hormones for four years, to have periods.

In this context, HRT enabled women to go on with a period of their life they wanted to lengthen. The idea of seeing HRT as such complements the idea of menstruation as purging/cleansing. This is quite different from some American women's expectations from HRT, where return of menstruation is cited as one of the unwanted side effects (Watkins 2007, 251). It is also true that some Turkish menopausal women, especially those who did not have menopausal complaints, welcomed the end of menses as a relief from messy, bothersome and unclean periods.

4.2 Literature and Self-narratives

The proscription of talking about menopause extends to the public sphere as well, where there are few non-medical studies done on menopause in Turkey, and even fewer examples of women's self narratives in Turkish literature. Dr. Tolga Ersoy's study on the interaction of menopause and culture is an example of the former. This study is interesting not only because of its findings, but also because of the way these findings and the book are situated. The book, *Menopoz ve Kültür* (Menopause and Culture), is a published master's thesis in social anthropology written by a medical doctor. Ersoy examined the affects of menopause on the role and status of women, using field data collected in Cevizlidere, a slum neighborhood in Ankara, in 1995. The field data were based on interviews done with 42 women between the ages of 45-70 out of a target population of 209. The reason given for this discrepancy was that most of the women declined to be interviewed "due to cultural reasons," according to the explanation of the author. The participants were interviewed either in their houses or in the local public clinic in Cevizlidere, in isolated settings (Ersoy 1998, 117). In the study, there were questions about women's contribution to the decision-making in the house, their knowledge of menopause and where they received it, and the changes in their lives and

their relations with others after menopause. After summarizing the findings on statistical questions, Ersoy commented on the answers on “knowledge about menopause:”

The lack of knowledge about menopause presents itself in every level of the study. Half of the women enter a natural period of their own lives without knowing. An important part of those who say that they have information say that they gather that information from those around them, and very few felt the need to consult a physician. As a result, woman lives her menopause on her own and does not feel the need to question it. (Ersoy 1998, 132)

According to the results of the study, on the issue of changes in their relations with others, seven of the 42 women noted a difference in the way their husbands treated them. Among those who noted a change, two said that their husbands started helping them more in household chores and listened to them more, and one said that her husband interfered in the way she dresses less than he did before. The other five mentioned negative changes, saying that their husbands got more aggressive and humiliated them more, using phrases like they were now useless women incapable of bearing a child. (Ersoy 1998, 133) Ersoy interpreted these answers as a sign for reducing menopause to reproduction and sexuality, in turn causing negative behaviors. I believe that both positive and negative reactions denote a decrease in femininity that comes with menopause, and a following decrease in expectations to fulfill the female gender role.

In terms of how women experienced menopause, the study showed that half of the women mentioned “relief” from menstruation, which was deemed to be dirty and uncomfortable and from fears of unwanted pregnancy and sexual obligations (134). Hot flashes and night sweats were the two most common complaints, seen in around half of the women interviewed; yet those complaints were not seen as reasons to consult a physician. Still, half of the women interviewed stated that they went to the doctor for reasons other than menopausal complaints. The reasons for going to the doctor were listed as high blood pressure and bone-joint aches, and these were seen as signs of old age rather than menopause (135-136). Ersoy stated that although most women knew that their menses were going to stop at some point in their lives, they were not aware of what was going to happen to them next, and they see the cessation of menses as the start of old age and consider the menopausal complaints as “faith” (138).

In the preface section, Ersoy mentioned that since there are so few publications on menopause, culture and status on Turkey, the chapter on menopause and culture is mainly based on medical publications. He further thanked a female colleague of his for helping him “get over the conservatism in the approach of women during fieldwork,” which underlines the fact that women felt more comfortable talking to a female researcher, and he also thanked another person in the pharmaceutical firm Ciba-Geigy for his help on literature (Ersoy 1998, 10). Although this was a social sciences study, it is possible to see the medical approach to the subject in certain comments and the research design. The questions and interpretations of certain answers framed knowledge on and seeking medical help in menopause along the lines of what medical culture sees appropriate.

In the field of literature, İnci Aral was already a famous Turkish writer when she produced one of the earliest accounts of menopause in the Turkish popular culture. In her memoir/novel *İçimden Kuşlar Göçüyor* (Birds are Migrating from Inside of Me), she narrated her story of undergoing a hysterectomy in 1989 because of cancer and her experiences of menopause and taking HRT, and the reactions of those around her; all told through the developments about the increasing visibility of menopause in Turkey between 1989 and 1995 (Aral 1998). Her menopause came suddenly and unexpectedly, since nobody warned her about what was going to happen to her after her operation and she did not think about it too much in the beginning. Her first reactions and opinions on menopause are in line with what I heard from some of the more educated, professional women whom I encountered during my fieldwork.

It is said that for some women menopause is lived more intensely. Women who are ill-equipped, taken less seriously and haven't produced anything worthy all their life have a difficult time to go through this passage; yet women who are at peace with themselves, have a job to do and are cultured could overcome it easily. I am full of self-confidence. Menopause, I sneer; it won't be difficult for me at all (Aral, 1998, 47).

She then described the way menopause is portrayed as a wonderful period in the books and articles she read, and how this portrayal does not match with the reality she experienced and observed around her:

I have been reading encouraging articles arguing that post menopause is the golden age of womanhood...However; I see that these opinions do not fit the realities of the women around me. Menopause is considered a

period where a woman settles down and retires from life. The enthusiasm for living and exuberance of menopausal woman is condemned; every step she takes out of the narrow and boring area of being a grandmother and a lady is found inappropriate (Aral 1998, 51).

In her effort to learn about menopause, she started to look for books on menopause, and complained that there were not any, except for parts of some books written by US-based feminists that described menopause as a period of maturity and change. She made some remarks about the invisibility of menopause in Turkey, and attributed this to the existence of many other, more important problems to talk about and eventually felt embarrassed for exaggerating her menopause.

For us, it is as if such an issue does not exist. Maybe its turn doesn't come in the midst of all problems. Corruption, scandals of bribery, the unpreventable rise of religious fundamentalism, fortune telling, magic, inflation... Lost people, torture, actor unknown murders, war in Southeast, unemployment, erosion... Menopause is a luxury for us.

I am ashamed of myself. I say to myself: try to hold on tight, be fine, and don't exaggerate anymore. (Aral 1998, 62)

Another more tangential instance was where a woman writer of detective novels included menopause as an undercurrent. In her novel *Kelepir Ev* (The Bargain House), Esmahan Aykol's character of a German detective living in Istanbul, Kati Hirşel struggled with irritability and hot flashes that she refused to attribute to menopause as she pursued to find the mystery behind a murder case (Aykol 2003). Menopause appeared in the book as a possible explanation for Kati's anger, irritability and mood swings while she dealt with her daily life and personal relations as well as solving the mystery of the murder that she was blamed for, and she mostly denied that these can be related to menopause.

The last set of examples of self-narratives is from a bimonthly feminist magazine, *Pazartesi*. In their special issue entitled *Beden* (Body) and issued in October-November 2006, there were several articles on menopause, mammography and hysterectomies. In one of these articles which was originally published in 1999, Nevbahar Songül told the story of her menopausal symptoms and how she started taking hormones for these symptoms, while commenting on the invisibility of menopause:

While sitting with women friends, I gather my courage and open up the issue. It's like they don't want to listen. The ones that are at the same age are evading the subject; the younger ones keep silent with looks that seem to be saying, "we're different." I am getting angry with all of them, my anger is increasing as time passes. What am I going to do with these women that don't understand me? I feel like I can get all of them out of my life and I start with the first steps. I am surprised that I can erase them that easily. So be it. I know I am right.

The newspapers are almost inviting one to menopause in the articles they publish on menopause. Such nice days await us: let's all enter menopause! Since menopause is a new and wonderful life, and the picture for the article cannot be "a watch," a naked woman of twenty-five—from the breast cancer connection— compliments the article and decorates the page.

Actually, the issue is a "no-no," women of letters write about their loves, pains, abandonments, betrayals with great detail but when it comes to menopause they don't seem interested (Songül 2006).

Looking at these examples, it is possible to say that menopause still carries its cloak of invisibility, even among urban, educated, middle class women.

4.3 HRT: Users and Reasons

The most important reason women told me they went to the doctor and asked for HRT was the severity of her disturbances, especially the hot flashes and night sweats. All doctors said that regardless of their socio-economic status, women who were having severe vasomotor symptoms were the most likely ones to seek for or accept taking drugs. The main difference between classes was that poorer and less educated women would be less likely to question, or be aware of the type of drug given, for a variety of reasons including lack of information pitched at an appropriate level of literacy. Apart from severity of complaints and lack of knowledge, issues of trust between women and their doctors, former habits of going to the doctor, obligation to stay healthy for others, and perceptions of menopause were factors affecting women's decisions to take or reject HRT.

The relation of trust between doctors and women is an important factor in a medical culture where doctors still have significant authority and respectability. Women tend to believe in the doctors, especially when doctors spend time explaining the

treatment in ways that convince them to use it. This issue of time spent explaining things to the patient, and the doctors' attitudes towards patients came up numerous times during the interviews. Despite concerns, women usually took the drugs that the doctor prescribed them when s/he makes an effort to convince them, and did it in a nice manner. I will elaborate on the subject of doctor-patient relations in Chapter 6, Clinic as Arena.

There was also a group of women who see taking HRT and being a menopausal patient as an extension of their previous 'medicalized' life. It was only natural to somebody who delivered her babies in a hospital, sought remedy from modern medicine any time she had a problem and who believes in modern science and medicine. These women who were willing to take hormones or could be convinced to do so had a more or less positive view of hormones. There was another group of women who took hormones because they needed them, or because they were prescribed hormones yet remained skeptical about their risks and were not very happy about the situation. As an example for the last group, one of the reasons that Meryem gave me for taking hormones was that she was a single mother taking care of her children, so she needed to work, and not be bothered by having hot flashes in the meantime.

[Hormones] are not recommended too much, but you take them when you have to. Now, about the drugs, I am in favor of menstruating a little more. Because it [menopause] affected me a lot, I don't know how it will affect me in the future psychologically. Because I have to work some more.

Hanife was another example stating caretaking responsibilities and the need for HRT. She said she had to be treated, because she had too many responsibilities, including taking care of her husband who had a stroke and she could not afford to not be in good condition at that point in her life. She presented taking care of herself and having any possible condition treated almost as an obligation towards others, or the right thing to do:

If I'm menopausal, instead of throwing this plate to the wall I will go and ask for help from a doctor. It has been like that generally, I had psychiatric treatment as well. I had to do that, because I had a patient...Around that time, my daughter had a boyfriend, he went to do military service, then came back, engagements, weddings...I mean, it's not easy. Everything is on you, the hospital, inside, outside, we have a big circle of friends and family, guests coming home, you have to do everything. You have to keep standing on your feet with [the help of] those drugs.

Being in good health to properly (and sometimes physically) take care of others is an aspect of being under medical control in menopause, even when one is not taking HRT. This was the reason for both Cemile Koca and Gülsen Dalkıran to come to hospital. Cemile, a 51 year-old housewife living in Kocamustafapaşa, a lower middle class neighborhood of Istanbul, was taking care of her grandson and although she was concerned about the drug's side effects she felt the need to make sure nothing is wrong with her.

I couldn't have my tests done because I'm taking care of my grandson. ... The smear came out a little weird, the doctor said it's the beginning of menopause, but I couldn't be treated, because of children and grandchildren...My husband is scolding me, [saying] why aren't you having it taken care of, you will have more problems later [if you don't], who is going to take care of the grandchildren then.

Gülsen was another housewife of roughly the same age as Cemile, and living in a similar neighborhood (Şehremini). She took turns with her sister to take care of her bedridden parents, and was concerned about breast cancer.

I will come [and have my breasts checked], I won't neglect it. What can I do, my health is important, I am taking care of my parents...We cannot [hire help], there are two people at home, I have my dad and my mom too. My dad is 93 years old. And they cannot get up, they're in bed all the time. We are helping them walk, eat their food, take their baths. Me and my sister, the two of us.

There is another argument that for some women, taking HRT, or being on any kind of drugs might mean the legitimization of their problems and suffering in the eyes of their families, especially their husbands. I have not heard this view being expressed by women themselves; it was only mentioned by some of the doctors whom I have talked to, sometimes in a half-joking context. Although the fact that this information came only from the doctors and not from women raises some doubts about its real meaning for women, it would not be too unrealistic to think that having a physical illness and having it validated by a medical authority can be important for some women, especially given the cultural portrayal of menopausal woman.

On the menopausal women's front, some of my participants arguing against HRT admitted they could take it for bone loss. In general, the fear of osteoporosis brings them to the doctor, and there is a general interest in having their bone mineral density

measured; however, decision for its treatment is left to the doctors. Most women I interviewed take other “bone drugs” as well as HRT, depending on the inclination of their doctor. Considering the interest in bone mineral density measurement among menopausal women I interviewed and depending on their accounts, the fear of osteoporosis is an established one, sometimes accompanied by vivid images of bones breaking with the smallest effect. Şeyda Üzgün was a 46 year-old woman who came to Çapa with menopausal complaints bothering her for the last six months. She used to work in a textile export company, but stopped working a while ago. At the time of the interview she was undergoing the routine tests and was worried about osteoporosis.

I am at the beginning of the whole thing, now they say I have an early case of osteoporosis, and that scared me too much. I have acquaintances around me who have osteoporosis, I am very scared when I see them. Their [bones] got really really thin now, for example if you touch, their bones can break with the slightest concussion, the doctor told them so. That scared me a lot. Because of that, I hope I can get a good result. I mean, I will do whatever it takes, whatever I have to do for it, because I am very afraid. I'm afraid of osteoporosis.

Although not as prevalent as in the North American context, hormones as a way of prolonging youth appeared in the interviews with women. Some referred to the way hormones made them look, sometimes content with the result of taking hormones, sometimes regretting that they had to stop; and some of them referred to other women that are taking hormones as examples of how much it helps the skin. For example, Gülsen, who took hormones for four years, said “They tell me that I look young, I tell them, swallow the hormone and stay young.” Serpil Atacan, a middle class housewife living in Dikilitaş, regretted having to stop taking hormones because she liked the effects they had on her.

When you take estrogen the skin looks livelier, you have less wrinkles. For example, I am 48 years old, my wrinkles increased because there isn't estrogen. But when I was taking hormones it was much better, I didn't show my age at all.

4.4 HRT: Non-users and Reasons

Although some women I interviewed subscribed to the medical view, seeing HRT as putting back what the body is lacking, some had different views of it. On the negative

side, the most prevalent notion attributed to HRT is that it is an artificial, alien substance entering the body. Women expressed concern about the possibility of its side effects, especially cancer, but going beyond that, there was the idea of not trusting that alien element, or at least, finding it unnecessary. This argument about HRT being unnecessary was usually backed up by the fact that the previous generations did not take it, and they were fine, and sometimes even healthier than the current generation. Following dialogue, passing between two members of the group Sultans of Menopause illustrates this argument.

Sibel- And hormone is something that you take from outside. [Menopause] is going to happen, it is something that every woman is going to go through. It is something that can be lived through, that will pass, why would we get a supplement like this from outside.

Hülya - Yes, did our grandmothers take it, in our country. My mom too, [took] nothing for menopause, I don't remember.

As can be seen in this example, women who support this argument usually try to talk others out of taking hormones too. Being skeptical of hormones and medicine herself, Nuray repeated the same point during the interview as well.

[I am] telling it to my friends that take hormones to not take them. Were there hormones in the past, our mothers, grandmothers, did they take hormones? They got over those problems as they went with their natural lives. I consider myself as having gotten over it myself too.

Apart from reference to previous generations, there is also the view that taking hormones from outside intervenes with a transitory period in the body and prevents the body from establishing its own balance. This was another point that surfaced in the group interviews, as is the case with Sibel's argument from Sultans.

Now, if we think about it logically, this is a period, first there is the premenopause, if you suddenly enter menopause your body can't find the balance anyway. Then [doctors] prescribe [HRT to those who suddenly enter menopause] anyway...But in its normal time, doctors say it's between 44 and 48 in Turkey, these four years are already premenopause period. You have periods every twenty days, or every two months, the body gets itself ready anyway. Estrogen decreases slowly. Say that you're having it put back from outside, how long will that last?...The doctor told me "you're going to enter menopause at the age of 47-48, how long will it take you after 50, you're going to cut it all of a sudden, and it will disrupt

the balance of the body even more.” But if you leave it [to the body] the metabolism adjusts that balance slowly in the premenopausal period.

The notion of balance came up in the context of what drugs were used for and talking about the alternatives to HRT, mostly herbs that are thought to relieve menopausal symptoms by “balancing the hormones.” Especially sage and fennel are described as good for hot flashes and nervousness.

The alternative to taking artificial substances into one’s body is to supplement the body with “natural” ones. Food, especially a balanced diet, is cited among the “natural” remedies for menopause. As I was interviewing Nurdan, her daughter, who was a second year medical student, was present. After we are done with the interview, she said that she wanted to add something, as an explanation for why her mother did not want to take HRT.

The reason my mother doesn’t take hormonal drugs is that she doesn’t want to disturb the balance of her body, because [hormones] are artificial. She thinks, instead of taking something artificial, [she] can supplement it by eating naturally.

Doctors responded to this argument of hormones not being “natural” and previous generations surviving menopause without them in different ways. One of them is the counter argument of “not everything natural is a good thing.” Oktay Kadayıfçı gave an example of this argument in his book, saying that flood and earthquake are naturally occurring events too, but the harm they make is undeniable (Kadayıfçı 2006, 75). However, a more interesting point that he made when defending HRT against these arguments was about the changing meaning of the word “natural.”

Personally, I see the estrogen that a menopausal woman takes as medicine as part of nature. Like an apple tree presents the substances it takes from the earth to us as an apple and an apple is part of the nature; the drugs that people make in the factories by substances they take from nature are the fruits of humans, so a piece of nature (Kadayıfçı 2006, 37).

Another counter-argument developed by doctors in response to hormones being unnatural or not having been used by the previous generations arguments was that we are not living as the past generations do when it comes to other technological advances, and there is no reason for drugs to be an exception. One of the women I had a casual conversation with on menopause told me the story of the time she wanted to stop taking hormones. When

her doctor asked her why, she said her grandmother or her mother never took anything and they were fine. The doctor's response, as she recalled, was asking her whether she was riding an ox-cart when going to Bodrum (a popular holiday resort in Mediterranean) for a holiday, or taking the plane. This statement is very much in line with Kost Shelton's argument about pasteurization and vaccines as quoted in Chapter 3. I heard some other doctors complaining about the attitude of their patients by referring to similar comparisons of using different kinds of technology.

Another reason cited by women who considered taking hormones unnecessary was the belief that there are already enough hormones that we take into our bodies nowadays, via food or water. Canan Evcil, who hosted the tea party in Sarıyer, mentioned this argument, supplementing it with the medical authority of her cardiologist.

My cardiologist...told me that it's not necessary [to take hormones] at all, everything that we eat has hormones in them anyway.

This idea of "environmental hormones" (Wynne 1996) came up during the group interview with Sultans too, when discussing the hormonal problems the younger generation is experiencing.

Esin - I think we are actually lucky, because all this food with hormones is unfortunately a big problem with the youth. I'm seeing it in my sister in law's daughter, she's 17 years old and she doesn't have periods for 2-3 months.

The same idea that exposure to environmental hormones was inevitable was used by the proponents of HRT among women as well, against the argument that HRT causes cancer. Hanife justified her position on hormones as such.

It is a must that everyone be treated. I mean, as see it from my own perspective, but everybody looks at it differently. They say it causes cancer, there are hormones in everything we take anymore, what doesn't cause cancer?

So, it is possible to say that the views of women on HRT are related to their views of hormones in general, as cancer-making substances when taken —deliberately or inadvertently— from outside, and a mysterious matter that has a delicate balance inside your own body. Following this thread, some women felt confused about the real rationale

for taking the drugs they were on, and whether it was a good thing to take them or not. Şükran was one of these confused women.

I am getting confused. I don't know it for sure whether these drugs only are good for my troubles, or they are putting back some things that are disappearing in the body. I wanted to ask that to the doctor, but he told me to take them and come back after ten days, so I thought of asking then. If it's certainly putting back something that is being lost, well, then again, I don't know if it's also causing some risks too. I want to go to a private doctor and talk all of these with him...with a good specialist.

Fear of potential risks of the drugs is an oft-cited reason for not taking HRT. Most prevalent of these risks is breast cancer risk. Breast cancer risk became embedded in the idea of HRT especially in the wake of the WHI study. Since fear of cancer is the number one reason for women to refrain from taking HRT, or hormones in general, fearfulness is a common complaint of the doctors, who say that hormones became equated with cancer in the minds of people, thanks to the media. For some women, fear stemmed from the information they got from the media, and for some it was rooted in their own personal experiences with relatives or friends who had cancer after being on HRT. Serpil's story of HRT was of the latter kind. Even though she was not sure that the hormones caused cancer, she decided to stay away from them anyway after seeing her *elti*³⁰ having cancer while they both were taking hormones under medical supervision:

My *elti*, for example, we were coming [to the doctor] together, she had cancer. Furthermore, she had it while she was under supervision here, we come here every year together. She had ovarian cyst, ovarian cancer, they took everything out. I said, I won't take anything. I stopped that day. I mean, I took it for three years, then I stopped... We were telling the doctor, we hear about the hormones causing a risk of cancer, and he was telling us the risk is as high as everyone else's for you. Who are you going to trust, naturally we were saying [thinking] whatever [the doctor] says is true.

³⁰ *Elti* is a word that does not have an exact English translation. It is used for a woman's husband's brother's wife. In other words, when two brothers both get married, their wives become each other's *elti*. Although it corresponds to the word "sister-in-law" in English, sister-in-law is not as specific as *elti*, being also used for the wife of one's brother or brother-in-law, as well as the sister of one's husband or wife. In many instances *eltis* happen to be roughly the same age, and since they are in similar social status having entered into their husbands' family as young women they can develop close friendships (or sometimes rivalries).

The time she and her *elti* started taking hormones coincide with the WHI study results. The first time they came to the doctor is in the year 2000, and according to her own narrative, she stopped taking hormones around the year 2002 or 2003, which is the year that WHI study results got publicized. She further explained how and what she learned about the risk of hormones, and her confusion about whether to take hormones or not, and who or what to believe in the situation that she was in, at the face of her *elti*'s cancer, who was using transdermal patches, while she herself took pills:

So, they gave us those drugs, we started with Divina, we were taking them very well, we didn't have any problems, both of us the same. One year after that they changed the medicine. We started on Kliogest. This time the newspapers were saying hormones increase the risk of cancer. So you get nervous when you're taking them, after reading these news. What if? There are always 'what if's. What if it causes cancer? But besides that, of course, they say there are protective aspects of [the drug you take], it prevents heart attacks, colon cancer. But mostly they say it causes breast cancer, according to my knowledge. And when my *elti* got cancer from the drugs...I shouldn't say from the drugs, but while she was under control taking the drugs, I stopped taking them immediately. I thought I shouldn't double the risk by taking drugs.

Stories of cancer affected women's views on HRT even when they did not witness the problem themselves like Serpil did. Neslihan Bilgin was a 54 year-old secretary working in the private practice of a gynecologist. She was in menopause for five years, and she never took hormones. She told me about somebody she knew who had cancer, and what she thought after hearing her story:

For example, I have an acquaintance. [Some doctor] gave her hormones, and she developed a mass in her breast. Or maybe she already had it, it became visible with [the hormones] earlier. So she had breast cancer, she had to have her breast removed. If you ask her, she says it's because of the hormone and her surgeon agrees with her on that.

Sometimes the views of women on HRT and cancer came up when talking about other women who were taking hormones. Zehra was not prescribed hormones because of a counter indication (she had a brain tumor) and she commented on the hormones when I asked her whether she would have taken hormones if she did not have that condition:

I wouldn't want to [take them], because they have too many side effects as far as I heard, and as far as my doctors tell me. They didn't think that it would be good for me. Plus, they thought that it would be unnecessary,

because the hormonal drugs, while they fix on the one hand, on the other hand can cause breast cancer. Many people don't want to take them, my peers, they don't want to take as well. They want to deal with [the menopausal problems] by natural ways.

Some women who are taking the hormones themselves also said that people around them did not want to take them, and even though they tried to convince those around them about their choice, they themselves sometimes felt uncomfortable about taking hormones. Some rationalized taking hormones with the argument that the risk to their own individual conditions was different from that of others who should not take hormones, like having an early menopause, having been prescribed the pills by the doctor after being examined, or having no family history of cancer. Şaziye was one of them, explaining her choice with her trust on her doctor and differences between women in their reactions to hormones.

Well, people don't want to take menopause drugs, I ran into very few people that said that they would take it. They are afraid [of cancer]. I told you, I took them, but God forbid, if something bad were to happen, of course my doctor would have made me stop. I took them, I passed through [menopause] comfortably, but there is no such thing as everyone will pass it like that, right? Maybe the body can't accept it.

Similarly, Gülşen, who I previously quoted on justifying HRT by her obligation to take care of her parents, emphasized her difference from other women and mentioned the reaction of her friends.

Now since there is no cancer risk in my family, neither uterus nor breast cancer, I could take [the drugs] easily, I am aware of that. So, it was risky, me insisting on taking these hormones was risky. I have been scolded by all my friends.

As seen in these examples, women who are taking hormones often found themselves in a position to defend their choice. The argument of “normal” and “abnormal” comes into picture again, as in the case with Gülden, who entered menopause prematurely.

There are a lot [of people in menopause] but there is no one who is on hormones like me. Nobody wants to take them. Risk of cancer. I'm telling them, they say it triggers if there is a cancer cell in the body, other than that there isn't any [risk], but no one is taking. Actually, they find it difficult to go to the doctor. They will go to the doctor, take the tests, be diagnosed by menopause: it takes a long time. There are some who want to take too, I don't know. They don't want to deal with it. They are quite

old, my sister in law is above 50, theirs is normal. Because mine is early I want more.

Here we see a two-fold description of “normal” and acceptable: In some cases, like Gülşen’s or Şaziye’s case, taking hormones is rationalized because they are more “normal” or healthier than some other women who carry certain risks. In Gülden’s case, this time being “abnormal” is cited as a reason for taking hormones.

There are also some women that take the hormones after their doctor prescribes them, but stop taking them after they hear about the risks. Sıdıka told the story of how her doctor and her social circle had conflicting views of the connection between breast cancer and hormones. Eventually, she chose to believe the non-medical view.

I entered [menopause] at the age of 53. I had problems back then, hot flashes and stuff. [The doctor] gave me hormones, I took hormones for two years. The [the doctor] wanted a mammography, it turned out that I have cysts in my breasts, but they’re not dangerous s/he said, just fibrocysts. Then, people around me said “don’t take hormones, it will trigger the cysts.” Still, I took them for two years, then I stopped, didn’t take any longer

For some, fear of side effects of the drugs prevented them from going to the doctor, like İnci, talking about her apprehension about HRT and doctors. In her account drugs and their effects get collapsed into seeing the doctor, forming an overall narrative of perceiving menopause as a medicalized period.

Why I didn’t go [to the doctor] is that I heard something like this estrogen turns into cancer in later ages. I didn’t go. I said, well, what did my mother do? What did my grandmother do? In fact, I thought something primitive, but I did it. I haven’t seen any side effects. Yes, I became a little irritable, a little anxious, that happens.

Another concern for women about taking HRT was weight gain. Şeyda told me about her fear of possible side effects of HRT that she heard of.

I thought the hormone drugs had other side effects. Like, when they were fixing one side, on the other side they are causing weight gain, or deformations in the body. I heard those, and those scare me. I don’t even want to take it, if they prescribe pills to me. Now I’ll research what calcium is, I don’t know any information about it.

As can be seen in this example, beliefs about hormones and fears about them sometimes spilled over to other drugs and supplements like calcium; generalizing the skepticism

toward medicine. Even when women believed that they were doing the right and “conscious” thing to go to doctors and accept medical authority, their skepticism and clashing medical views caused them to follow non-medical means at times. Some, like İnci, thought it was outside the modern and conscious image, calling the refusal of medical authority “primitive,” and justifying it with references to a previous life style. Some others, like Sultans of Menopause members quoted above, thought being skeptical was the conscious attitude. And some others, like Canan, used the conflicts within medicine to back up her avoidance of HRT.

4.4.1 Alternatives

Some women who wanted to avoid hormones because they were artificial said that they preferred herbal treatments. In this context, what they meant was not herbal extracts, but some herbal teas they prepared themselves. There is less information about the herbal extracts, and women had their own interpretations of them, again in relation to the ending or continuation of the menses. Hatice Genç, a 48-year old daycare worker who migrated from Bulgaria and living in Avcılar, told me about one of her friends interested in herbal treatments.

I had a friend who said that there are herbal pills to end [the menses] altogether, so that you don’t have them again. But, she says, she doesn’t know if there’s going to be [vasomotor] problems after that, she didn’t take them, she wants to try.

Although she did not specify what these herbal pills were, I guess that they are black cohosh or primrose, relatively new supplements in the Turkish menopause market. When it comes to herbal teas, they could be recommended by someone else, or they could sometimes even be any kind of tea a woman believed to help her condition. Hatice went on to tell me about a neighbor who had her own remedy for hot flashes.

I have a neighbor, she is older than me, she had [menopause] before I did. She gave me [the package for] something like a tea from tropical fruits, said that it helped her a lot and asked me to get more for her. I took it to the *aktarcıs*.³¹ They said that they had teas for separate fruits in that tea,

³¹ An *aktar* is a small shop that sells spices and herbs, and -cı is a suffix in Turkish that denotes “somebody who does that job.” So she means both the shop and the shopkeeper with *aktarcı* in

but not all of them together. And they said it cannot be of any help, that she made herself believe in it psychologically...They suggested something else in a jar, something called yarrow I think. It is steeped for five minutes, and you can drink it either hot or cold. They said it would help a lot, but I didn't take it.

There were more conventional, traditionally consumed herbal teas that are believed to do the job, and this information was shared by several women. Gülşen mentioned sage as a remedy she uses for hot flashes.

Sage is good [for hot flashes]. Even if you don't take hormones, sage balances out your daily hormones. You can drink it when you're going to bed, you can also drink it in the morning. Two glasses.

Likewise, and despite being part of the medical system herself as a nurse, Banu had her own alternative herbal concoction.

I have been using herbs constantly for three years...Sage and chamomile, I can recommend those, they eliminate stress, take away the sweating and hot flashes, make one feel more comfortable...[There is] mint, mint tea. I blend them all together and use them constantly.

It is worth noting that the herbs women told me they were using for menopausal symptoms were not the same ones that the newspapers or magazines were writing about. Yarrow and black cohosh were mentioned in the media; however women seemed to prefer the herbs that they themselves were more familiar with, which are known for their relaxing effects. This may be parallel to the idea of using something "natural" for a natural period in one's life, and the qualities of "the natural" may include familiarity.

In the daily newspapers, alternatives to hormone therapy were cited every once in a while, usually in the context of healthy eating in menopause or "natural remedies" for a number of conditions including menopausal complaints. Chickpea was one example of the suggestions for vasomotor complaints, with the argument that it includes phytoestrogen, which is defined as *sebze hormonu* (vegetable hormone) in the newspaper. Grapes and prunes were also cited for they "increase the estrogen level in blood." Soybeans, parsley, flax seed and currants were also examples of food that helped menopausal complaints. As for herbal teas, advice on newspapers coincided with the participants' views. Most cited herbs were sage and yarrow, as well as chamomile and

this sentence.

aniseed. Green tea, oregano, ginger, fennel and valerian were less mentioned remedies in the media, but still existent. Starting with 2005, imported herbal extracts made their way into the market, and into the newspapers. Evening primrose oil and dong quai were the examples for these, although they were not mentioned in my fieldwork. Inferring from that, I can say they were either too new to be known by the public yet, or hold a marginal place in the menopausal remedies market. In addition to the herbal alternatives, many participants mentioned taking various kinds of vitamins, and calcium, mostly to prevent osteoporosis; and a few mentioned the benefits of regular exercise.

4.5 Menopause and Others

In August 2005, one of the daily newspapers in Turkey, *Hürriyet*, published the results of a survey on sexuality in Turkey. According to these results, it was claimed that in Turkey “half of men have never heard of menopause” (Erşan 2005). The ratio of women who have never heard of menopause, however, is 14%, and most of this 14% are women under 18 and with a low education level. The results suggest that menopause is known mostly by those who are affected by it, mainly women of middle age. Men or younger women are either not aware or not interested in menopause. This finding is partially supported by the comments of some of my participants about not knowing much about their mothers’ or grandmothers’ menopause because they were so young and did not pay attention.

Nevertheless, menopause is not lived and defined in a social vacuum. The perceptions of menopause, and managing of menopausal symptoms are determined to a certain extent by the living conditions and the social environment of women. In that sense, who they live with, and who they speak with about menopause becomes an important issue. In the Turkish context, women’s immediate families are the most frequently cited as those affected by women’s menopause, and they are also the first ones to turn to for support in dealing with menopausal complaints. This approach is supported by Prof. Dr. Ertüngealp’s description of menopause as “not only the woman’s problem, but the whole household’s problem” during a meeting for menopause awareness campaign (*Akşam*, October 4, 2006).

In this context, the reactions of men in general, and in particular, husbands, constituted an important part in defining menopause, as interviews with menopausal women show. Neslihan thought that men should be knowledgeable about menopause as well as women because it is a “sensitive” period.

Of course not just as women, men should know these too. They should know how to approach the woman, I mean one goes through a sensitive period, no matter how much you say you aren’t, you are still vulnerable. You get touchy, you can be irritable, you can exaggerate some things. That’s why it should be known by everyone, women or men.

Sıdika, on the other hand, blamed herself for her irritability in this period, even though she also wanted her husband to be more understanding.

As far as I heard, spouses should be understanding towards each other. I have problems, irritability, I used to get mad, get angry at things that wouldn’t be worth it. My spouse was asking me what was going on with me, telling me I wasn’t like that before. I was saying “excuse me” after that, “maybe I’m like that because of the menopause.” I was apologizing.

Some participants mentioned the reactions of their fathers as part of the explanation for why they did not hear much about their mother’s menopause. According to this explanation learning about menopause would not make much difference for women unless it is known and acknowledged by their families, especially husbands. Sırma Köroğlu was a 49 year-old civil servant working in a public hospital, originally from Silivri, a town close to Istanbul. She was tracing the invisibility of menopause in previous generations to relations between spouses.

Were old people more resilient? Or there wasn’t a spouse that would understand them perhaps, I can put it that way too. Now the spouses are more conscious, I mean when we say that we are not feeling well, are sensitive in this period they are more conscious I guess.

Aside from being a period of sensitivity and irritability, menopause is seen as a sign of aging both by women and husbands. Hülya from Sultans of Menopause protested the way menopause is connected to old age, talking about a friend whose husband reacts badly to the name of their group.

There is a friend in this group...her husband says it’s a thing of old age; she says he doesn’t even let [her] mention the name of menopause. What old age? Thank God we don’t feel old at all.

During our interview, Sultans mentioned some other women who were previously training with them, but left the group after they named themselves Sultans of Menopause. Women who stayed with the group did not feel ashamed of using the name. They thought of themselves as women capable of taking on multiple roles and refused to be called old or less feminine because of menopause. Sibel's description referred to the multiple responsibilities expected of them.

We women are heavy laborers. Seriously. We are cooks, psychologists, ladies, maids, doctors, and menopausal women. We have all of these, all these qualities. On top of that we also take care of ourselves, don't neglect our make-up, our fun, our children, anything. We are women to the core.

Sexual problems in postmenopause usually came up in the context of the necessity of prescribing hormones in my interviews with physicians. Menopausal women I interviewed were much more reluctant to talk about the issue, some of them vaguely referring to it and some explicitly asking me not to talk about sexual matters. I believe this in part stemmed from my social identity from their perspective as an unmarried young woman; and partly from my decision to let them decide on the content of the interview. Some of the doctors told me that postmenopausal women that they see usually do not mention their sexual problems unless they are asked directly.

Sometimes women referred to the sexual problems after menopause, especially as an issue that affects their relations with the spouse, but usually in a very cloaked manner. Rukiye was one of those women. During our interview, which took part in the waiting area of the hospital, she mentioned problems menopause causes between spouses, but could not go into details because her daughter was sitting next to her.

I can say that in menopause people become like a man. This is a serious issue that affects husband and wife relations.

The issue of sexuality was more easily spoken in tea parties, which were more relaxed and "safe" settings for women to talk among themselves. In Canan's party, Canan and Münevver mentioned end of sexual relations with husbands as they were telling me their experiences with menopause.

Canan - Of course, that business with men ends after menopause (laughter).

Münevver - Yes, it ends and then problems start.

Canan - Then fights start. We didn't have that problem because my spouse got sick before I entered menopause.

The general problem cited related to sexuality in menopause is that the lack of it has adverse effects on relations with partners. Along the same lines, Şeyda told me the problems encountered by menopausal woman based on what she heard from her friends and relatives. Her account illustrates the fears and concerns of women regarding their relations with their husbands and the questions in their minds:

I heard that they [the menopausal women] become so irritated, that they don't take any pleasure from intercourse, because of that they have problems with their spouses that can lead to separation, even heard of beatings. Men don't believe in menopause, there are some that say "what menopause?" I heard of these around me. My mom and grandma are dead but what I hear from the environment is like this, from my friends, from those that are older than I am and are menopausal. This is, in my opinion, lack of knowledge, lack of knowledge by the other side. Because what is menopause? In old times no one used to enter menopause. Before, the ladies in the villages, in the homelands were at least having intercourse, having sex until the age of 60 at least, or giving birth, that's what I hear. What scares women most, and it scares even me is the end of intercourse between a husband and wife, that there would be loss of interest. It scares me a lot too. I mean, I'm not very fond of it either, women maybe always hold themselves at this age, but for the other side, for men, it makes me afraid, concerns me. This time men start looking for it outside, of course since they don't give birth like we do they don't get worn out like we do, they stay healthier, younger. From time to time it comes to my mind. Would mine do that too?

4.6 Conclusion

In the "local" popular culture, the prototypical menopausal woman, jokingly called as *menopoz teyze* (auntie menopause) is a nervous, a little overweight housewife (or retiree) that talks too much, likes baked goods (*hamurışı*), and going to daytime tea parties among women (*kabul günü*). Alternatively she can be attending arts/crafts courses like wood painting or following the Oprah-like morning shows for women (that is, by going to the studio, not just by watching them on TV). The former is a more middle-class type coming from neighborhoods like Beşiktaş, Bakırköy, or Ataşehir, and the latter more working class, identified with the neighborhood Avcılar. There is a subtle image of disturbing the people around them. This was present in the United States as well.

Whenever I mentioned my research, the first reaction was coming from the husbands, who roll their eyes, sigh and make remarks like “Oh yes, *we* are having a very hard time during menopause.” There is almost a perception that menopause is not simply a disturbance for women but also a “social disease” that affects those around them, especially their families.

When the doctors I met for the first time learned about my research topic and my plans of interviewing women of menopausal age, some were wishing me luck and commenting half-jokingly that I’m in trouble because the menopause patients talk too much and do not say anything useful. This fits the social prototype of the menopausal women, as I gather from news stories, websites, interviews and observations in medical settings and informal conversations with people that I ran into and happened to mention my research. Some doctors offered to choose among the menopausal women that would give me better information, “the more conscious patients,” as they put it. I tried to explain that I needed to talk to the others as well.

This insistence on the meaninglessness of menopausal women’s complaints resonates with the Hindu word *bakbak* that Lawrence Cohen mentions in *No Aging in India* as a concept explaining the situation when the words and mumblings of the elderly become the noise, the nonsense. *Bakbak*, the useless and nonsensical talk is one of the ways that voices of old people are defined, among with the angry voice and silence. This representation is countered by another image of the voice of old age, one that is “incredibly productive, a wise and inexhaustible source of experience and social memory” and “[t]he line between productive wisdom and *bakbak*...depends not only on the content of the productive voice but frequently on the politics of the hearing” (Cohen 1998, 176). Cohen traces the shift to the perception of old people’s voice as *bakbak* to two transitions: the loss of authority and the loss of usefulness (Cohen 1998, 241). In the sense of menopausal women, unlike the case of aging men, loss of usefulness comes with loss of the ability to bear children, and the ability to look young and attractive.

Shifts in the boundaries between modern/pre-modern/postmodern were prevalent in women’s narratives of menopause as well. For example, women who spoke of menopause as being a non-issue for the previous (and not-so-modern) generations used this fact as justification of their (otherwise modern) behavior of refusing drugs or going

for check-ups. Some women cited newspapers or the Internet as sources of knowledge to counter the doctors' advice. Regardless of the references, talking about menopause was legitimized only with the language of medicine, as part of awareness about one's body and the modern responsibility of taking care of it properly. The only other form of popular visibility for menopause is as a period that poses a hazard to those around the menopausal woman, while at the same time bothering her. Discourses that counter this kind of portrayal, like the second spring, are presented within a medical framework, promising women a time that they can finally have for themselves, free of worry and responsibilities. In reality, having time for one's own takes more than coming to the end of one's reproductive life, as expectations of families and especially husbands still continue. Except for a few isolated examples, the instances where I heard the voice of menopausal women about their own experiences happened in private, either when I was asking them questions or listening to them talking among themselves in tea parties. Despite the popular view of overly talkative menopausal woman, their voices about their experiences are unheard in the public discourse of menopause.

5. Menopausal Patients: Medical Menopause of Turkey

It was a hot day in July, late afternoon. I was chatting with the ob/gyn doctors in the small local clinic in the middle of Osmaniye, a lower-middle class neighborhood in Istanbul after their daily working hours and before they went home or back to the hospital for the night shift. As usual, there was a specialist, an ob/gyn assistant in training, and another assistant training to be a family practitioner in the small room where they accepted patients, asked about their complaints and their medical history, and did the paperwork before taking them to the exam room next door. Knowing my research topic, they were trying to help me with the stories of their patients, about the menopausal women they saw that day and what was interesting about them. The specialist was telling about a woman who seemed a little upset when they looked at her test results and told her that everything was normal. “You shouldn’t say that it’s normal to a patient” he said, “...they get upset. What is wrong with our patients is over here,” he laughed and pointed to his head. The family practitioner added the story of another woman who was menopausal but did not tell it to the doctors when she was asked, saying she does not know, showing them her test results and asking them to check for themselves. “The word menopause is almost ominous, she didn’t want to utter it no matter what. And when we prescribe a drug or explain her something, she calls her husband and asks us to tell him, too, for she doesn’t understand. Actually she does understand, she just wants us to tell him, too.” This was just a usual day in the clinic, doctors and patients meeting in a small room with different understandings and expectations that sometimes conflict and trying to find their way around these differences.

This chapter is about the “medical” side of menopause and the HRT story. It starts with a description of TSMO, the professional organization for menopause and osteoporosis in Turkey. Then it moves into the way menopause is described and understood by doctors I interviewed, their views on HRT, their prescription practices and the way they learn about new developments in their profession. As part of the last point of learning, I will elaborate on two professional conferences I attended between 2006 and 2007. Lastly, I will give details on the types and brands of hormones available in Turkey in 2006.

5.1 The Institution: TSMO

The acceptance of menopause as a disease and the popularization of its treatment roughly coincides with the establishment of TSMO in 1992 by a group of doctors in Cerrahpaşa Medical School, led by Prof. Dr. Erdoğan Ertüngealp. The “about” page in the TSMO website, written by the head of the society, Prof. Dr. Ertüngealp, summarizes the aims of the society as well as its view of menopause and HRT.

The increased average life span in the world exceeded the 80's in developed countries and 70's in our country. Our women are condemned to live without estrogen for an equally long period as they lived with the estrogen hormone. Menopause, which is an inevitable event for a woman that lives physiologically natural [sic], became inured to. Because it is accepted as natural by everyone, a small group of patients with very severe early symptoms consult the clinics for treatment. However, it is possible to treat the symptoms that we call as early symptoms like hot flashes, sweating, crying fits, touchiness, absent-mindedness and lots of others known to everybody.

Cardiovascular diseases and heart attacks, despite developing technology, constitute a big number of deaths in the world. Likewise, osteoporosis and the fractures it causes are known as the insidious disease of humanity. Yet, in our country, the interest of our doctors, our women, and verbal and written press in this issue was inadequate.

Our women had to made aware that infarct, which is known to become a man's disease, is a woman's disease in the post-menopausal period and constitutes the first reason for death in women.

The fear of estrogen had to be explained to the doctors, the public and the media with an education campaign in the light of latest opinions and the benefits of the treatment had to be expressed.

In our country where the average life span is expected to reach 75 years old within the next ten years, the necessity of estrogen for protection from the fractures of osteoporosis had to be told to the public and socio-economic losses had to be stopped.

With the reasons we specified above, doctors interested in the subject got together in the year 1992 and founded National Society of Menopause and Osteoporosis in our country. Our aim was to organize congresses and invite speakers from abroad who are experts in their field to our country and present them to the service of our doctors. It was our additional aim to organize panels about the issue, and publish brochures and a book. Aside from that, we wanted to educate our women by organizing conferences

and meetings for them and provide the interest of our media in the issue in the light of latest findings and prevent the misinformation up to date.

In the light of these aims, we started working by planning to organize our first congress in September of 1992.

We started our activities with the expectation of the days we will teach the need to use estrogen in order to increase the life quality of our women, and by initiating the bone mineral density campaign in 3000 healthy women.

We wanted to greet everybody with my slogan regarding this matter: “Woman is beautiful in every age” (Ertüngealp 2007).

Prof. Ertüngealp is probably the most influential figure in the menopause/HRT field in Turkey, and definitely the most visible one. Aside from chairing TSMO, he is a professor at Cerrahpaşa Medical School and practices medicine in Cerrahpaşa as well as in a private hospital and his own private practice. He is also very active in the international professional communities: at the time of our meeting he was the treasurer for Council of Affiliated Menopause Society of International Menopause Society and the vice president of European Menopause and Andropause Society. On my question of why the name of TSMO includes osteoporosis, Ertüngealp said that they decided to use osteoporosis as a way to attract attention to menopause. He told me that they found the first group of patients for the Cerrahpaşa menopause clinic by doing free bone mineral density measurement tests. During our interview, he spoke very enthusiastically about TSMO and its activities, and stressed the importance of HRT after menopause. Especially in the aftermath of WHI study, he said that he made the effort to get out to the press and explain that women should not be afraid of HRT, trust their doctors, and not skip their doctor’s visits. At the time that I did the interview, in January 2007, there were regular workshops organized by TSMO for ob/gyn practitioners, with the help and sponsorship of Schering once in every two weeks. These meetings will be described in detail later on in this chapter.

TSMO was also conducting research on menopause. According to a study that TSMO performed on 136,000 women in 2002, the average age to enter menopause in Turkey is 47, and the average age for starting treatment for menopause is 49. Primary reasons to ask for treatment in menopause are cited as fear of osteoporosis with 30 percent, and urinary complaints like incontinence or cystitis with 20 percent. Another 15

percent ask for medical help for sexual problems. The reasons for discontinuing HRT are fear of cancer with 40 percent and fear of weight gain by 11 percent (Erşan 2005). These numbers correspond to my qualitative fieldwork findings to some extent, where the most frequently cited reason for not taking HRT was fear of cancer, and one of the main reasons for taking HRT was the fear of osteoporosis.

5.2 The Language Issue

As mentioned in Chapter 3, how the doctors refer to menopause affect the prescription practices of HRT. For example, when menopause is defined as a deficiency disease, prescribing HRT cure is justified and becomes a more acceptable a medical practice. For this reason, before explaining the medical practices I want to explicate the medical language around menopause and HRT in Turkey.

5.2.1 Menopause as Non-disease

When it comes to the attitudes toward menopause among physicians, especially ob/gyn specialists, the main issue seems to be whether menopause is a disease or not. Occasionally, one of the doctors I interviewed stopped for a moment to think about what they were saying when they talked about menopausal women as patients and corrected himself or herself. Dr. Okan Arısoy, a male ob/gyn professor teaching in the same medical school he graduated twenty years ago was telling me about the negative effects of the WHI study and its misrepresentation in the media:

Of course, since this is a wrong mentality, unfortunately some rare occasions are generalized and perceived as the real factor of [cancer]. A wrong perception is created and related to that, and the patients who will benefit from the treatment—or let's say women, not patients—are drawn away from it.

Sometimes the description became more interesting, when a doctor referred to the menopausal woman as patient, yet still talked about menopause not being a disease, as Dr. Ali Uğur, a male ob/gyn specialist working at a private hospital does in the quote below.

If there is a drawback for the treatment then we tell the patient all about it. Actually, our patients are now aware that menopause is not a disease, it is a completely physiological condition. Because of that, they realized too

that they should enter menopause very consciously. In fact a patient that accepts menopause like that, I mean not as a disease but a physiological condition, does not have too many complaints anyway.

Using the word patient, yet also saying that menopause is not a disease might seem contradictory, but the usage made sense in the daily language of doctors. I believe that it denotes a pervasive level of medicalization, but I do not think that it is very straightforward: calling a menopausal woman a patient did not necessarily mean the doctors thought of her as sick and in need of treatment. The term “patient” was used for anyone who comes for a doctor’s visit, regardless of their health situation. Some of them needed to be treated, all of them had to be examined, some might have had to go through tests and still be considered “healthy” in the end, some had to go through tests just because they were in a “risky” age period (that is, post-menopausal); but all of them were grouped in the same convenient category of “patient.” Using the term patient became so habitual for doctors that sometimes they accidentally used it to refer to people outside their practice accidentally. I recall Dr. Okan talking about a *dolmuş* (a shared ride van) driver picking up passengers, saying, “he is picking up patients.” He quickly realized what he had said, laughed, corrected himself, and explained that he is so used to the term that he sometimes forgets and applies it more broadly.

The emphasis on menopause not being a disease was a constant line of narrative in the interviews of doctors, popular books on menopause and newspaper articles alike. Sometimes doctors stopped themselves from talking about menopausal women as patients, because saying menopause is not a disease made them aware of the language. I witnessed a moment like this with Dr. Teoman Altıntaş, a male ob/gyn specialist working in a public hospital.

[I prescribe HRT] for the purpose of protection. Let’s not call her a patient; because this is not a disease, this is a natural condition, the woman carries her normal physiology to advanced ages [with hormones].

The same line of describing menopause as a non-disease yet insisting on the necessity of its medicalization can be seen in the newspaper interviews doctors give in an effort to inform public about menopause. As will be explained in the following chapters, especially TSMO is very active in providing the media with healthcare information, and making sure that they get and publish the “right” kind of knowledge on issues that they

have expertise. In an interview with Prof. Dr. Erdoğan Ertüngealp, head of TSMO, he responded to the interviewer's question of "But, menopause is not a disease" by saying it should be considered as such, because of the dangers it brings, and complained about the lack of consciousness about healthcare risks coming with menopause.

[Menopause] is not a disease, but it has to be considered as such. It is a natural incident, but heart attacks increase tenfold. Bone fractures, Alzheimer's, eyesight defects and loss of balance occur. A short while ago I was with a very well known theater actress. She said that she is 61 years old, smokes like a chimney and does not feel anything. Whereas, since she smokes, if she doesn't have a heart attack, she is going to face bone fractures after 65, and Alzheimer's after 75. Such a conscious woman, she said what has menopause got to do with all of these. We have made very widespread awareness campaigns. This is the point we came (Tuna 2002).

In the medical narrative mainly provided by TSMO, and accepted by most gynecologists, menopause is a period of increased risk for all women, requiring lifestyle changes and medical attention. However, this seems to be a more current understanding of the period. In terms of how menopause is understood in the medical world over time, some participants, like Dr. Rifat Demir, tell the story of how menopause became a "disease." Dr. Rifat was an ob/gyn professor who has been teaching and working in the same university hospital for twenty years after he graduated from medical school in 1985.

Back in the times when I was a student, menopause was not something treated, the approach to treat menopause came out only in the time that we were assistants. First menopause was accepted as a disease, interpreted as a condition to be treated, then because the known side effects were demonstrated an escape from [HRT] started. I mean, it is like we went back to twenty years ago.

Following the narrative of doctors from different generations, it can be seen that the medicalization of menopause in Turkey is closely connected to its relation to the concept of "disease." According to the accounts of most participants, menopause, which already existed as a category in the medical literature previously, became a disease to be treated in the late 1980s and the early 1990s. After this, it gradually became a "non-disease" but a risky period again, yet the need for treatment remained unchanged.

5.2.2 HT or HRT?

Contrary to the trend in North American context where the abbreviation HRT turned into hormone therapy (HT) in an effort to de-emphasize the medical view of defining postmenopausal hormone levels as deficits, the medical culture in Turkey preferred the term hormone replacement therapy, the emphasis being on replacement. The term was used in the media, and in popular publications aimed at informing the public. An example for the latter might be *99 Sayfada Menopoz* (Menopause in 99 Pages), which is a long interview given by the vice president of TSMO, Prof. Dr. Hakan Seyisoğlu (2006). Part 5 of the book is entitled *Menopoz Tedavisi* (Menopause Treatment), and starts with the question, “Under which condition do you decide on hormonal therapy?” Seyisoğlu’s answer to the question is as follows:

The hormone treatment implemented in menopause is giving woman the diminished estrogen, which is the female hormone, according to a plan. Thus, it is a treatment of putting back. That is why this treatment is called “hormone replacement therapy” (67).

When the term “hormone therapy” was used instead of HRT, it denoted a technical correction about the dosage of the products used today as opposed to the earlier days of the treatment; rather than being an attempt to be politically correct as it usually is the case in the United States. According to the explanation of Oktay Kadayıfçı, the reason why it was called HRT before is the fact that the treatment aimed at giving hormones at the level that would equal a pre-menopausal woman; thus replacing the missing hormone and “completing” the blood level of estrogen. Today hormones are given at the smallest possible dose that would still be useful; thus the treatment is called “hormone therapy” since now the replacement element is no longer existent (Kadayıfçı 2006, 49).

In medical practice, the concept of replacement seemed to be the prevailing one, as can be seen in the examples from interviews, where doctors were explaining the meaning of HRT or menopause, or when they were telling me about their patients and their understanding. Dr. Nurcan Aslan, a female ob/gyn assistant in the third year of her training in a public hospital, explained the reason for prescribing HRT:

[With the hormone treatment] our aim is to replace the declined hormone and continue the function it serves...There is a group of patients who know nothing about something called HRT. I mean, it’s not like what I

will give them is a hormone replacement treatment, a putting back what is lost in menopause, but they just want a relief from the hot flashes, the irritability. They come saying please save me from these, whatever you give me, just save me.

Along the same lines, Dr. Ayhan Durmaz, who is a male ob/gyn specialist in the same hospital with Dr. Nurcan and one of her mentors, gave the reason for HRT with an analogy.

There is also a rational reason for it, because, what you do when you run out of salt at home is to go to the grocery store and get some. Well, now there is something that runs out in the body, it should be replaced.

During my fieldwork, I also saw doctors explaining the concept of replacement to women, as opposed to the concept of cure. On one occasion, a woman was telling the doctor that she took the pills they prescribed to her, but she had not gotten better. The doctor's explanation was: "That drug is putting what is lacking in your body, you have a lack of a hormone in your body, and it is replacing it. Don't think of it as killing some microbes. Your hot flashes should have disappeared by the time you stopped taking the drug you're taking. If they haven't, it means we have to continue." As can be seen in this example, the meanings of "medicine" or "drug" can be different for menopausal women visiting the clinic and the doctors. For some patients, a drug is supposed to cure, and it is expected to do so after one prescription. For doctors, hormones replace something missing, and protect something that is deteriorating due to a "lack," so they should be given without necessarily expecting immediate short-term benefits.

As mentioned earlier, menopause as non-disease is a notion that came up frequently in interviews with the doctors. It was used as a reason for not taking HRT (by women), and is also, ironically, offered as a reason for taking it (by doctors) – it is not a disease, HRT replaces what is missing. Dr. Yılmaz Kilimci, a male ob/gyn specialist working in a public hospital was saying that some menopausal women did not understand the need to be treated for menopause.

Some of them see [menopause] as a disease to endure without taking any medicine, like a normal disease. They think they can go through [their troubles] without being treated in the menopause period.

The idea of “suffering” (i.e. women denied of HRT are suffering) also is tied to HRT, it gives a meaning like a remedy that stops suffering. Criticisms towards the WHI results were supplemented by this idea of leaving the woman alone in a period when she needs medical help, withholding what she needs or structuring the situation such that she is caused to avoid it. Dr. Alper Cengiz, a male ob/gyn assistant in his first year at a public hospital, was questioning the practice of not prescribing HRT because of possible risks.

Now, leaving that person open to all of the bad influences of menopause because it increases [the breast cancer risk] by five people in one thousand depends on the initiative of the doctor, it is related to the school.

Similarly, Dr. Okan was complaining about the interpretation of WHI results in the media and their results.

With the WHI research in 2002 the breast cancer risk increase with HRT, even though very minimal, spread like a storm in Turkey as well as the world. In reality, this was just a misinterpretation of the statistical analysis of the research...Of course, this situation, wrongly, led to not alleviating the menopausal problems of women like hot flashes and sweating...In this context, starting with 2002, even though these symptoms had an effective treatment, it wasn't used.

As seen in the examples, doctors can have very different rationales or explanations for prescribing hormones, but certain groupings according to the most common reasons to prescribe—and not to prescribe—are still possible.

5.3 Medical Practices

After the WHI study results and the public discussion following it, TSMO published a series of recommendations for the indications and duration of HRT prescription. TSMO convened a professional meeting in November 2002 where the recommendations were produced by a panel of medical doctors. A summary of these recommendations, presented below, can be accepted as the guideline for HRT use in Turkey:

1. Currently, there are no other choices as effective as hormone replacement therapy for vasomotor disturbances and genito-urinary atrophy.
2. HRT should not be used solely for primary and secondary CV protection.

3. HRT still retains its importance for the prevention of osteoporosis. However, it should be ensured that exercise, calcium, and sunlight are utilized during the menopause.
4. According the the[sic] available data, there is no consensus on the duration of postmenopausal HRT use. However, with respect to breast cancer, patients should undergo an individual assessment for periods longer than 4 years.
5. At present, the lowest doses possible, which are effective in eliminating vasomotor complaints, should be preferred for HRT. Any preparation with a dose lower than the standard is not available yet.
6. The risk of breast cancer associated with HRT is not different from that associated with such factors as alcohol consumption, excessive body weight (BMI >30), first delivery being after the age of 30 years, and late menopause.
7. Increased risk of breast cancer associated with HRT disappears within 5 years following the discontinuation of the treatment.
8. The above-listed recommendations do not cover early menopause (that before 40 years of age), perimenopause, and surgical menopause.
9. In postmenopausal women, the balance of benefits and risks and cost of HRT should always be considered.
10. Whether they have any complaints or not, whether they are on HRT or not, women between 40 and 65 years of age should be under the supervision of the relevant specialist (Hormone Replacement Therapy Consensus Group, 2007).

During my fieldwork, all of the ob/gyn specialists I interviewed said that they were prescribing hormones for menopause. The main difference among them was the duration and indications of HRT, and whether they took the WHI study results seriously or not. Some of the doctors, especially the ones from Cerrahpaşa, who are more closely affiliated with TSMO, mentioned the guidelines above, saying they followed them as well as the international guidelines which do not differ in important respects.

Although some menopausal women I interviewed told me they knew of doctors who opposed prescribing hormones, I ran into only one ob/gyn practitioner who described postmenopausal HRT as an illness invented by pharmaceutical corporations and doctors who sell themselves to these corporations. He considered HRT appropriate for premature menopause (before the age of 40, as he defines it), and/or surgical

menopause. Giving hormones to a 65 year old woman, however, he compared to “doping a horse that needs to be taken down and taking it to the race,” according to the metaphor he used.

Except for that one example, doctors mentioned colleagues who are against HRT mostly in a critical manner. They frequently underlined that it is the other branches that cause a scare among patients, or some ob/gyn practitioners that do not follow the new developments. For example, Dr. Yılmaz compared the ob/gyn practitioners with other branches in their approach to HRT.

Actually, there are people among doctors who think HRT is unnecessary too...[There are] those among the ob/gyn practitioners as well. Most of that is because of lack of information, or wrong things that they read and knew from the past. It's because they aren't following the new information. Among doctors, the ratio of those against hormone replacement therapy is higher in the other branches. Among the ob/gyn practitioners, some of them are against it, some are in the middle and some are for it. Ask them, ask whether they are against hormone replacement therapy as an ob/gyn specialist, whether they would prescribe it to their wives, some of them will say no.

Instead of general comparison among branches, Dr. Rifat focused on surgeons as the main professional group to scare patients off of HRT.

[S]ince physicians in Turkey don't have too detailed information, they scare [the patients], [the other branches]. Especially general surgeons are important in this regard, they don't even want to pronounce the name hormone. They consider hormones almost equal to cancer, so [prescribing hormones] becomes even more difficult.

Dr. Rifat's criticism was not an isolated one. Among the different non-ob/gyn branches, surgeons constituted the group most criticized for scaring patients away from HRT. Surgeons are followed by orthopedists and oncologists, as can be seen in the account of Dr. Selim Erinçsiz, a male ob/gyn professor who has been teaching and practicing in a research hospital for twelve years:

Now, because of the education of ob/gyn practitioners, and because they know the problems in these publications...they have much less question marks in their minds about the issue. But the [doubts] of the public are continuing, they don't want to [take hormones]. Other assisting branches are in the same mindset. Especially the oncologists...Here too, in surgery we have problematic professors, from time immortal. [I heard] that, five or ten years before there were doctors, breast specialists, who showed their

patients the door because they were taking hormones; telling [the patients] not to talk to them again.

The reason given for both ob/gyn practitioners' and other branches' objections to HRT is lack of knowledge. There is an element of claiming to have the "right" and the "most recent" knowledge/information. If it is the case of other branches, it is usually said that they did not know enough about ob/gyn (for example, they have read or heard about only one research study, usually the WHI, and did not follow the revisions and discussions about it) so they were acting with insufficient information, or they lacked the critical tools to see the mistakes in the research.

Another criticism of the different branches derived to the idea that each specialty focused on the body in a limited way depending on their specialties, as opposed to seeing the effects of drugs on the body as a whole. In this regard, for example orthopedists were blamed for being interested only in the bones, and breast surgeons paying attention only to the breast. Their concern for the organs that they were interested in and possible side effects of HRT on these organs prevented them from understanding the overall benefits that a woman can have by taking HRT, according to the ob/gyn practitioners. In a sense, they had too limited of a focus on the reproductive system to effectively engage in the risk/benefit analysis required when deciding on a drug. Nevertheless, they constructed themselves as concerned with the overall health and well-being of women. I observed the attitude of seeing women as a whole as their focus of interest and specialty instead of just women's reproductive system in most gynecologists I interviewed. In this context, the other branches are blamed for denying women of the benefits of taking HRT by disregarding the parts of her body that lied outside the realm of their own specialty, as can be seen in the quote from my interview with Dr. Doruk:

Today go ask one hundred surgeons [in Istanbul]. Ninety-five of them will say don't take hormones. For sure. Go to the internal medicine, radiology, most of them will say don't take hormones. But are they saying "don't use" with knowledge on the underlying structure, I do not think so. Actually, I said in that congress, and there has been some hassle with the surgeons of course, I said if a woman is comprised of just the breast, then OK, let her not take it. But she is not just breast, that woman has a brain, she has hair, skin, vagina, bones, there is her feeling [herself] like a woman. And you know what happens in menopause, there is no estrogen,

it decreases, and then [all of it] deteriorates. It is not right to tell a woman to be deprived of all of these after the age of fifty.

There is also an underlying dispute on what (sometimes which part of the body) lays within the specialty of gynecology and what belongs to the realm of other specialties. Dr. Doruk also stated that the breast is supposed to be within the realm and responsibility of gynecology.

Breast exam [within the gynecological exam] is new in Turkey. Today in Europe, in some Anglo-Saxon countries the breast belongs to the gynecologists. In Germany, for example, gynecologists even treat breast cancer. It is not like that in Turkey, but my claim is that, and I still defend the same thing, breast is a genital organ and is under the control of the gynecologist, which means that every gynecological exam should include examining breasts and a gynecologist has to know breast diseases. S/he has to know the diagnosis of breast cancer too, but it is the surgeons who treat it.

Although I have little data about doctors who were totally against HRT, I have met some doctors who accepted the WHI results as valid, and said they have become cautious in prescribing HRT because its dangers are scientifically proven. Their discourse was equally authoritative as those who advocated HRT when commenting on the issue, like that of Dr. Ali when he was describing me the latest developments in HRT and menopause:

Lately the harms of hormone replacement therapy came to the fore, especially its harmful effects on the breast and the endometrium. Because of that we started to administer this treatment more meticulously. We don't start the treatment before we complete the tests of the patient that we are going to give HRT, especially breast and endometrium tests.

Similarly, Dr. Rifat mentioned the effect of clinical trials other than WHI as reasons for supporting the cautionary approach to HRT.

Of course the studies that come after WHI are important too, like the Nurses' Health Study, Million Women Study. All of these supported each other actually, and accordingly, the beliefs and knowledge about hormone use have changed radically. As a result, we are not as comfortable as we were before as physicians, and we feel the need to warn the patients for four-five years down the road.

Behind the criticism of doctors scaring patients is the belief that patients are highly susceptible to whatever their doctors tell them to do. Sometimes this is presented

as a good thing, for example when doctors are talking about patients coming from a poorer or less educated background as being “better” than others, because they take the drugs the doctor gives them without questioning and making extra demands. If the doctor in question, however, is someone who does not share the same ideas with them, the trust between doctor and patient becomes a problem. Dr. Utku Paker was one of the younger ob/gyn assistants in a public hospital I interviewed, in his second year of training. He pointed out the possible variety in motivations of doctors who do not prescribe HRT.

Probably they learn either from the TV or, say, she went to a doctor, and it's in your hand to scare people. If you don't want to prescribe, you say that it causes cancer and you don't prescribe, there are people like that. Because some physicians think that menopausal HRT is a luxury for our country, because we still have children lacking measles or rubella vaccines. They say it causes cancer and don't prescribe it. There are also doctors that say you've entered menopause now, you'll get used to it in time.

As a more experienced physician, Dr. Ali commented on the effect of doctor-patient relations in the decision making process for HRT.

Now of course women are dependent on their physicians here. Even when she knows the harms and benefits of the hormones herself, it is still the physician that will direct the patient. And you cannot accept all patients as the same, you have to evaluate patients one by one, and this is the duty of the physician. Because of that, a patient who says that she wants to take hormones at her will does not, and cannot, insist in front of the physician.

Doctors' complaints about hormones being equal to cancer in the mind of their patients, and the fear that patients will stop going to the doctor if they stop taking HRT coincides with women's narratives of avoiding the doctor altogether to avoid the drugs. Doctors look for ways to change this situation, often blaming the fears and the resulting avoidance on media misrepresentations following the WHI study. Dr. Zafer Birsal, an ob/gyn professor who has been teaching in a research hospital for 16 years, described the difficulty of convincing women to take HRT.

I'm telling [her] that there is a situation like this, and because of that it would be beneficial for you to take this hormone treatment, and if you take this hormone treatment these are the possible risks. If you approach the patient like that her mind can change. But despite all of these, the moment you pronounce the “h” of hormone therapy, I can't give you a certain number, but I can say that 95% of the patients think of cancer. Whether

she refuses the treatment or she takes it, doesn't matter...This is what this last study did.

For doctors, the fact that women were afraid of hormones and as a result shied away from treatment was a major concern. However, the same fear of cancer became desirable when it prompted women to be under regular medical control. This difference in approach can be seen in Prof. Dr. Oktay Kadayıfçı's book. In the section where he explains the relation between breast cancer and hormone therapy, he stated that:

Even though the benefits of menopausal hormone therapy are known by women and physicians, most women are scared to start hormone therapy primarily because of the fear of breast cancer. However, this fear is exaggerated, and according to us, if hormone therapy is administered consciously in menopause and there are regular check-ups, this fear is unnecessary (Kadayıfçı 2006, 92).

Later in the book, where he talked about benign breast diseases and hormone therapy, he mentioned the benevolent effects of the fear:

Since breasts are examined more frequently because of the fear of cancer in women who are taking hormone therapy, if a malign disease develops in the breast, this disease is both diagnosed earlier, and the spreading and damaging power of cancer in the cancers developing in women that take hormone therapy is lessened (Kadayıfçı 2006, 100).

Following the line of fear, another concept that came up during my interviews is the role of HRT in making women more "disciplined" patients, thus making it easier for doctors to diagnose dangerous diseases like cancer. One of them mentioned that he managed to scare women by osteoporosis and convince them to be under supervision for menopause. Others stated concern about the decreased number of women taking HRT after WHI study, saying that it will decrease the chance of early diagnosis for reproductive cancers. Dr. Doruk was one of the supporters of HRT for increasing the amount of medical control over a woman's body.

[I] still claim that if [this woman] doesn't take hormones she will not go to the doctor that frequently, and if she doesn't come that frequently her check-ups will not be as regular. And I am not looking only at her breast, I'm looking at her uterus, her ovaries, her everything. If this trend goes like that, I mean if everyone stops taking hormones, today maybe we have the chance to catch uterus, cervix, ovarian cancers earlier on, but we won't have the same chance ten years from now.

So, in order to protect the menopausal woman, her fears should be managed: fear of cancer was a good thing, as long as it did not scare the patient away from the treatment and stays as a reason for regular check-ups. What exactly a menopausal woman should be afraid of has to be taught to her by raising her level of awareness, or consciousness.

The relation between menopause and osteoporosis was very much underlined in the Turkish medical culture, as explained briefly in the previous chapter. As a result of that, most doctors insisted that HRT is still an important choice in prevention of osteoporosis, despite the presence of other drugs like SERM's, supplements like calcium and life style changes like increasing exercise. Their overall argument tied to the definition of menopause as a "lack" of hormones, and the most logical thing to do to prevent osteoporosis, as well as other possible diseases is to replace what has been lost, instead of trying to go in roundabout ways and protect only one organ –in this case, bones. I will explain the way osteoporosis was used as a way to convince women to take HRT, and women's reactions to this discourse in Chapter 6. However, it is worth noting the way osteoporosis is connected to menopause, and HRT is constructed mainly as a means to protect the bones in the minds and narratives of menopausal women and gynecologists, even when they do not have concerns about aging, femininity and beauty.

It would not be an overarching comment to say the most important health concern of women in or approaching menopause in Turkey was osteoporosis, partially thanks to the awareness campaigns of TSMO and the news stories on menopause stressing the bone loss element. Even doctors who prescribed HRT mainly for vasomotor symptoms and for short periods made the remark that estrogen was very effective in preventing rapid bone loss within five years of menopause onset for it was related to calcium metabolism in the body. More often, however, osteoporosis was cited as *one* of the reasons for HRT, not the only or primary reason. This may stem from the fact that in the medical climate after WHI study debates, osteoporosis remained as one of the non-conflictual indications for HRT. On the other hand, two of the gynecologists I interviewed argued that for Turkey osteoporosis is not as big a risk in menopausal women as it is in European countries or North America. Dr. Berna Toprak was a female ob/gyn specialist working in a public hospital for fourteen years, and she was postmenopausal herself. She did not agree with the view that osteoporosis was a big risk for Turkish women.

Is osteoporosis a big risk in Turkey? I don't think so. Because as a race we are not inclined to have osteoporosis. Some of our women are overweight, we have a lot of women who are overweight and this is a factor that protects the bone. Actually life expectancy is not too high in Turkey either, we do not live as long as the Western countries where you see late term fractures and such...Additional risks, alcohol, smoking, these are not too widespread in Turkey. Maybe it is more in the younger generation but not so much in the generation that will undertake menopause therapy...Plus, we live in a country with a lot of sunshine. Even our women who we think are covered benefit from sunlight in the village, in their gardens and so on. In terms of physical activity too, we do not have a society that can live a very sedentary life, because it's a society where everybody has to do their own job.

Aside from osteoporosis, doctors sometimes made the point of HRT protecting the youth and femininity during the interviews, referring to these issues as part of "quality of life," with more emphasis on sexuality and women's relations with their spouses than I encountered in my interviews with menopausal women. It is a notable difference, I believe, that doctors seemed to be more concerned about protecting women's sexuality than the women themselves. However, the explanation doctors themselves had for this absence of sexuality in the discourse of menopausal women was due to a cultural barrier on the women's part that would prevent them from talking about sexuality unless they are asked directly. Whether they talk about it or not, the best cure for women suffering from sexual problems and problems of self-esteem because of loss of femininity was HRT. One of the ways Dr. Doruk justified his case for HRT was by referring to the protection of youth:

It's not just hot flashes and sweating that is important in menopause, femininity of a woman, her sex life, her self-care. This is at a higher level in Europe or America, a woman goes to the doctor in order to live her femininity before these deficiencies occur. But there are some [women] like that in Turkey too, and they are increasing. I have so many patients whose mother has breast cancer, whose sister has it too and her own risk for it is very high, yet she says that if she doesn't take hormones her psychology, her skin, her vagina deteriorates, so she takes that treatment despite all.

Dr. Zafer made a similar case for the connection between women's concerns about femininity and HRT use.

Vasomotor symptoms are just a part [of life quality]. There are psychological symptoms, like depression. The self-care of the woman, loss of sexual function, what I mean by self-care is the loss in the feminine qualities from her skin to her hair, nails. Of course, how you find out about these is by questioning. Nobody tells you that they lost their feminine qualities when you ask them what are their complaints. She'll tell you that she has hot flashes, that she's distressed, and she'll only tell you that she has sexual [function] loss if you ask her. You take it out, and there are scales for these, so you can measure the life quality of the woman through these scales. If you detect decrease in her life quality, there is no stronger treatment for it except for hormone therapy.

One important line of argument was the comparison between menopausal women and their spouses in terms of sexual activity, and basing the need for HRT on "keeping up with the husband." Like his older colleagues, Dr. Burak Eryilmaz, a fourth year ob/gyn assistant in a research hospital mentioned the importance of sexuality for postmenopausal women and their husbands.

Sexual life is very important. The patient does not want to lose it. Because, when a 50 year-old lady enters menopause she withdraws from certain things but a 50 year-old man is more active sexually and his demands continue. Because of this women want to [take hormones] to keep up with that.

The most striking example for this argument was presented in one of my interviews by Dr. Kemal Nergis. He was one of the most senior of the ob/gyn professor in a research hospital, who insisted that it was the woman's fault to not take hormones and endanger her marriage.

Dr. Kemal -[Think about] sexual function disorders. There is a 50 year-old man, and a 50 year-old woman. One of them has no losses, the other is [at the point of] zero. She's zero in terms of hormones. What are you going to do? Then there are divorces, second marriages and so on. They say the man got oversexed, it's not the man that gets oversexed, it is the woman that makes him get oversexed. This is the same way all around the world.

Maral - You are blaming it on women again, *hocam*.

Dr. Kemal - I am not blaming it on women, just on those who don't take drugs, you have nothing missing if you take drugs.

When the positive effects of HRT focused on the individual woman rather than her environment, the language used bore references to her life quality. Anti-aging was also a

newly emerging term and field that includes andropause as well as menopause. In 2006, second national anti-aging congress was being held, supported by TSMO and with the initiative of Prof. Erdoğan Ertüngealp, who is also currently the President of Anti-Aging Research and Education Society in Turkey.

5.4 Ways of Learning

When it comes to where doctors themselves learned about new developments, and in this case, particularly the results of the WHI study, several different routes can be identified: a few followed the literature themselves; more went to medical conferences and workshops and learned from the discussions there (including TSMO meetings); some learned from the informational meetings that the pharmaceutical companies organize; and, lastly, many learned from the drug representatives. (This list excludes the medical school students, or interns and assistants who mainly learn from their professors and peers)

5.4.1 Learning from the Pharma

Oya Saraçoğlu, a drug representative that I interviewed who used to work for Wyeth in the menopausal drugs section at the time WHI study results came out, explained what happened in Turkey after the WHI study, and the reaction of doctors to it:

Some of them already knew the study from A to Z, they went on defending [the treatment]. But some of them didn't know, they wanted to get information from us. So we informed them. We had passed on the details about the study to them, they read and evaluated from there.

The way of learning about the drugs and their effects from the drug companies seemed to be a pretty common trend for doctors who rarely have time to keep themselves updated about the latest research. During my fieldwork I observed doctors asking drug representatives questions of the dosage and effects of the drugs they are prescribing, in addition to consulting the Vademacum, or consulting with one another.³²

³² There is an interesting dynamic about whether or not to consult someone or a resource when the patients are present. One of the young female doctors training to be an ob/gyn practitioner had the habit of consulting the Vademacum for dosages and different drug types before prescribing it

When there was a scientific controversy in the medical field, drug companies held meetings, sometimes with the help of professional organizations and/or well known professionals in that field. Doctors mostly relied on peers they consider experts in their field, especially seniors, in evaluating the sides of a controversy. If they took part in the setting of a workshop or congress, then the information gained more leverage in terms of professional legitimacy, and the role that drug companies play in shaping the story became less visible. Although there was skepticism about the one-sidedness of the information given, pharmaceutical company sponsored professional meetings were still the venues for forming opinion on drugs. This was especially true for younger doctors at the beginning of their careers, like Dr. Burak, explaining where he learned about the WHI results:

I listened about WHI in an Angeliq meeting recently, I don't know the details too well but there were those who said that the group selected [to take part in] WHI was not selected correctly. [There was] a speaker saying that the HRT used in the study was used on patients above 65, at a late age, so wrong population is selected. I don't know how sided it is, but s/he was defending Angeliq, and its protectiveness on the heart.

There were several ways that the pharmaceutical companies disseminated knowledge about their products and tried to shape the opinion of the doctors. One of them was to approach them directly, via drug representatives who did short on-the-spot presentations about the drug, leaving brochures to remind them about the product, sometimes leaving some small gifts and encouraging the doctors to prescribe their

in front of the patients. She told me a story of how two different patients reacted to it. The first one, she says, thought that she was doing a thorough job by double-checking before she gave anything, and the patient saw this as a sign of importance given to her as a patient and she bragged to person next to her saying "She looked at the book before she gave me the drug, she's a good doctor." Another patient, however, saw the same act as a sign of incompetence: "She doesn't know anything, she had to look it up." The second type of expectation is fed by (and feeds into) doctors' concern of performing in an authoritative way to the patients, even when they are not sure of what they are doing themselves. This seems to be part of the training as well, as I saw in several instances where an assistant asked a question about the dosage or administration to the specialist when prescribing a drug to a patient who is present at the moment and got warned not to do it in front of the patient.

medicine more. This practice, called “detailing” in the United States medical literature, will be explained in more detail in Chapter 6. A less direct way was sponsoring medical conferences and workshops, and having some important names to speak in favor of their products in “lunch meetings” or “special sessions” within these congresses. The general character of these meetings was a scientific presentation with a certain bias known to all the participants. It can be called an effort to convince the doctors about drugs by giving them numbers and research results, and the reason some doctors went to these meetings is also to be more convinced about a drug they are already prescribing.³³ A third way of disseminating knowledge and encouraging prescription was to hold public conferences and awareness campaigns, not directly advocating their products but increasing the visibility of the medical condition that required their drugs, and encouraging people to visit the doctors and be under medical supervision as part of a healthy and conscious life style.

5.4.2 Sharing the Truth: Medical Conferences

Medical conferences and workshops can be considered as arenas for they are places where the social worlds of medical research, clinical practice and pharmaceutical corporations come together and discuss the shaping of medical practices. I would like to examine these arenas on the basis of two different examples: the 2006 Annual Congress of EMAS, which is a big international professional congress that is closed to public, and a small professional workshop organized by TSMO for ob/gyn professionals. Both of these conferences and workshops took part in Istanbul between 2006-2007. In terms of the larger globalization framework, EMAS can be considered as the international leg of information flow from medical research to clinical practice. Negotiations between these two social worlds converged and diverged at different times. TSMO workshop can be considered as the local level of the same process.

³³ This was prevalent in an anecdote when, on my way to a lunch meeting at EMAS, an Israeli physician mistook me for a doctor and asked whether I prescribed the drug to be discussed regularly. I explained my status, and asked her whether she prescribed it. She said: “I already do, I came to be convinced more.”

Conferences were organized for one-way information flow, with the general structure of the speaker informing/teaching an audience on a specialized topic, with limited time for the audience to ask questions. In both conferences the audience consisted of professionals, and the distance of authority between the speakers and the audience was bigger in EMAS. This difference in distance was reflected in the tone and style of presentations, the interactions between speakers and the audience, and the questions asked and answers given.

5.4.2.1 European Menopause and Andropause Society Congress, Istanbul, 2006

The Seventh International Congress of European Menopause and Andropause Society (EMAS) took part in Istanbul in June 2006, with the title “Managing Midlife Health: A Gender Specific Approach.” It lasted five days, had numerous symposia, pre-congress courses, keynote lectures, lunch-time symposia sponsored by the pharmaceutical companies, poster presentations, and a trade exhibition. In the trade exhibition, biggest booths were those of Organon’s Livial and Schering’s Angeliq. Turkish firms had smaller booths in the back, mostly promoting calcium, vitamin supplements, and black cohosh. Greek and UK menopause societies had two booths: they were both candidates for holding the ninth annual EMAS congress in 2009. TSMO had a table in one corner, with one person sitting there occasionally. The visuals and slogans were focused on sexuality and bone loss: Actonel (P&G) had the picture of a gray haired woman walking a dog, and in the second picture, there was a square on the body of the woman, showing an x-ray of the bones, and talking about the weakening of bones. Livial’s slogan was “Something to get really excited about,” with a sketchy drawing in the form of a naked female silhouette. Fem7Evro Patch had the picture of a young woman shown from the back, wearing a dress that left her back bare.



Figure 2: Livial booth in EMAS.

The general approach to HRT in EMAS as can be observed throughout the presentations, addresses, and question and answer sessions, was one of defending a technology/drug that fell out of grace because of a misguided, mistaken or misunderstood research, which was blown out of proportion. WHI was widely and wildly criticized by almost everyone that presented, criticisms ranging from “results misinterpreted” to “huge clinical incompetence.” The most common criticisms were that the women under study were much older than the women who are actually starting to take hormones, and that they used the same dose and same route of delivery for everyone, although HRT should be individualized. Some even went to lengths of showing the details of research design mistakes. However, some of them were not that critical when accepting that the same study shows cardiovascular benefits in starting HRT at an early age. Although the topic was gender specific approaches, and many presentations were on the differences between genders in areas like cardiovascular events and life expectancies, by far the most frequently talked about issue was the effect of the WHI study on postmenopausal HRT.

The presentations usually involved summaries of research done on a specific field with lots of statistical information and generalized statements, with a question and answer session to follow. Questions from the audience were sometimes broad theoretical level questions on the presented issue and sometimes geared towards specific advice on clinical practice. For instance, after a presentation on the latest findings on the effect of HRT on breast cancer, a clinician from the audience asked what should be the line of treatment for her patient whose twin sister has breast cancer and who is herself complaining of severe hot flashes.

In their study on estrogen replacement therapy, Kaufert and Mc Kinlay stated that the doctors have had the feeling of being persecuted and were angry that the discussion about the risks and benefits of estrogen was not kept inside the boundaries of the profession (1985). There was a similar sentiment at EMAS, where a frequently heard criticism of WHI was the premature announcement of the results to the public, before they could properly be discussed within the boundary of medical profession. This approach creates a certain view of “the public,” as a unified and irrational mass prone to panic that should be protected from sensational sounding information. As well as the WHI team who should have kept and discussed results “inside” before explaining them to public, media was also to blame for blowing the results out of proportion and “misrepresenting” them, causing the “media terror” as one of the presenters put it.

Most of the speakers defended HRT as still valid for menopause. Some of them said that HRT could (and should) be used with more caution, and for a shorter duration, some believed that it should be given as long as it is required for the specific patient. One of the rumors I heard in the congress was that the whole WHI study and its aftermath was a corporate conspiracy engineered by drug companies producing statins competing for marketing share against those producing hormonal drugs. Leaving aside whether it is true or not, even the existence of this story among medical circles gives a different perspective to the view of pharmaceutical companies as having the unified aim of pushing their products on doctors and patients, drawing attention to the inner conflicts of this seemingly unified pharmaceutical industry.

The same views on HRT and criticisms for WHI were shared by TSMO, which is a member of EMAS, and many ob/gyn practitioners who attended conferences or

workshops organized by TSMO in order to counter the “media terror” after the WHI study. I will return to the relations between media and doctors in the next chapter.

5.4.2.2 Turkish Society of Menopause and Osteoporosis Workshop, Istanbul, 2007

On a Saturday morning in January, a group of Obstetrics and Gynecology specialists invited by TSMO and the organizer of the meeting, Schering, met at the Green Park Hotel in Bostancı, Istanbul. Breakfast was provided for those who could make it early enough, followed by three presentations by members of TSMO on HRT and breast cancer, cardiovascular effects of HRT and the current situation with HRT. The mediator of the meeting, Prof. Dr. Sezai Şahmay, opened the workshop by stating the need for scientific conversation on controversial issues like HRT use, and the necessity of distinguishing the scientific debate from the influence of drug companies. The workshop was a much smaller professional event than EMAS, but the discourse of “talking among ourselves” was repeated. The aim was informing the invited specialists. There was an air of collegiality despite the authority granted to speakers by the participants. Since this was a small workshop without the participation of the public, there was less pressure to appear professional and authoritative. For the doctors, it was a safe environment in which to admit that they were unsure of certain issues and conflicted among themselves.

Each presentation was followed by a question-and-answer session geared towards controversial medical issues around HRT, for example whether progesterone use increases breast cancer incidence; or advice with regard to problems in the clinical practice like, “Patients usually take tamoxifen irregularly. According to what you said, they shouldn't stop taking it and start again, right?” or “For example, a patient enters menopause at the age of 51, her complaints start or become unbearable seven or eight years later. Is it appropriate to start HRT in this patient?” The conversations were a mix of discussing latest research results and consulting on hypothetical or real cases.

There were times that the professors presenting could not reach a consensus among themselves when answering the questions. In one of these instances, Prof. Şahmay felt the need to make an explanation to the audience, expressing that the aim of this gathering was to engage in a mental exercise on still unknown subjects. Another presenter stressed that point before starting his talk, saying that it was possible to have

every kind of discussion in a scientific environment but the moment the doctors step out of the door they had to protect the patient. He further criticized a colleague for giving an interview to the papers on the decrease in breast cancer incidence after the decrease in the HRT use in United States,³⁴saying that as doctors they had to be very careful about what they said to the public. In this context, protecting the patient and the public means not giving them information that would confuse them.

Prof. Dr. Şahmay went on to advise that it is not right to believe in the results of every research published without questioning, because what is considered as beneficial at some point in time can later on be proven to be harmful. Doctors should certainly read the publications but not directly apply them on the patients. Guidebooks supplied a checklist but one could not treat a patient by looking at them either. What should be done is to tailor one's practice according to the patient, and not be afraid to consult other colleagues, sometimes those in different branches like cardiology. This piece of advice is important in seeing the link between medical research and its transfer to the clinical setting, through a meaning-making process of professional consultation. Not to forget, of course that public and the patients were supposed to be protected in the meantime, by controlling the amount of information that got to those outside the professional circles and the forms that it takes.

5.5 Tracking HRT: Products, Producers, and Alternatives

During my interviews, I asked each doctor I interviewed, with ages ranging from mid 20's to late 60's, what has changed in the understanding and treatment of menopause since their medical school years. Their answers revealed a timeline of menopause and HRT being visible in the second half of 1980s, a period of popularity with the idea of a lifetime usage starting with the 1990s and going on till the WHI study results of 2003.

The WHI study was an important watershed for HRT in Turkey, just as it was in the United States and Europe. After the news spread in the media about the results, there was a decrease in the number of women taking HRT and the number of doctors willing to

³⁴ Around the time the workshop was held, the news on the decreased breast cancer rates in North America after the decrease in HRT prescription following the WHI study just hit the papers and caused debates and criticisms in the Turkish medical circles.

prescribe it. TSMO engaged in consciousness raising campaigns and tried to fight with the panic, but the HRT market received a serious blow. As a result, Wyeth, one of the biggest players in the 1990s and early 2000s, decided to shut down its menopause department in Turkey. Wyeth had introduced Premelle, which is the equivalent of Prempro in the United States, to the Turkish market in 1998, marketing it aggressively through doctor visits by the drug representatives and public meetings to increase awareness for menopause. In 2002 when the WHI study results became public, Wyeth's steady progress in the market halted.

By 2006 the main names in the HRT market in Turkey were Schering, Novo-Nordisk, Organon, and although less pronounced, Eli Lilly. Schering was the producer of Angeliq, the low dose combined HRT pill that contained 1 mg estradiol and 2 mg drospirenone. In addition to that, it had Climen and Climara, a cyclic estrogen preparation and a transdermal estrogen patch respectively, which are other highly-used drugs, older than Angeliq. Novo Nordisk had Activelle, the ultra-low-dose combined HRT pill in addition to Trisequens, which is a continued estrogen and cyclic progestogen treatment usually prescribed for women in perimenopause (that is, still having irregular bleedings, so not yet in menopause) with uterus; Kliogest, a continued estrogen plus progestogen treatment for postmenopausal women with uterus; Estrofem, continued estrogen treatment for women who underwent surgical menopause and Vagifem, a vaginal tablet for local symptoms. Wyeth's Premelle and Premelle Cycle were still being prescribed, but because of the company's marketing strategy change it was becoming increasingly hard to find them in the market, especially the higher doses. Organon's Livial was prescribed especially to women with fibrocystic breasts, and contained tibolone, which the company defined as a STEAR: Selective Tissue Estrogenic Activity Regulator. According to the claims of Organon, it relieved hot flashes and vaginal atrophy, but did not affect breast or endometrium tissue. Eli Lilly's Evista contained raloxifene, and was marketed primarily as a drug against osteoporosis after menopause. Like tibolone, raloxifene is not technically a hormone, it is—again, as the company calls it—a SERM (Selective Estrogen Receptor Modulator), with the idea that it has good estrogenic effects on bones, but will not affect uterus or breast tissue. One notable difference between the promotional material that these companies distributed in medical conferences and to

doctors' offices was the way they referred to their drugs. While Schering preferred the term HRT, Novo Nordisk used the term HT, a name more in line with the FDA guidelines that also avoided the problematic notion of "replacement" with its negative connotations.

The "medical" point of view on the commonly used drugs after menopause can be discerned from consultation of Prof. Dr. Oktay Kadayıfçı's book on menopause (2006). Kadayıfçı classified the drugs used as HRT according to their ingredients as 1) drugs that have estrogen, 2) drugs that have progesteron, 3) drugs that have estrogen + progesteron (divided into a) continuous and b) cyclic), and 4) gonadomimetics (Kadayıfçı 2006, 49). He then listed the brand names and ingredients for all of these categories (Kadayıfçı 2006, 50-53). Below is a slightly changed form of his list: I added company names in brackets after the brand names, omitting the ingredients, to give the readers a sense of who the main players in the menopause market were in 2006, as well as a sense of the technological innovation that had occurred in this arena since the early twenty-first century.

Oral estrogens

Cyclical: Climen (Schering), Cyclo-Progynova (Schering), Divina (Orion/Abdi Ibrahim), Premelle Cycle (Wyeth), Trisequens (Novo Nordisk)

Continuous Combined: Angeliq (Schering), Premelle (Wyeth), Kliogest (Novo Nordisk), Activelle (Novo Nordisk)

Estrogen Only: Premarin (Wyeth), Estrafem (Novo Nordisk), Ovestin (Organon)

Transdermal estrogens

Patches: Estracombi TTS (Novartis), Climara (Schering), Estraderm TTS (Novartis)

Gels: Estrava Transdermal gel (Merck)

Vaginal and intrauterine preparations

Vaginal Creams: Ovestin (Organon)

Vaginal Tablets: Ovestin (Organon), Vagifem tb (Novo Nordisk), Colpotrophine (Merck)

Vaginal Rings

Implants

Nasal Estrogens

Aerodiol Nasal Spray (Servier Laboratories)

In 2006, Schering's Angeliq and Novo Nordisk's Trisequens were the most commonly prescribed forms of HRT for women with a uterus, in the fieldsites that I observed. For women who had a hysterectomy, the preferred form of treatment was usually the estrogen patches. If the woman did not want to be on the pill (or if the doctor decided that she should not use it), she was sometimes prescribed local estrogen treatments, in the form of a vaginal cream or a vaginal estrogen tablet, Vagifem being the example for the latter. In addition to the hormonal drugs, calcium was a highly prescribed drug for the prevention of osteoporosis. All the doctors I met prescribed calcium to all the menopausal women who were their patients, whether they are on HRT or not, and especially if they were not. In the calcium market, Bayer's Cal-D-Vita was the leading brand, which is a combination of calcium and vitamin D in the form of an effervescent tablet, owing most of its popularity to the fact that it was covered by public health insurance plans.

5.5.1 Alternatives

The market for the hormone-alternative drugs was just starting to grow in Turkey in 2006. Black cohosh extracts were newly introduced. In the black cohosh market, there were two important names: Remifemin and Klimadynon. Remifemin was produced by a German company called Schaper and Brummer and imported by a Turkish pharmaceutical firm FarmaPek. Klimadynon was produced by Bionorica, a US-based pharmaceutical firm, and imported by Biomeks in Turkey. These drugs were prescribed to women who either refused to be on hormones, should not be on hormones, or those that had very severe symptoms and did not complete the tests yet. In both research hospitals the standard procedure was to run a number of tests before deciding to start HRT or not. The typical tests included pap-smear, mammogram, breast ultrasound and sometimes bone mineral density. The problem was that both hospitals had long waiting lists for especially the ultrasound and mammography, and completing the tests would take several months. For women who came to the doctor because of the severity of their complaints this would be a very long time to wait. Some preferred to complete the tests in

private labs outside if they had the means to do so, but if they did not, they would negotiate with the doctors for a quick remedy, and sometimes they were prescribed these extracts, with the belief that it would help their symptoms a little, or at least create a placebo effect. Dr. Teoman explained his motivations to prescribe these drugs as such:

Menopause has these symptoms like sweating and hot flashes, we have some drugs of herbal origin for these, we can use them too, they also lessen [the symptoms]. They're not synthetical but herbal, made of herbal essences. If the patient sees it necessary and we convince them too she takes and uses them.

Another doctor who commented on phytoestrogens was Dr. Rıfat.

And in some people phytoestrogens really work in vasomotor symptoms. We experienced that too. So, it seems like phytoestrogens are going to gain a market share too.

A doctor's likelihood of prescribing herbal/alternative drugs was also related to how he perceived the side effects of HRT. Those who took the WHI results seriously and wanted to be extra careful about it might prefer the herbal alternatives before they prescribe HRT, and only moved to HRT if they made sure that the woman in question did not have risks and absolutely needed the hormones, like Dr. Ali.

Even when we are about to start the [hormonal] treatment, if the patient does not have too many complaints and there aren't too big losses due to the estrogen deficiency in the tests that we ran, we start the treatment with herbal estrogens.

One problem with the herbal extracts was that they were not covered by insurance. For that reason, some doctors were saying that patients did not prefer them. Dr. Nurcan explained the rationale behind prescription practices with concerns about insurance:

Since we are a SSK [Institution of Social Security] hospital, a Ministry of Health hospital we can mostly prescribe the drugs [the insurance] pays for. If they don't pay for Klimadynon, we can't prescribe it. If the patient requests it, if she says that she can buy it herself she will and then you will know [whether it helps or not]. Since we can't prescribe it, frankly we don't know if they benefit from it or not.

Her statement was confirmed in interviews with other doctors from the same public hospital like Dr. Şahin Aras, who was a male ob/gyn specialist, graduated from medical school in 1997.

There are these herbal extracts that came out recently, we recommend them too but not many [patients] take them, because they have to pay for it.

Another issue doctors had with herbal treatments was their suspicion about their reliability. It was a common complaint of doctors that people preferred the herbal or alternative medicine with the thought that they are more “natural,” even though the effects of these substances were not properly studied according to the medical/scientific research methods. Dr. Zeynep Tekkaya was a young female ob/gyn specialist I interviewed in her private practice, and she shared these concerns.

Yes, people have quite an interest in alternative medicine. They think that it is less harmful, like it will not have any [harm] when it is natural. But you know, these are drugs that haven’t been researched very well. My advice to the patients is that if you need a treatment for hot flashes, etc. then it is more reasonable to prefer the drugs that we know, that we know the ingredients of, we know the dosage of that has been researched. Most of them actually accept this.

Dr. Selim also expressed suspicion about herbal supplements and companies that market them.

Then there are herbal phytoestrogen [companies], we don’t have good relations with them. We don’t believe in phytoestrogens, their research is [much more limited]...They work on the basis of pharmacies, from pharmacy to the people. [They say] “These are herbal, they’re harmless, here take it”...However we tell to all our patients that these are much more harmful because they don’t have [proper] research. There is research that we found out that they are harmful actually, about breast cancer for example, and their dosage can’t be titered well. [So we tell the patients] either don’t take anything, or let’s give you our low dose drugs that have been researched, hundreds of times, and are still being researched. When we say that the patient doesn’t take it...But she doesn’t say let me take yours, take the hormone since it’s the same thing. She leaves the phytoestrogen and doesn’t take our hormone either, for example.

Other drugs used as an alternative to HRT were antidepressants, raloxifene and a group of drugs used against osteoporosis, which doctors called “bone drugs.” Although bone drugs were an important part of EMAS congress and they are mentioned in the interviews I made with gynecologists, antidepressants and cardiovascular drugs were not too visible in the menopausal market. The latter was especially interesting, considering the stress put on the cardiovascular disease risk increase after menopause in the

arguments for HRT use. There was an undefined boundary between cardiologists and gynecologists in defining who was going to treat whom, but the line was blurrier between gynecologists and orthopedists, and gynecologists and psychiatrists. In Turkey, women's health is the realm of gynecology/obstetrics and did not emerge as an interdisciplinary specialty unlike as in the United States. However, following the established boundaries of medical specialty, gynecologists referred some of their patients to other branches. This was a kind of practice I observed especially in the menopause clinic, which acts like the first stop of an overall check-up for women who are considered to be at risk. Routine blood tests, mammography and bone density measurement were performed with regular intervals as part of the follow-up, and depending on the result of these tests, women were (sometimes very strongly) advised to consult a cardiologist, dietician, orthopedist, or in some rarer cases, a psychiatrist.

5.6 Conclusion

In Istanbul, in 2006, HRT was a double-edged sword: it was the best remedy for aging and other horrible things that await a menopausal woman, like osteoporosis and problems with spouses, yet it was a very dangerous drug, causing cancer, one of the most feared diseases. Both sides included fear and risk, and it is through that language of risks and benefits that women were convinced to take the drugs or not; aligning with whomever they trust most: the doctor or the neighbor? And even then, which doctor: the one at the hospital or the one they see on TV?

Moreover, HRT was not “natural,” for women, who defined it as an artificial matter taken inside their body. And anything that got into your body like this was potentially dangerous, suspicious at least. Doctors and pharmaceutical companies defined and redefine the boundaries of “natural” by new drugs, herbal extracts, menopause as a natural process and natural as not necessarily being “good” anyway. These redefined boundaries can be seen as part of the shifting boundaries of modern/premodern/postmodern as exemplified in the previous chapters. Once you chose to believe in the modern medicine and decide to become the “conscious” patient, you are rewarded by information and relief.

There were open meanings, like relieving of hot flashes and protection from osteoporosis; and there were implied ones, like the ability to keep up with the husband's sexual demands. For every unspoken concern that a menopausal woman had about this new period she was stepping into, the medical world had a fear, and sometimes, multiple fears; and a benevolent desire to control and "fix" her body for her own good. Medical paternalism in its most traditional form was still alive in the Turkish menopausal arena in that sense, and effective in the medicalization of menopause in Turkey. However, medical professionals are only part of the process of medicalization of menopause. As Nelly Oudshoorn commented on the social and cultural dimensions of medicalization in her article analyzing the exclusive focus on female menopause and discussions around male menopause (or andropause), there are multiple social worlds involved:

Health problems can only be classified as illness and be medicalized if there exists a cultural climate and a medical infrastructure that actively transforms health complaints into diseases. The medicalization of health problems ultimately depends on the attitudes and interests of medical professions, patients, and last but not least, the pharmaceutical industry (Oudshoorn 1997, 143).

In the next chapter, I will elaborate more on the interests of the pharmaceutical industry in shaping the definitions of illness and the role of media and consciousness campaigns in that process.

6. Media and Consciousness Raising

The following news story, titled “Turkish Woman and Menopause” came out in May 2005:

The results of the study that was done by German drug company Schering with 1007 women in 19 cities in order to understand the attitudes of Turkish women towards menopause and menopausal treatment methods has been announced.

THE AGE TO ENTER MENOPAUSE IS 45.8

According to the study that shows 72 percent of women between the ages 42-58 in Turkey are in menopause, the average age for entering menopause is 45.8. Those who enter menopause at an earlier age (43-47) are mostly women from Central Anatolian and Aegean regions and urban areas. Women who enter menopause between the ages of 48-52 are from Mediterranean and Black Sea regions and rural areas. According to study results, while a big majority of women define menopause right, 13 percent of them do not know the exact definition even though they are in menopause.

61.8 PERCENT DO NOT KNOW THE REASON

When they are asked about the reason for menopause, 61.8 percent of women answered “I don’t know,” and others responded with “old age” with 9.4 percent, “end of reproduction” with 8.1 percent, “end of menstruation” with 7.4 percent, “stress” with 3.7 percent, “a natural incident” with 3.3 percent and “disruption of hormonal balance” with 2.4 percent. According to the study, menopausal complaints like stress, insomnia, nervousness, irritability, bone pains and osteoporosis are experienced most in the Marmara region, and least in the Eastern Anatolia. According to the study results, 61 percent of Turkish women in menopause go to the gynecologist 1.3 times a year on average for the purpose of regular check-ups. The frequency of going to the gynecologist is higher for women in the 43-47 age group.

DON’T FIND THE INFORMATION ADEQUATE

According to the study, 51 percent of the women take information on menopause from their doctors, 29 percent from the TV, and 27.8 percent from their friends and acquaintances. 38 percent of the women find the information they get adequate, while 62 percent think it is inadequate. While the study revealed that 79 percent of women do not know about “hormonal support therapy,” 15.3 percent of women stated that they take some drugs for menopause. When the participants to the study were asked

with whom they shared their menopausal problems, spouses took the first rank with 40.1 percent.

THEY COMPLAIN OF HIGH BLOOD PRESSURE

According to the results reached with the 1007 women that participated in the study, high blood pressure is the most frequent health problem in menopause with 21.5 percent (NTVMSNBC, May 28, 2005).

Despite the fact that it is not a medical publication, this news story is a good example of the medical portrayal of menopause in Turkey and its reflection on the media. There are several points to be made here: first, the one and only large scale survey on attitudes of menopause and HRT in Turkey was done by an international pharmaceutical company of German origin, with the help of TSMO. This point was not emphasized in the news story, yet it is an important fact denoting the influence of international pharmaceutical corporations on setting the local medical research agenda. The second point is the answers given to the questions for the reason for menopause: Although the researchers seemed to be somewhat displeased about the “wrong” answers, they were important in the sense that they show the meanings that people associate with the word “menopause,” like the end of reproduction, a condition that is caused by stress, hormonal imbalance and the “naturalness” of the process. The researchers’ insistence on asking about the definitions of and reasons for menopause is also telling about what kind of knowledge mattered to them. Reading between the lines and inferring from the rest of my field data I can say that the main motive for asking these kinds of questions is to detect the “wrong” knowledge and “right” it with corrective awareness campaigns and public outreach projects. Awareness campaigns on menopause and HRT generally involve news media, as mentioned briefly in the previous chapter. In this chapter, I will talk about the awareness campaigns, focusing on the example of a women’s health conference that took part in June 2006.

6.1 Media: The Two-Way Bridge

The popular perception of menopause was shaped by the media to a great extent. Newspapers and TV programs were to blame for misinformation, according to angry physicians, and they were cited as sources of information by women when I asked them

where they learn about menopause and HRT. Turkey is not very different from the United States in that sense, where media is the chief source of health communication.

Newspaper articles on menopause in the Turkish daily press between years 1996 and 2006 can be divided into two groups for the purposes of analysis. The first category is news stories that were directly on menopause and how it should be treated. I include discussions on HRT (especially around 2002) in this group which also includes question and answer articles by “newspaper doctors,” letters from the reader to “Güzin Abıa” asking for advice on their own menopause or that of someone they know and interviews with doctors about menopause and/or HRT.³⁵ The general tone of these articles, no matter who is speaking (a doctor, columnist, or the newspaper editorial staff as an anonymous author) was informative, giving lifestyle advice to women and sometimes alleviating their fears on certain treatments, and sometimes warning them against some dangers waiting for them if they were not under proper medical care, like reminding them the need to have their mammographies and stay away from tobacco. The message usually is: “menopause is not the end of the world, don’t worry, but be careful.” This message contained the hidden presumption that women are overly worried about menopause (which, I might say, suggests that they *should* worry about it if they are women, since everybody else *is* worried). A subcategory within this one is the news about the activities of certain firms or organizations like TSMO about menopause.

The second category is news not directly on menopause, but tangentially involved in the construction of menopause. I include the news on fertility after menopause; herbal remedies for various illnesses and complaints where menopause is just another item on the list; articles on vitamins and minerals (especially calcium), with the argument that the need for calcium increases with menopause; news on other medical conditions like osteoporosis, female sexual dysfunction or heart disease; and news on andropause that compares this period with menopause. Although very limited in actual “text” on

³⁵ “Güzin Abıa” is a “Dear Abby”-like personal advice column in the popular daily newspaper *Hürriyet*, and was run by the same person for a very long time – pretty much until her recent death, after which the column was taken over by her daughter and still exists under the same name.

menopause or HRT, these articles are important to show the gendered lens through which menopause is viewed. A very limited number of texts gave direct clues about the portrayal of the menopausal woman, which can be put in the second category in their brevity. Usually the references were made to the hot flashes and the nervousness and irritability of menopausal women.

An unexpected yet interesting theme that emerged from the media analysis was the link forged between menopause and infertility treatments and by the emergence of the technological possibility of having a baby after menopause. Especially the news on Kutluk Oktay, who is a famous Turkish doctor living and practicing medicine in the United States, constitute an important part of these news but worries about early menopause and the discourse on “postponing menopause” existed in my field data as well. Oktay performed an operation on a cancer patient who entered menopause prematurely due to chemotherapy and helped her get pregnant in 2004. Her ovarian tissue was frozen before the woman started chemotherapy and when strips of frozen ovarian tissue were transplanted under the skin in her abdomen, she started producing eggs. Despite the fact that this treatment was developed for cancer patients who lose their fertility prematurely, some news stories mentioned future possibilities of the technology, including postponing menopause. In a few interviews Oktay denied that it was possible to postpone natural menopause by this technique, but he said the studies on using it for premature menopause were continuing. The tone of news reflected a sentiment of awe for scientific and medical progress and the national pride that this progress has been accomplished by a Turkish doctor.

Aside from the news stories, menopause occasionally appeared in columns, sometimes directly and sometimes just as a reference. One interesting example to quote here is a semi-humorous column by Pakize Suda, a woman journalist who was a former singer, and became a columnist overnight in one of the big daily newspapers in Turkey, where the author was revolting against the gloomy picture painted by the news on lifestyle advice and menopause:

...And then there is menopause, which, according to what has been written, is worse than death. Whichever women’s magazine I look at, there is a picture of a lady who holds her head between her hands as a sign of

her being in menopause, and under that information which would drag those approaching the dangerous ages to suicide.

The general meaning that comes out of the information is this: You lived whatever you could until the age of 40, stand or sit, and thank God for every healthy day of your life after 40.

When I say “stand or sit,” I mean it in the metaphorical sense. Since, it is medically proven that you cannot stand or sit. Because your bones are disappearing. Constantly. Do you remember the skeleton in the biology book? The one that describes the bones? That skeleton does not represent you. It belongs to someone below the age of 40. You still brag about having a femur.

Like hell you do!

Let me tell you what you have: Night sweats, sleep disorders, loss of sexual appetite, nervousness, absent-mindedness. And there are wonderful (!) effects those have on your social and family life. What do you think? Delicious, isn't it? For those who want to balance this, there are also cardiovascular diseases as icing on top.

What? You are way past 40 and don't have any of those? It's not possible. If the science says that it is the case, then it is. You are just not aware that you're sweating. Set the alarm one night to wake up and check.

Actually, if the human life didn't get longer there wouldn't be any problems. However, since it got longer, this situation has become an important problem. That's what the experts say.

Which means:

In the old times, a woman's entering the menopause and reaching heaven were more or less simultaneous. Yet, since human life is longer in our time, a woman happens to have entered menopause in almost halfway through her lifetime. And she has to spend the second half nervous, irritable, sweating, sleepless, disagreeable, boneless and manless.

Scaremongers!

We got it. You've been explaining the situation over and over for years. Can you find a solution to it? If you can't, just get out of the way.

Well, I shouldn't be that harsh on them, there are those who say what the solution is.

You'll visit the doctor. Frequently.

And he will give you drugs. Lots of them.

Then you will read here and there that the drug causes some other serious diseases.

You'll be stuck between a rock and a hard place.

This is the solution (Suda 2001).

Contra the humorous portrayal of menopause as a nightmare from which a woman only awakes upon her death, there were stories that made the point that it is not actually a time of dread, but a new period of life during which one can be healthy and free of the responsibilities of childbearing and childrearing if one follows medical advice. This was reflected in the title of one of the newspaper article series, which is “Menopause: The Second Spring.” In the first article of the series, menopause was described as “not a disease,” and the concept of second spring was explained.

Grey hair, children leaving home... When irregularities in menses are added to all of these changes in 40's women panic. They accept menopause not as a natural process but a disease. Of course this approach is not applicable to all women. However, most of them insist on not seeing the beauties of life with the thought of “menopause equals disease.” Whereas menopause is a natural process like adolescence, or reproduction. Those who do what is required for a healthy life enjoy the second spring (Eminoğlu 2002a).

The term second spring (*ikinci bahar* in Turkish) is actually not the invention of newspapers. Originally, it was the title of a famous pop song by Sezen Aksu, which came out in 1982, with lyrics reminiscing about finding true love in advanced age. Later on, in 1999 it became the title and theme song of a popular TV drama centering on romance between two middle-aged people both of whom lost their spouses and are struggling to have their relationship accepted by their children and the neighborhood in which they lived. After this TV series, both the song and the term became widely popular, used as a name by many things from dating websites to nursing homes. Especially, it started to be used—in a half-joking way sometimes—to describe enjoying life at an advanced age; and for menopause, as supposedly a period of this sort; sometimes menopausal complaints being referred to as *ikinci bahar sendromu* (second spring syndrome) (Eminoğlu 2001a).

The concept of second spring came up in interviews, too, like the Duygu Asena interview done in 2004 in the newspaper *Akşam*. Asena was the most well-known feminist in Turkey in the 1980s and the 1990s, and below is an excerpt from the interview that she gave at the age of fifty-eight, where she answered a lot of questions on aging.

Menopause can be a nightmare for women. Asena reminds that one should not be afraid of menopause: Menopause should be what they call as the second spring. No risk of pregnancies. No painful menses that come every month. A nice and comfortable period for women. Men portray it as a horrible period. Sexuality of women doesn't deteriorate physiologically in this period either (*Akşam*, May 21, 2004).

The fact that the same term was used in the menopause awareness campaigns that were organized by TSMO shows us the ways in which discourses of different social worlds pass into each other. As newspapers and magazines borrowed terms and concepts from the medical world —and sometimes changed their meanings as they use them— medical organizations and professionals sometimes utilized popular terminology to make their message clearer. The words of Ertüngealp form a news article on the national awareness campaign for menopause started by TSMO in 2005 illustrates this point.

Chair of the society Prof. Dr. Erdoğan Ertüngealp, referring to the fact that the average life span went beyond 80's in developed countries and 70's in our country, said "While menopause is a natural process, it brings certain difficulties due to the decline of hormones. With the nationwide Menopause Awareness Campaign that we started, we aim to inform our women from an early age on about the period of menopause that we define as the second spring of life, and to make them conscious about living this period healthy and happy without compromising their quality of life" (*Hürriyet*, May 13, 2005)

I have encountered women using the term "second spring" during my fieldwork, which shows that the concept also bled into the daily lives of women experiencing menopause. One of these instances happened during a public women's health conference entitled "18+ Women's Health Conference," which I will turn to later in this chapter. In the conference there were sponsored panels and workshops on health issues like birth control, diets, sexuality, menopause, and depression. In the panel on sexuality, there was a woman asking the speaker what she should do about her hot flashes and problems with

her husband who does not initiate sex. She said now that she is in menopause, she wants to do things that she did not have time to do for thirty-five years, while she was working for her husband in his workplace. When her husband pressured her to go back to working with him, she told him to leave her alone, for she was “living her menopause,” she wanted to read, or do other things that she felt like doing. Here it looks like the trope of “second spring” can be used by women to claim menopause as a time for one’s own needs. The medicalization and popular visibility of menopause helped them to legitimize their demand to retire from living for others and begin to create a “room of one’s own” for themselves. The effects of this concept were not always positive however, as I observed in another instance when I ran into a woman complaining about menopause in the doctor’s office, saying that the whole propaganda about menopause as being a second spring was wrong. In this context, praising menopause as second spring caused disappointment for some women who were having severe symptoms, and may not be receiving enough support from those around them.

6.1.1 Menopause and Andropause

There was a stereotypical story of a middle-aged couple created (or reinforced) by the media. It involved a menopausal woman unable to satisfy her husband, who is in andropause wanting to prove he is still young and this situation ending in the husband cheating on his wife:

If the woman enters menopause and the man enters andropause simultaneously, the risk of sexual problems increases. If the man who tries to prove himself again in the period of andropause does not receive attention from his wife, he seeks happiness in another woman. Experts state that mutual understanding is a must in situations like that and say “Especially if the man has problems in workplace and a complex of being successful, the risk of having sexual problems during andropause increases” (Eminoğlu 2002b).

In most news articles mentioning andropause, decrease in sex hormones was almost used as an excuse for the lifestyle changes to which middle-aged men aspire (the stereotype being buying a red cabriolet and leaving the wife for a woman half his age). The following excerpt is from a newspaper article that quoted a British newspaper on a medical news article. According to the latter, two experts from The Wellmen Clinic

Duncan Gould and Richard Petty came up with the term “manopause” combining “man” with “menopause” and their hypothesis was summarized as such by the Turkish newspaper, *Hürriyet*:

“Middle aged men who all of a sudden one day buy a red cabriolet for themselves, start taking dance lessons and body building are the victims of hormone loss, just like women entering menopause.” According to the experts, it is possible to observe irritability, depressive moods, hot flashes, sweating, fatigue, loss of sexual appetite, difficulty in concentration and weakening of the memory in men suffering from this condition (*Hürriyet*, March 28, 2000).

The same “life change” desire, however, was not condoned for women, whether it was attributed to hormones or not. Following is an example from the advice column Güzin Abula, responding to a doctor whose wife was cheating on him with her daughter’s boyfriend:

My wife is 46, and my daughter is 24 years old. We are in a good state socially and economically. Or we were. Until my wife cheated on me with my daughter’s boyfriend. Yes, unfortunately this is true... My wife is now living with her young lover. And the reason she gives us, who are appalled and helpless at the face of this situation, is this: “I want to feel young again.” I, on the other hand, cannot face my patients and my friends. She is my wife of 25 years, mother of my child. This is the family drama that forces me to write to you, Güzin Abula. Or call it a family comedy if you like. The real reason for writing you this letter is the fact that nobody takes seriously the “middle age depression” or “preclimacteric psychiatric syndromes” that you frequently encounter among your readers. I don’t want to take your time with what I have lived through, but I could not help but tell how a family is destroyed because of these problems.

Nickname: Doctor

The psychological problems that occur before or after menopause, which you described as middle age depression in medical language, can of course be seen even in the wife of a doctor like you. The condition of your wife, as you understood as well, should be the result of a concern like “my youth is over, I am getting old, I should catch something before everything ends,” that is frequently encountered in men, or as you explained, a mid-age depression. This must be a psychological disturbance. And as you said, nobody sees it as a serious problem. Although it is seen in men more frequently, it can sometimes be seen in ladies after the age of 40. The person encountering that psychological situation, be it a man or a woman, can see the reality after a while. They can understand the mistake they made, and come back to their senses. I am sure your wife is going to

realize how exhausting and embarrassing this unbelievable relationship that she is having with a man young enough to be his son is. If you can show the (really) big maturity that most of the time women show, you will accept her back (Güzin Aba 2002).

Despite this narrative of sexual problems between middle-aged couples because of the woman's menopause, there is data that gives the sexual problems a different twist. In a research done by Süleyman Akhan et al. on factors affecting sexual function in postmenopausal women, the most important sexual problems for women turned out to be lack of communication, and premature ejaculation and erectile dysfunction problems of the male partner. The authors concluded "the most important factors affecting women sexuality in menopause are woman's relationship with the partner and the sexual performance of the partner" (Akhan et al. 2006).

This finding is supported by the observations and experiences of Dr. Berna, who argued for finding the underlying causes of problems postmenopausal women are going through and that are specific to the conditions of Turkey rather than giving them hormones without questioning:

For example the effect of menopause on sexual life, this is an issue that is commonly studied. We did a research with Organon, it was a big scale research on sexual functions, urinary incontinence, dyspareunia, etc. First of all, there is a very common impotency that develops with age in men. Until we did that study I didn't know that sexual problems of most women are related to their spouses, his erectile problems. Actually, erectile problems are also related to vascular diseases. So, in Turkey there are common vascular and metabolic diseases [more than any other country]. [Looking at] the way we eat, our life style, this is expected, not surprising. There has to be studies on that. I mean, we are going to start giving hormones to the woman, she says "I'm not having coitus anyway, because of my partner. I have it every once in a while." Now you will...(pauses) The reason for [vaginal] dryness or pain is not the thing about woman, there is a sexual relation that became so infrequent, that does not exist anymore.

This "embeddedness" of woman's sexuality within her relations with others –and primarily her husband in this context—can be compared to Germaine Greer's comment on testosterone treatment in menopause for the loss of libido as a treatment for the sake of the husband:

When we give a male hormone to a married woman who has lost interest in sex, we are consciously tailoring her sexuality to fit her husband's; the whole business smacks of women's willingness to try anything for a quiet life...The medicalization of everyday life is here taken to its absurd extreme. The husband has become the wife's health problem, and testosterone in her body the treatment for him. If the wife's problem was desire for a husband who was impotent or not interested in her, testosterone would hardly be the drug of choice; if her psychosexual problem was that she lusted for young boys or girls, testosterone would be stringently withheld. The hormone is given to her for the sake of another; she is to desire someone whether he is desirable or not, because she is his wife (Greer 1991, 177).

A similar idea existed in the Turkish medical approach to menopause and HRT, where menopause was considered to be a social problem as well as being a natural yet risky period for the individual. Although there are no clear data to prove the connection, similarities with the American example suggests there can be a transfer of expectations and roles from the Western context with the transfer of the concept of menopause itself, which did not exist as a medical category in Turkey

The general attitude towards HRT and the meanings created about and around it are more difficult to find in the media than those pertaining to the phenomenon of menopause itself. However, there are still some common themes that occurred in the Turkish print media between the years 1999 and 2006, in roughly two periods divided by the WHI study in 2002.

In the pre-WHI era, HRT, sometimes specified as "hormone treatment" and sometimes referred to as just "treatment" (after menopause), was portrayed as very important to protect yourself from osteoporosis and cardiovascular diseases. Together with the affirmation that menopause is not the end of the world and the warnings about how essential it is to go see a doctor for this period regardless of the fact that menopause is a natural phase; being treated for prevention of possible diseases, especially osteoporosis, was advocated. Statements like "Women who do not take the treatment seriously are inviting osteoporosis and cardiovascular diseases" illustrate this approach (*Akşam*, July 2, 2002).

Apart from news stories, answers that the resident doctors writing in newspapers were important sources in forming public opinion. Dr. Gündüz Tezmen, who wrote in the daily newspaper *Hürriyet* is one of them. In 1998, in answer to the question of "Are there

any other solutions besides hormone therapy in menopause?” he described what HRT was and commented on its use:

The hormones used for [the purpose of HRT] are the hormones that are present in a woman’s body before menopause. The treatment has no meaning besides replacing the missing amounts. Because of that, it is also meaningless to exaggerate a concept like the side effects of the hormones. Both the natural form of estrogen hormone as present in the woman’s body and the artificial form given by drugs have an effect of speeding the cancer growth...In sum, the risk of a premenopausal woman whose hormonal activity continues is equal to a woman who is under a consciously regulated hormone therapy in menopause...Those who are not taking hormone therapy in menopause are under greater risks. The most dangerous of those are the increase in heart attack and stroke risks because of acceleration of atherosclerosis and the increase in bone fracture risk because of weakening of the bones (Tezmen 1998).

Although most doctors in this period –be it the newspaper doctors, or those giving interviews to the newspapers—expressed quite positive views on HRT, there were outliers who pointed to the development of the menopause market in Turkey and argued that doctors should be more cautious when talking about menopause. In the same year that Dr. Tezmen wrote about hormones, another doctor, Prof. Dr. Timur Gürgan was quoted in an interview saying:

A fad of menopause is created in Turkey. The reason for this is 8-10 million women who are in or about to be in menopause in Turkey. And the issue of menopause became an issue of profit. It is constantly being said that the bones can be lost, the heart will get sick. Because of this profit, menopause clinics were established before reaching true and real information. In the short and long term there can be losses, women’s trust can be shaken because of wrong information...One has to be very careful about the hormonal drugs as well. There are so many different types of drugs. Furthermore, they are expensive drugs. Who is going to be prescribed what should be determined right. (Kartal 1998)

The wave of support was replaced by a wave of panic after the WHI study results. This time, the news started to emphasize the dangers of HRT, although there were still examples of supportive material, often in the form of interviews with doctors, mostly from TSMO, trying to prevent the wave of panic. Bad news about research that showed risks of HRT started to be seen as early as 2001, with study results showing increased risk of second heart attack in women who are taking HRT and who have already had a

heart attack (*Akşam* July 10, 2001). However, they had remained as isolated small news stories until the WHI study results. Newspapers and magazines started to publish lengthy stories discussing the benefits and risks of HRT, as well as consulting and quoting famous doctors in the field for expert opinion. The tone of these news stories ranged from alarming to balanced, depending on whether it is just a translation of research results, possibly from foreign press, or it involved medical opinion from a local expert.

Another turning point in the media portrayal of HRT came with the further results of WHI study in February 2006, which showed the existence of a window of opportunity for using HRT to prevent cardiovascular diseases. According to these results, used immediately after menopause estrogen prevented plaque formation, but if it was given after a period of no HRT, the treatment made it worse, by causing a rupture in the already formed plaques. Gynecologists who were in support of HRT used this news to argue that it was actually still a good treatment, it just needed to be tailored to the individual and used with caution. News in the media followed suit, together with the publicity formation attempts of TSMO and other ob/gyn practitioners who thought HRT should regain its good reputation.

The last turning point in the HRT debate came with another “scary” study presented in December 2006, showing a 7% decrease in breast cancer in USA in 2003, shortly after women abandoned HRT because of the WHI study results (Ravdin et al. 2007). This unexpected drop in cancer incidence has been linked to the drop in the use of HRT by the researchers and the media alike. Against this portrayal, doctors I interviewed argued that this is not a realistic statistical result, for it took much longer than one year for cancer to form and develop.

As can be seen above, it was also common to see examples from and comparisons with Western countries about HRT use, both before and after the WHI study. In an informational series on menopause in the newspaper *Akşam*, views of a doctor were presented in the osteoporosis part:

Women who think they can protect themselves from osteoporosis by saying ‘I’m taking calcium, consuming milk and dairy products’ are mistaken. Dr. Hakan Rauf Tüfekçi, who stated that hormone therapy in menopause is an important step to prevent osteoporosis and calcium and vitamin D intake and an active life are also effective; said that 80 percent

of women in France are protecting themselves from osteoporosis with hormonal therapy (Eminoğlu 2001b).

The quote above is not an isolated example. Numbers and research from the United States as well as European countries were quoted frequently by both the proponents and opponents of HRT. I attribute this link partly to the number and prevalence of research done in these countries and their dominance in the global medical world. Yet there is still a part that links to the ideals of Westernization/modernization and the desire to be like “the West” in order to be modern, including the consumption of drugs and description of medical conditions. Almost one hundred years later, the West still set the example for Turkey.

The most important alternative, and sometimes supplement to HRT in protection against osteoporosis was calcium. Doctors often stressed the importance of nutrition, advising their patients to consume dairy products like milk, yogurt or cheese; and prescribed calcium supplements to almost all menopausal women. These were repeated in newspapers as well. Importance of exposure to sunlight was also commonly accepted advice, both by the doctors and newspapers, yet the extent of it seemed to hinge on the attitudes towards the issue of dress and religion. Dr. Alper criticized the way menopausal women who come to the public hospital he works were dressed, in relation to osteoporosis.

There is a bone loss in menopause, if you see what those people [patients] are wearing, they come here dressed like a cabbage, and I don't think they [their bodies] see the sun at all.

There is certainly an element of class and secularity involved in his criticism. What was implied here is that these women are uneducated (or unconscious), usually poor, having a rural background and conservative enough to cover their bodies in line with tradition and religious beliefs. His approach suits the professional identity of Turkish doctors as educated, modern and secular elites responsible to educate the patients as well as healing them. The argument that covered women had a higher incidence of osteoporosis was refuted by the Islamist sources by using the same “scientific” arguments, as can be seen in the following excerpt taken from the newspaper *Zaman*, entitled “The reason for osteoporosis is not “covered” dressing but lack of calcium”:

Osteoporosis is a health problem that can be seen in every woman after the age of 30, and especially after the onset of menopause. While some experts see this as a health problem, some consider it as a natural part of human life. Due to decrease of estrogen in body with menopause, a lack of calcium occurs and this lack in turn increases bone loss, because estrogen contributes to binding of calcium to the bones. Vitamin D, on the other hand, helps the absorption of calcium in the intestines. Sunrays facilitate the utilization of already present Vitamin D in the body. Physiotherapist Dr. Saime Demirci says that exposure of any part of the body to the sun would be enough for the Vitamin D amount necessary for the body. Demirci, who states that sunlight which touches face and hands can meet the need for Vitamin D explains: "It is possible to sunbathe with the sunshine coming inside the house by opening the windows, or when one goes out to the balcony or to the street. If a woman sits in the balcony with her hands and face uncovered for an hour, this is enough for that day. The need for Vitamin D does not require women to do anything against their beliefs." (Özdemir 2005)

6.2 Consciousness Raising

When I asked for his views on media, a senior ob/gyn professor told me a joke: One day the Pope visited New York. As he was stepping out of the plane, a journalist asked him whether he would visit the brothel. He answered: "Is there a brothel in New York?" The next day all the headlines said the first thing the Pope asked as soon as arriving New York was whether there was a brothel in New York. "That is how media works," he said. This rather negative take on the media was not unique to him. Another popular figure whom I interviewed, a member of TSMO and a professor in a medical school, told me that journalists sometimes called him while he was in the car and asked him questions, then published whatever he casually told them on the phone in the following day's paper. Others told me about their conversations with journalist friends of theirs. One of these journalists told his doctor friend that they would go to a hospital when they cannot find anything else, because there was always some issue about which they can write. Another journalist, when asked by a doctor why they always wrote horror stories about drugs replied: "If we write that green apples are good for the health, only a handful of people will read it. If we write that green apples kill, everybody will read." Most doctors, like the ones who told me these stories, were very skeptical of the media, and annoyed at the way health issues are portrayed.

Despite this negative view of media in the medical world, it was also the same media that professional organizations like TSMO used for their consciousness-raising activities, and whenever there is a controversy they made sure they gave interviews to the newspapers. A number of TSMO doctors frequently appeared on TV and commented on women's health issues, especially issues of menopause and osteoporosis, as Ertüngealp stated in our interview:

We were already doing awareness campaigns with famous [names] like Nükhet Duru, Nilgün Belgün, etc. since '99...Then we started with Derya Baykal last year. With weekly intervals we regularly have [our people] appear in TV programs as educators, as speakers, and there has been 55 [TV] broadcasts in main channels last year...We tried to let people know that the chill after the WHI study went away.

The love and hate relationship between media and doctors is not unique to Turkey. Deborah Lupton talked about the complicated relation between the health promotional literature and the mass media:

Advertising is represented both as a social good (if it supports the current claims of health promotion) in encouraging socially positive behaviour, but also as a potential source of harmful manipulation creating false needs (if it undermines health promotion efforts). (Lupton 1995, 113)

When awareness campaigns of TSMO involved famous names, like the actress Derya Baykal, they were also interviewed in the papers, and mentioned the importance of having the right consciousness (*bilinç*). Baykal's account of how she got involved in the awareness campaign is especially important to detail the meanings of consciousness about menopause.

Before we started the project we had a meeting here, I almost left that meeting crying. There are so many dangers that await us. Here, starting with the chair of Menopause and Osteoporosis Society Prof. Erdoğan Ertüngealp, very valuable professors explained the subject in great detail. Since I was going to run the campaign, I had to be more conscious about the subject. Now I took out a very big responsibility, I have to explain this very well to everyone. When I looked at it, I saw that menopause was widely perceived as a period when womanhood ends, women are pushed away by their husbands and therefore feel very bad. However, it is not like that at all. Actually these ages are a woman's best times. She enters a period when she is mature, can look at life with different eyes, has high tolerance, raised her children and can have time for herself. But if she suffers these disturbances unnecessarily, first her psychology is disrupted,

then she starts deteriorating physically as well. That's why people think [of menopause] that way. The truth is, it is a period when womanhood ends if you don't take precautions. When precaution is taken, you go back to your normal functions. Live your life maybe even better than before. It's very simple: you will go to the doctor, take your tests and have some precautions for this (Kaşı 2006).

This excerpt summarizes the multiple meanings of *bilinç*. First of all, a woman is conscious if she accepts to go to the doctor. Second, she has to know that menopause is not the end of the world (or being a woman), despite the common belief. Once again the message of “it is a natural period, there is no need to be afraid” is repeated, followed by the usual “...but you have to go to the doctor.” There is a myth of menopause as a horrible period of life that popularized medical discourse seems to try refuting. However, in this attempt to refute there is a hidden threat of this myth turning into reality if the woman does not do the conscious thing, which is being under medical supervision.

6.2.1 18+ Women's Health Conference, Istanbul, 2006

Aside from the media, organizing and taking part in public health conferences was one way of making sure that the public gets the “right” information. The 18+ Women's Health Conference was an example of these conferences. It was a two-day event that took place in Istanbul in June 2006. During these two days, there were parallel workshops and meetings going on in various rooms of Lutfi Kırdar Congress Center, all involving doctors talking about their area of specialty and answering questions. Each one of these meetings was sponsored by private hospitals, insurance firms, health food or cosmetic companies. It was different from the first two conferences, because it was not an event limited to professionals, and the aim was not to discuss medical developments. Public participation was not only permitted, but encouraged: the event was free and publicly advertised. The conference venue was located in Taksim, which is a very central and busy district in Istanbul easy to reach by public transport from most other places. However, traveling to Taksim from the poorer and remote neighborhoods was still costly for working class women, and ads for the conference appeared in newspapers, and in a more limited way on public TV and radios. Furthermore, it would be difficult for women from conservative circles to get out of their neighborhood and come to Taksim for a conference, especially not accompanied by their husbands or other relatives. Thus, most

people who actually attended the conference were middle to lower middle class women with financial resources and mobility, although there were exceptions. The participating sponsors had small booths in the hallway that surrounded the conference rooms, giving away small gifts and promoting their products. The products in question ranged from herbal teas to Femore, an over-the-counter cream that enhanced blood flow to clitoris to increase sexual pleasure. The program closed with a live performance of the Sultans of Menopoz, an amateur folk dance group of middle-aged women who became popular with that name shortly before the conference.



Figure 3: Sultans of Menopoz performing in 18+ Women's Health Conference.

Workshops and conferences were in the form of a physician giving information on women's health subjects like sexual problems, contraception, menopause, osteoporosis; or more general health subjects like immunity, diet and nutrition or depression, and a long question and answer session. The presentations were much more informal than the professional conferences. Doctors made sure they used few technical

details and medical terminology. Questions were mostly based on personal concerns like: “How much caffeine is harmful for the bones?” “Should every woman in menopause have a bone mineral density measurement?” “Is it normal to not have an orgasm?” “I entered menopause surgically. Does that mean my sexual life is over?” “I’m having very intense periods. Is it going to pass when I get married?”

These were questions about the medical “facts” that women heard either from their doctors, the media, or their friends and family. At the conference, they were trying to confirm these by asking an expert on the subject. Trickier questions pointed to the more “social” aspects of health issues: “Why don’t men want to use a condom?” “Taking a young girl to the gynecologist is seen as wrong by our elders, how can I take her to the doctor?” “A few minutes ago another doctor said that 50 mg. [of calcium] is enough, that the required amount frequently mentioned is exaggerated. Who are we going to believe?”

In general, the conference offered an environment of public health awareness or consciousness-raising for the doctors who took part; an opportunity for sponsors to advertise their products; and a place to gather and confirm information on health and body for the attendees. On the other hand, there seemed to be more than just information flow in the conference for the women. By coming to this conference aimed specifically at women, they were doing something just for and mostly by themselves, and for some this was an interesting and empowering experience. This element of women enjoying medical attention as a sign of social recognition came up later in my fieldwork again, in my conversations with doctors and menopausal women in the clinics.

6.3 Conclusion

In Fall 2006, a new book appeared on the bookshelves in Istanbul and quickly rose in the bestseller lists. It was called *Satılık Hastalıklar*, and it was the Turkish translation of *Selling Sickness: How the World’s Biggest Pharmaceutical Companies Are Turning Us All into Patients* by two Australian writers, Ray Moynihan and Alan Cassels. The original version of it was published in 2005, and the Turkish edition was published more or less at the same time that the paperback edition was released in the United States, in July 2006. The book explained how conditions like high cholesterol, depression, high blood pressure and female sexual dysfunction were “created” and then medicated with the help of

marketing strategies of pharmaceutical companies; and one chapter was dedicated to menopause, with the title “Working with Celebrities.” It told the story of Lauren Hutton’s appearance on the cover of *Parade* magazine as part of the marketing campaign of Wyeth, with the aim of “educating consumers,” then moved on the more examples of similar campaigns:

As part of the campaign...the Australian experts had developed a free information booklet for patients, and a series of consumer seminars would soon be held around the nation....Like the press release, the newspaper ads featured the name and the logo of the Australasian Menopause Society (Moynihan and Cassells 2006, 54).

The campaign in Australia was similar to the “awareness campaigns” that were organized by TSMO and sponsored by Schering or any other pharmaceutical company willing to be the sponsor. Yet another similarity was the “company-sponsored medical meetings and scientific conferences all over the world,” (Moynihan and Cassells 2006, 50) exemplified by the mid 1990s international conference in Sydney in the book, reminding me of the EMAS conference of 2006.

Another interesting point here is the timing of developments in Turkey and Wyeth’s launch of a new campaign around the time HERS study results—a study that was sponsored by Wyeth—were published, in 1998:

...[I]n that same year, just a few months before the publication of the HERS trial results, Wyeth unleashed a worldwide campaign to remind women and their doctors of the dangers of “estrogen loss” at the menopause (Moynihan and Cassells 2006, 52-53).

This piece of information on global marketing strategies of Wyeth becomes more intriguing when put in conversation with the narrative of Oya Saraçoğlu, who used to work as a drug representative in the HRT department of Wyeth in the 1990s and the early 2000s:

Our relations with the patients were like that: we made women’s only meetings in order to expand the market. These meetings were done in collaboration with the municipalities. Women were invited to these meetings, and there were speakers, who were doctors, leaders in the area of menopause. They spoke entirely for the purpose of informing [women], like, how will a woman understand that she’s in menopause, what are the symptoms, what is she supposed to do, that she has to go to the doctor, be treated, use the products, they gave information about these. She needs to

have her annual smear and mammography done, these were being told and the patients were asking questions to the doctors. They could have the chance to find the answers for questions in their minds, like I have this complaint, what can I do, there is cancer in the family, would I have cancer, etc. In that sense the market had really expanded, there was a demand created in people. They could say that they had hot flashes, sweating, having troubles, “I’m in menopause.” They started going to the doctors to get treatment.

There are striking similarities in the way medicalization of menopause happened in Turkey and the general “global” ways of going about medicalizing it—with a twist of the local of course, as is the case with most cases of globalization. However, it is also striking that the reactions toward medicalization of menopause, the counter-discourses, were also becoming “global,” again with a “local” twist. In October 2006, the daily newspaper *Zaman* published an interview with the doctor who wrote the preface for *Satılık Hastalıklar*, Erol Ergüder (Akman 2006). Together with the discussion of the book and global strategies of selling drugs, there were a few points in the interview that related to more local issues. Ergüder mentioned that there were lobbies to legalize direct drug advertising in Turkey, which is not permitted by today’s laws. Also he pointed to the fact that almost all professional medical conferences and congresses in Turkey were sponsored by big pharmaceutical companies, despite the decision and advice of Turkish Medical Association. The impact of this financial relation can be better assessed when thought in the light of the ways of learning for healthcare professionals, as explained in the previous chapter. As professional conferences, publications and research are funded by international pharmaceutical companies, the profit driven agenda-setting is legitimized as being scientific, and young doctors grow up in a professional environment where these relations are normalized.

Another point related to the previous one was the definition of “normal” in bone mineral density measurements, at the face of regional, racial and ethnic differences. The same point was also brought up by Dr. Bora Teksoy, a family practitioner I met at EMAS Congress, who argued that the machines which measure bone mineral density in Turkey were imported mainly from United States and Europe, and had the built-in values for what “normal” bone mineral density should be, calculated from a United States or European based population sample. All of these examples denote the link between the

universalized global discourse and its dissemination to the local context. There was resistance against dissemination on the policy level, in the form of rules of Turkish Medical Association (despite their ineffectiveness in practice), or national laws against direct to consumer advertising. Less visible forms of the disseminations, like values of the normal embedded in new technologies such as medical devices generally went unnoticed. I would argue values and discourses constructed around drugs fall on this less noticed area of global influences. Western bodies become the standard of measurement, and these standards are carried within the technological devices –in this case bone mineral density measurement machines—to other countries. During my fieldwork, only a few doctors and healthcare workers commented on what these machines are actually measuring, or the meaning of comparisons made by them. Most doctors and patients accepted the numbers unquestioningly.

Globalization of medical culture contributes to a universalization of healthcare research and what diseases and problems are considered important. Some diseases that are considered important for the Western population, or for those who can afford expensive drugs and treatments become hyper-visible, while local health issues for developing countries go unnoticed and under-researched. Dr. Berna was pointing to the fact that there are more important health issues in Turkey than menopause, yet menopause got popular attention because of the efforts of pharmaceutical firms to set the agenda. Yet, some issues like anemia, which is a wider problem especially in women were not even researched, and there is not even statistical information available about them.

For example, anemia is a very serious problem for women in Turkey, but you see neither a publication on it nor an article on the journals. In recent years it started [to become publicized] with the aid from WHO for anemia in children but before that there wasn't anything. We did a research on pregnant women for example, and there is a very high incidence of anemia in Turkey. This is [probably] due to malnutrition. What I am trying to say is what determines the agenda somewhat is the pressure, or direction of the [pharmaceutical] companies, not the desire to have a program on the real healthcare issues in Turkey. Or, there is no statistical research to indicate these issues. The universities do not do such research.

She went on to describe that the reasons for this absent local research was the tendency to look to the West as a measure of science and research, ignoring our own national problems and priorities.

In Turkey we do everything as it has been presented to us [by the West]. Our university professors don't think of doing social research, doing research on what is going on in Turkey to act according to our own society's needs. Whatever the West researches, we take it and construct an example of it here. This is the deficiency of Turkey, we do everything as the West suggests...We need more statistical research, on what is prevalent in our society, to what extent, what is missing, what kind of treatment are we supposed to concentrate on, on all these fronts, go look on the Internet, you can't find any publications on Turkey.

Some other doctors also pointed to the need for a more local "national" research agenda that was lacking, as part of the medical problems in Turkey, like Dr. Okan.

I think that especially when it comes to drug production and diagnostic technologies we are too much dependent on [other countries] and national resources are pouring intensively into this area. I also do think that there should be very serious control mechanisms within the system, and healthcare has to be over and beyond politics, like national education or national security, because it [healthcare] is very much affected by [politics]...Especially it is very important to control resource allocation to universities and research and development projects in universities. We need to be a country that makes inventions, not one that imports them.

Dr. Doruk also commented on national health policy. He was retired after teaching in the same medical school with Dr. Okan, and was working in his private practice and a private hospital at the time of the interview.

There are very good examples of systematic work done in Turkey. In Atatürk's time, in the 1930s all Turkey was suffering under tuberculosis, leprosy and malaria. There were 250-300 doctors in total in Turkey in those times, and you can be the judge of the budget of Turkey in those years of war. In that poverty, Turkey fought against tuberculosis to set an example to the world and got rid of tuberculosis, and leprosy...This happened as a result of systematic thinking and decision making aimed at how we can do better. There was a serious state authority, meaning it had serious principles. Today there is no such thing in Turkey. Today the market value of a [pap] smear is 50 million in the private clinics. In Turkey of that time, chest x-rays were free for everyone. Today, a smear test, a very simple test that gives the opportunity to catch the disease before cancer does not fall on the [responsibility of the] state. The state does not produce a plan or a project for this.

These complaints on the absence of a local and social healthcare policy can be considered as a specific example of “undone science,” where the needs and problems are defined by a “global elite,” rather than the local conditions (Hess 2007), and the interests of multinational corporations. On the other hand, there was the underlying resentment in most doctors’ account for the erosion of a state-led healthcare system similar to the earlier years of the republic. As this idea of paternalistic state responsible for the well-being of its citizens was replaced by neoliberal market policies (or pharmaceutical paternalism, as Fisher (2005) puts it), priorities in both research and clinical practices changed, and this change was criticized especially by older physicians even though they went on working within the system of private hospitals and clinics.

7. The Clinic as an Arena: Intersections, Overlaps, Clashes and Mutual Adjustments

In the beginning of this dissertation, I defined my primary arena as “the clinic,” as a general term for the medical settings where doctors and patients come together. That term, “the clinic,” might refer to very different experiences regarding the type of medical institution; like private, public or research hospitals, private practices of doctors or small local clinics. The experience one has with these differing institutions can vary tremendously depending on the existence and/or type of health insurance despite the recent efforts of combining the three different social security systems, as explained before in Chapter 2. I had the chance to observe mainly the public and research hospital settings, with a brief period of time spent in a private hospital and several private practices. As a result, most of my quotations and observations refer to the public and research hospital settings and people I met in these places. Into each of these settings, doctors and patients came with their own ideas of and languages for menopause, aging, HRT and medicine. Almost always the worlds clashed, views were negotiated, and both parties adjusted to each other’s discourse, when they are faced with each other. The way these clashes and negotiations happened, however, were quite different in different arenas; the main difference being the uneven time and resources available to both doctors and the patients.

7.1 Clashes, Intersections, Variations

The clash of social worlds was ongoing and inevitable between arenas. In the clinic, primary forms of how the clashes occur were communication problems between doctors and patients due to different understandings of illness, health, drugs and more generally, world view; and even when they understood each other, there was the issue of compliance on the patient’s part to carry on with the doctor’s treatment. What was expected from a patient in a medical setting was to understand and comply with the medical discourse on body, health and illness. However, there was always the element of resistance as in all power relations.

Despite the existence of a general dominant medical discourse on menopause and HRT in the clinic, it is hard to say that all the physicians “enacted” this discourse in the

same way. There were differences between the attitudes of doctors, which influenced the experience of the exam. More than the words that are used, non-verbal communication, like the tone of voice and the body language, seemed to be the key to set the tone of the doctor visits. Even when the tension rose, doctors tended to remain calm and return to the “business” rather than engaging in personal conflict with the patients. That way of being the rational one in an emotionally sensitive interaction made them seem more in control of the situation, and was seen as more in line with the professional identity of the doctors. The efforts it took to create that kind of professional attitude is exemplified in the story of an *intern* helping out the assistants as part of her training in the research hospital. In an instance where she had two patients sitting in front of her, she asked one of them about the date that she had an operation, to which the patient replied “I don’t know.” At this point, the other patient suddenly turned to her and asked “What do you mean you don’t know your operation date? Two things one does not forget: her birthday and her operation date.” The medical student, not expecting that kind of a reaction, burst into laughter. It took her a few seconds to pull herself together and continue with the exam. Later on, telling me about the incident, she attributed this reaction to her being new and inexperienced (*acemilik*). She thought that part of the professional attitude she should have included being able to control herself in front of the patients.

Despite differences in the enactment of medical discourse, there were institutionalized practices aimed at creating a common ground by standardization. These attempts followed the line of creating a unified front in what can be explained to the public, and adhering to tacit professional norms of interacting with the patient, as explained above. In addition to increasing efficiency, standardization helped solidify the boundaries of the medical profession and its authority, contributing to a division of “us” and “them” when faced with the patients. Part of what standardized the medical discourse was the documents: the forms, and the procedure of which tests will be performed with what frequency for what kind of patient: In the ob/gyn clinic in the public hospital, this was done via registering patients on the computer, with fixed categories assigned for every complaint. In the Çapa menopause clinic, this routine procedure was secured by the existence of forms that go into the file of each patient, including set spaces for the last period that she had, the drugs prescribed, results of the tests that are done regularly, her

complaints and medical history. The forms enabled doctors to follow a set of questions. On top of that, they copied the test results on these cards (as they called them), and they put their names and also took notes about what has been done. This helped them to know what happened before. Whenever a patient came for an annual check up or because of a complaint, she was supposed to have her file taken out from the archive and present it to the doctor. The cards and also the reports from tests done on a yearly basis (and for those on HRT, once every six months) had the additional function of replacing the patient's story. When there was a conflict between what the patient says and what is written in the card, usually the card trumped the patient's words. In that sense, forms and the cards were the "materialized" forms of medical discourse.

Even though at first this kind of preference for written documents comes off as some kind of domination over the patient where the doctor ignored the patient's side of the story, I believe a more complex analysis is required here. There was surely an effort at disciplining the patient, but there was also an effort for creating a mechanism where the past is documented. This is what the doctors in my other field site were complaining about: They had a case with an undocumented past, they knew that something had happened, like the patient had a surgery, but they did not know why the surgery happened, how it went, or what the outcome was. It was not uncommon for the patient to be unable to recall (or have no idea at all about) the reason for a surgery performed on her own body. At this point, labeling the efforts of standardization as mere paternalism from the perspective of a social scientist would be oversimplifying the situation.

Women themselves had a different way of communicating and sometimes bonding than the official doctor-patient relations. I observed this a few times when the doctor went out, leaving two or three patients in the room. The complaints became the starting point for a conversation that quickly evolved into comparing stories of surgeries, medical conditions, and almost always relating it to events about the family, children, and other people's illnesses. They spoke with more authority about their conditions when they were secure and gave far more personal details –details that they were reluctant to share with the doctor, or the doctors were not interested to hear. The air resembled that of primary school when the teacher leaves the classroom and kids loosen up and chat informally. When the authority figure walked away in a setting where s/he is expected to

be present, it created some kind of bonding and sharing among those who were in the subordinate position. A similar practice of information sharing through informal chats could be observed in the waiting areas, sometimes with the addition of airing common complaints about issues about the hospital like the long waiting lines, and sometimes comparisons with other hospitals or clinics the patients visited.

The medical hierarchy and the privileges that came with it trickled down to those who are close to doctors and nurses. There was in fact a written rule that said relatives/affiliates of the medical personnel were to be given priority in the research hospital in which I did my fieldwork, posted on the window where patients would go to make appointments. The reason for this rule, according to that posting, was to enable the medical personnel to get back to work as soon as possible to go on serving others. I had seen that rule in action many times, even for medical students (when they bring their mothers, for example). I think beyond the precaution to minimize the amount of time the medical personnel spends out of work, there seemed to be some kind of fraternal idea behind the rule, where those who are in the club were treated differently.

In the research hospital, doctors had some common complaints with those in the public hospital about the patients for not bringing their previous test results, being ignorant, or “unconscious” (“not knowing themselves” as one doctor put it), and not understanding or following the directions about drugs prescribed to them. One difference was about the patient profile before and after the integration of social security: the doctors said that their patients were better before that, when they were either civil servants or retired. Now all kinds of patients came to the university hospitals, they were not much different from other public hospitals. This is an example of the “preferred patient” ranking that I encountered many times, according to the old system, patients that belonged to the *Emekli Sandığı* are better educated and, for doctors, easy to communicate with. They are more “conscious,” and they are more compliant patients, as opposed to the more unruly *SSK* patients. Although there is clearly a class difference in here, it was mostly stated as a difference of education. At the same time, I also observed the opposite of this preference, that is, doctors preferring working-class or less educated patients. This is a point I will come back to later in the chapter.

In the private hospital setting, explanations were more detailed and lengthy, and the air was more relaxed. There was less tension between doctor and patient. Nevertheless distrust of the doctor for the patient ensued. It changed shape in the sense that the patients who could afford a private hospital can go to a different doctor or hospital. In the public setting this was still true, but the doubt that they would just disappear, or not take drugs but come back was more of an issue. Coming back to the clinic for a follow up visit was an issue of compliance. Follow-up clashes are partly caused by the lack of a unified system to keep medical histories, as mentioned earlier. One thing that annoyed the doctors was patients' not bringing previous test results with them. Since most patients went to different hospitals at different times, and on top of that, had their diagnostic tests, like mammograms and ultrasounds done in private labs because of the long lines in the hospitals, doctors usually did not have a way of keeping track of all results for the patients. In the absence of a unified system of keeping medical histories and sharing them across different medical institutions, patients became the bearers of responsibility for keeping their own medical history. This fact adds another element to the issue of trust between doctors and patients. At the face of such uncertainty, doctors usually asked for tests to be repeated in their own institution when they did not have the proof for past results, which tended to create resentment in the patients.

Doctors occasionally complained about patients not understanding what they are saying even when they can find the time to explain their treatment to them. There were a lot of stories, jokes and urban legends about how patients misunderstood the instructions among the doctors. I assume that at least part of this “genre” of ignorant patient stories stemmed from the frustration of doctors with non-compliance, for it gave them a feeling of incompetence as healers. The stories were usually about how patients misused a drug, either taking it at irregular times, or with wrong delivery methods —like swallowing a vaginal suppository. The difference in time perception seemed to be one of the major problems between doctors and patients, where doctors blamed patients for not knowing the calendar. Dr. Yılmaz was complaining to me about his patients during one of the lunch breaks.

They don't understand. The other day someone came, I am telling her, you are going to start the drug on the fifteenth day of your period, you will take it for ten days, stop, and when you have your period again you will

count fifteen days and start once more. You are going to do this for three times. Did you understand? She said no, so I told it again. She said let me call my daughter. Her daughter came, I explained her, she didn't understand either. She said let me call my husband. I said, how will your husband know? They are like that. They don't know the day of their periods, we ask when her last period was, she says: "the second day of Ramadan." They memorized only the Ramadan and the *bayram*,³⁶ nothing else... They don't know about the date, the calendar, which day are we in, which month are we in. Then we prescribe them birth control pills, they use it wrong and they come back saying they got pregnant. How did you use it? Apparently, she was taking it before the intercourse. Or they take it whenever they feel like it and get pregnant.

This difference in time perception and the complaints of doctors about it had an implicit element of blaming the patients for not being "modern" enough, for having a different understanding of time than the standard Western calendar, and for not paying attention to their own cycles by using that calendar. Women themselves seemed to have reference points related to what was going on in their lives rather than the year/month/date format. During my fieldwork, I heard different women using phrases like "at the end of *bayram*," "in Ramadan," or "the year when the big earthquake happened" when they were asked about the last time they had a period. Even when they could give more specific points in time like four years ago, or last month, they still referenced events happening around that time.

Taking the drugs regularly was an important point of conflict, partially due to the time perception issues, and partially because of the difference in the perception of what is a drug. In addition to taking hormonal drugs at random times, some patients stopped taking them when the prescription expires, like after two boxes. This makes the doctors rather frustrated, as can be seen in the example above. Sometimes women considered these drugs to be taken only when they felt bad, and stop taking them when they feel better, or when the drug was not available or it would be hard to obtain again—for example when they had to go to the doctor to refill the prescription. In that sense, they were not properly disciplined patients for taking hormone-based drugs. For the doctors, HRT replaced something missing, and protected something that is deteriorating because

³⁶ *Bayram* literally means festival and in this context it refers to the three-day religious festival after Ramadan.

of the deficiency. For patients, a drug was some substance that was supposed to heal, and for some, it had the additional element of justification of illness, a proof that they really have a problem.

The issue of privacy and the gender relations between doctors and patients—in the ob/gyn practice, the gender of doctors, more specifically—provided another side to the lack of communication. Some patients, especially those coming from more traditional backgrounds, felt ashamed to be examined by a male doctor, and insisted on a female practitioner. Inferring from this preference, it is possible to assume that they could talk about their more “private” complaints like vaginal dryness and sexual problems with a female doctor. This inference is supported by account of some doctors that I talked to as well, like Dr. Burak.

All in all, why does one complain of [vaginal] dryness, unless she has problems with [sexual] intercourse. They can talk about their sexual problems easier with female doctors. They can open up more clearly to a female doctor than a male doctor.

Furthermore, some doctors mentioned that even with the female doctors, some complaints that are considered shameful to talk about, like sexual problems or urinary incontinence, were left out of the stories of the patients unless the doctor directly asked about them. Following is a conversation I had with Dr. Gözde İleri, a young female fourth year ob/gyn assistant in a research hospital, who was telling me about the common complaints of menopausal women who came to the clinic.

Dr. Gözde - There is something about urinary [incontinence], if you don't ask, most of them don't tell...[W]hen you ask the patient, they say, oh yes I have that, some of them say that they are using pads

Maral - As if it is a very normal thing?

Dr. Gözde - Yes.

Maral - I think they don't say anything about sexuality either unless you ask them?

Dr. Gözde - Yes, and, honestly, I think I don't ask. I don't ask as a direct question. If the patient has a complaint we do something about it but I don't directly ask if they have a [sexual] complaint, something ongoing.

The reasons for non-compliance can sometimes be related to the lack of patients' or hospitals' resources. For the patients, the reasons could be lack of money, time or health insurance; and for the hospitals it could be limited amount of diagnostic equipment like ultrasound or lack of personnel that caused long waiting times. These factors were especially relevant for a non-vital condition like menopause, for which doctors insisted on follow ups and women were inclined to avoid doctors' visits if it proved to be too costly, time consuming, or bothersome. Under these circumstances, women who actually became compliant and disciplined patients were often those who had material resources and/or time to go to the doctor for follow ups and refills; or those who had severe enough symptoms.

Doctors especially complained about the lack of time to explain patients their conditions and treatments, and the lack of a system for follow up. Both of these, especially the latter, disturbed them, for it decreased their sense of control over the treatment they were trying to prescribe. Medical surveillance in that context had a meaning beyond controlling the patient; it included the physician's feeling of incompetence and sense of not being able to help the patient properly. Dr. Utku's description of what happens after a doctor writes a prescription is illustrative of this point.

Plus, you don't give information. We neither have time to explain nor any brochures to give that say this is what happens in menopause, this is what happens when you take [HRT] and this is what happens when you don't. So we tell the patient, OK *hanım*, take these drugs and go, when you run out of it come and refill the prescription, you'll take it for a year or two. And since the patient is going from one doctor to another, you don't even know whether she is taking the drug you gave her or whether she's taking it regularly. Another doctor can change it for another drug. You don't know if she takes that drug regularly, either.

The issue of trust is an important one in the doctor-patient relation. Patients tend to not follow instructions given by a doctor they do not trust, which increases non-compliance. In the Turkish gynecology/menopause clinic setting, lack of trust was a two-way street: just as some patients did not trust doctors, some doctors did not trust patients to be compliant. Trust was sometimes constructed as who the patients believe when it comes to medical advice. A common complaint by the doctors was that menopausal

women, especially those with lower education levels believed in their relatives, neighbors, or the media more than the doctors. Dr. Zeynep was one of the doctors disturbed by her patient's lack of trust.

For years, this [rumor] goes around among the people that it is harmful to take hormones...The sad part is that they can respect their neighbors or hair dressers more than the professionals. I mean, sometimes what that neighbor says can be more precious [than the doctor's word]. The healthcare education of the people is not good, and it starts with 'we don't take hormones,' including birth control pills.

This complaint in women's getting information from "wrong" sources and believing it shows parallels to the advice given to menopausal women in the United States during the 1980s in the informational pamphlets produced by drug companies:

A booklet put out by Mead Johnson Laboratories, entitled "For the Woman Approaching Menopause," advised: 'Menopausal women should keep up to date with the latest thinking about menopause from reputable professional sources. Avoid forming your judgments concerning management of your menopause on the basis of casual chats with friends, hearsay, and sensationalist media reports.' The message here was that there were both good and bad sources of information; medical experts were 'right,' nonprofessionals were 'wrong,' and women should steer clear of the latter. It was acceptable for women to pursue their own education in health matters, so long as they sought information from within the medical-pharmaceutical community (Watkins 2007, 179).

Even though they come from different sources and belong to different times, both quotes above represent a similar medical discourse about the patients and healthcare education. As explained in previous chapters, the effort to disseminate the "right" knowledge to the public is institutionalized in TSMO's media campaigns in Turkey.

On the other side of the trust issue, menopausal women told me about their own hesitation in believing the doctors. The trust issues I encountered ranged from trusting or not trusting the particular doctor they see, to not trusting medicine in general. For example, Şükran mentioned the need to compare different medical views when I asked about her experiences with the doctors.

Doctors are really good [in this hospital], not just in ob/gyn but in all departments. But there is still an uneasiness, did they understand [what is wrong] or not? Because they don't necessarily understand everything just because they had the education. That's why one feels uneasy. I believe

that when you have something, you should ask three doctors, if two of them say the same thing, than it is true.

There are differences in the ways that the patients resisted taking drugs or coming for their next appointment. Some of them openly confronted the doctor, saying that they did not want to take hormones, for example. Some of them appeared to be following the doctor's advice, but got into some kind of “passive resistance,” where they stopped taking drugs that they did not like, or did not come back when they said they would. Sometimes doctors were aware of this passive resistance. The curious point here is that there were times when both patients and doctors are aware that the patient is not coming back, or taking the drug prescribed, but both parties pretended like everything is going according to the book as if they were playing a game.

In terms of the severity of clashes between doctors and patients, a common complaint was about how doctor-patient relations changed over time, as the tension between these two groups increased. There were different ways that these worlds clashed, but the tone of the clash, according to both parties, was changing. Doctors complained about the lack of respect on the part of patients, and said that they were getting more aggressive. Dr. Demet Gülseren was a second year ob/gyn assistant in a public hospital, and she was going for her second specialization after finishing medical school. She was telling me how things have changed in the past few years.

Dr. Demet - Before they [patients] were more patient, they knew how to wait. Now they don't...For example, a patient brought her 16 year old daughter the other day, she said she wants to be present in her daughter's exam. I told her that she did not have such a right, and asked her to please go out. I said I can communicate with your daughter, does she know how to speak, she said yes, she does, and I won't go out. Then I said there is nothing to do, I cannot examine the patient. Because if a mother brings her daughter for examination you get suspicious of something. Maybe there is nothing in there, or maybe she came to the exam with her mother's pressure, I could not ask her complaint. I mean, I couldn't talk to the girl, and I didn't listen to her mother. Then she filed a complaint to the head physician, he came and said that it wasn't possible, she has to stay outside while her daughter is being examined. But her attitude was like, you wouldn't do that if I came to your private practice. The respect is completely gone, there is no respect and the demands are absurd. Sometimes they come and throw a piece of paper in front of you, and ask

you to request the [tests] written in that paper. Like you are a lab technician. There are patients like that.

Maral - Are there too many like that?

Dr. Demet - Too many. Every day you have to deal with them, and your attitude changes towards the patients, too, because when they do not show respect for you, you cannot give them what you want to give either.

While Dr. Demet only stated her observations, Dr. Berna attributed this increase in aggressiveness to factors outside the medical arena, like changing living conditions in Turkey, media or political decisions, which in turn got reflected on the doctor-patient relations.

Dr. Berna -As a result, patients have started to show their reactions to the doctor directly, and I believe that because of this doctor-patient relation has deteriorated, and it is deteriorating even more increasingly.

Maral - Is it getting more aggressive?

Dr. Berna - Yes, it is getting more aggressive, and it is normal that it is getting aggressive, normal for both the patient and the doctor. Because the living conditions of the average person in Turkey are increasingly getting worse. In a country that gets worse so much it is not possible for people to still be happy and not aggressive.

Dr. Ayhan, who also worked in the same hospital with Dr. Demet and Dr. Berna, was saying similar things about the changing doctor-patient relations, and holding the media responsible for the change.

The doctor-patient relations became extremely aggressive. The reason for this is that the media's [provocation] of the people against us. There are two innocent sides in healthcare and they are against each other: people and the healthcare workers. All the decisions come out of politicians in Ankara who do not work in the field and maybe do not know [about this work], and two innocent sides are pitted against each other, people who want to receive healthcare and the healthcare workers who are trying to give that service.

Increasing demands of patients was disturbing for the doctors, and as in the example above, these demands were sometimes related to more tests. There has been an increase in the use of diagnostic tests like MRI's and ultrasound for virtually every field of medicine in the last ten or fifteen years, and the culture of regular check-ups, as

portrayed in the media and popular culture has contributed to further demand for these tests. Although the tests helped the doctors in diagnosis, there was also an element of undermining their authority, especially in a growing patient-as-consumer culture. Dr. Ayhan complained about the situation as such:

Back in the days they would come and say that they have a certain complaint. Now they come and say “I want a mammography, breast ultrasound, bone mineral density [measurement], I want this and that.” They learn this from the publications.

Apart from the undermining of their professional authority, some doctors complained about the number of unnecessary tests performed and the lack of regulations for the private centers that perform these tests. As explained in Chapter 2, privatization in health sector after the 1980s in Turkey led to two different kinds of medical institutions with different standards. Dr. Şahin pointed to the problems came with this privatization process:

In Turkey there are lots of unnecessary diagnostic tests and treatments performed and there is no institution that tracks them down. We have no institution investigating this. Even the Ministry of Health, which normally should inspect [these places] does not inspect anything...You see, in Turkey in every corner there is a private hospital, in every corner there is a lab, in any given neighborhood there are more x-ray centers than groceries. None of them are inspected. When one of them explodes and someone dies then the Ministry of Health goes and starts an investigation, that is the mentality we work with. With this mentality healthcare in Turkey cannot go anywhere. They perform angiography on everyone. In some hospitals, they do 80 angiographies per day, they do an angiography on whomever says his heart hurts. Everybody who says they have a pain in their arms or legs go and have an MRI done.

In terms of the patients' perspective, some of my participants said that the doctors used to listen to them more, instead of just looking at them and prescribing medicine. They also complained about the conditions of the hospitals, mostly attributing the lack of attention on the doctor to the overcrowded hospitals. There are those who say the opposite, advocating the younger, newer generation of doctors with the belief that they are more knowledgeable than the older doctors and treat the patients more kindly (*gücleryüzlü*). I believe that at least part of the difference comes from the age difference of the patients and doctors in public hospital settings, where assistants examined

menopausal women who are the age of their mothers or even grandmothers. I observed that in an attempt to build rapport with the patient, and perhaps comfort the patient before the already dreaded exam process, sometimes these doctors treat them like they are their elderly relatives. Some referred to them as *teyze* or *teyzeciğim* (auntie), or *abla/ablacığim* (elder sister) and in return the patients called them *evladım* (my child), *kızım* (daughter) or *oğlum* (son).³⁷ In addition to building rapport with the patient, doctors' approach involved an attempt to overcome a kind of "power clash" in the particular setting of the exam room, where the doctor is in the position of having the professional authority and the patient has the less visible social authority that comes with her age vis-à-vis a younger person. Turning the exam process into a less professional experience framed with kinship idioms referred to the implicit authority of the patient, downplaying the authority of the doctor and easing the tension.

Apart from the resistance and non-compliance, there was the issue of forming alliances with others when there was a clash between doctors and patients. Sometimes patients found allies among the hospital administration while the doctors found allies in the relatives of non-compliant patients, like daughters or husbands. I heard of stories about patients who complained to the hospital administrator about doctors who refused to examine them without making an appointment, who in turn called and asked the doctors to examine the patient. From the patients' side, sometimes the request for an alliance came from the patient's relatives, like the daughter of an older woman who asked the

³⁷ This may sound very unprofessional and awkward for someone not familiar with Turkish culture, where it is not uncommon to address strangers with words implicating imaginary relatives. Deniz Kandiyoti referred to that way of addressing in relation to the project of modernity in *Gendering the Modern*:

The kinship idiom continued to provide an effective vehicle for easing social interaction and defusing tensions in cross-gender interactions among unrelated persons. The common use of terms of address such as *ağabey* (older brother) and *abla* (older sister), or *amca* (uncle) and *teyze* (aunt), in everyday interactions implied respect owing to seniority, while terms such as *oğlum* (son) and *kızım* (daughter) designated a young person worthy of protection. There were, therefore, a variety of culturally sanctioned ways of signaling the sexually neutral character of interactions, ways that could be mobilized and put into use in novel settings (Kandiyoti 1997, 126).

doctor to convince her mother to get a biopsy. The mother refused to make an appointment and have the operation, saying that she was going to go to *haji*, and promising to come after that. Her daughter was worried that it would be too late, and if there was something wrong with her health, it would get worse when she was in pilgrimage. Instead of arguing against her going to *haji*, the doctor pretended to adopt the mother's religious worldview, presenting the whole issue as one of taking care of what God gave her:

Now why are you going to haji? For the sake of Allah, right? Well, then, aren't you supposed to take good care of the life that Allah gave you?

This is an example of the tactics that both sides employed in negotiating with each other when clashes occurred in arenas. It is these negotiations that I now turn.

7.2 Negotiations, Overlaps, and Translations Between Multiple Social Worlds

In an environment of clashes and alliances, all parties entered a process of negotiation, in which they tried to convince each other to adopt their point of view, adopted one another's language and discourse, and sometimes met in a middle ground after concessions. There were also instances where they used artifacts like drug packaging as "boundary objects" (Star and Griesemer 1989) that eased the negotiations and translations.

Clinic doctors were at the core of the negotiation process. On the one hand, they negotiate with the pharmaceutical representatives who were trying to convince them to prescribe their drugs; on the other hand, there are patients who wanted or resisted certain drugs or treatments. On top of these, in the search for medical developments, there were professional organizations like TSMO, which tried to convince them to adhere to certain guidelines and other professionals that presented their findings in medical conferences they attend. Doctors themselves were in a position of convincing patients, and sometimes pharmaceutical reps. They used several tactics to convince the patients, ranging from talking them into taking drugs by giving them numbers and assuring them that it is good for them, to scaring them with what can happen if they do not comply.

Some women were non-compliant or confused when it came to taking HRT. Most of the doctors I talked to mentioned the importance of taking the time to explain the patients what is wrong with them and what they can do about it. Since there was the implicit agreement on the cultural authority of medicine between the patients and the doctors, and the doctor is the representative of this authority, the understanding was that if there is enough time for explanation, there is no reason for the patients to not comply. The portrayal of the patient here is one that is to some extent rational and ready to accept the explanations of the doctor, while the doctor is also expected to comfort and heal the patient, as can be seen in the explanation of Dr. Ali:

Now women here of course depend on their physicians. Even though she knows about the side effects and benefits of the hormone, it is the physician who is going to direct the patient. And you cannot accept every patient as the same, you have to evaluate every patient as a unique case. This is the duty of the physician. Because of that, a patient who says she wants to take hormones on a whim does not, cannot insist against a physician. If her physician comforts her and can end her complaints by also explaining the dangers, then [according to today's tendency s/he gives hormones] at the smallest dose for the shortest time.

In this interaction between the doctors and the patients the way doctors talked to the patients could have an effect on the convincing process. Dr. İrfan Karadeniz, a middle aged male ob/gyn professor who taught in a research hospital, argued that the reason for patients to be confused and skeptical was the confusion of the doctors over prescribing HRT that are reflected on the patient.

Let me tell you this, when the doctor talks to the patient, the patient accepts [HRT] and takes it. But if the doctor behaves hesitantly then the patient doesn't take it. That is the whole story. When your doctor is good, the patient is not a problem. When you explain, tell [her] to use [HRT] for five years, nothing [bad] will happen, the patient takes it with pleasure.

Although doctors focused on being authoritative and decisive in order to convince patients, menopausal women stressed the way the doctors treated them more than their hesitancy. Meryem was telling me how she became convinced to have a mammogram after talking to the doctor, who was very kind and helpful to her.

I was afraid, but I gained courage when I came here. It is also nice that the doctors are convincing you. Now, if the doctor had frowned upon me, said this or that, I wouldn't have gone and had [a mammogram]. Maybe I

wouldn't even have the tests made, I would slam the door to his face and leave. I mean, it depends on the doctor too. When the doctor knows how to explain well, with a smiling face and all, the patient gets directed better.

In relation to the issue of doctors being nice to patients, there was also a narrative of doctor paying enough attention to the patient, and patients liking that attention. "Attention" here can mean doctors' showing interest in what is going on with the patient beyond her medical complaints, requesting tests for further examination of a certain situation, or calling her for follow up. Some of the doctors, like Dr. Berna, thought that more medical attention appealed to women, in a way making them feel privileged to be the object of medical attention.

Come to think about it, in a crowded [outpatient] clinic she comes with a complaint, it is one thing to be simply examined and get a prescription, it is another thing when the physician does a lot of tests, gives her a treatment, calls her with regular intervals for follow up. Of course, [the latter] is a more satisfying response for the patient. Because of that, the patients loved this to start with.

The existence of menopause clinics and their appeal to women was explained through the line of attention by Dr. Selim, who was involved in the establishment of one of these clinics:

There was a profile of the menopausal patients who liked [that] attention very much, who would, despite very bad [conditions] wait there [in the clinic] for one-one and a half hours on a bench, chatting with each other. But back then I guess people didn't know about menopause or hormone therapy [in terms of applying them in their] private practices. Now maybe people, doctors, know better. Maybe [the menopausal women] go to the private practices of the doctors...or maybe to the private hospitals, but even then there are very few that want to take [HRT]. I mean, the whole attitude of "doctor, I leave it to you" happens much less as the level of education increases. I think this [attitude belongs to] the [population] that doesn't read the newspaper too much and goes to *SSK* [hospitals] because she hears from the neighbor; and because everything is done well [at the hospital], and she is being followed up from there she trusts the doctor. Of course this is the right thing. Here we see the harms of too much Internet or media. You know, the worst is one that knows a little, it is sort of like that here, too. The patient in [*SSK* hospital], maybe there are some among them that know a little, but the ones that don't know at all, or don't have time to know—when I say don't have time, like she has kids and family, doesn't have the means, etc.—they say I leave it to you [the doctor].

Despite the general preference for middle class patients to working class ones for the reason that the latter are harder to communicate, here we see the reverse. Some doctors , like Dr. Alper, preferred the working class, or less educated patients, for their higher levels of trust and compliance, due to less exposure to media, the Internet, and other sources of information that contradict the doctors' views.

To tell the truth, we have this convenience, even though they don't understand, since they listen to the doctor, whatever he says, maybe they don't take [the drugs] but when they are leaving they say thank you doctor, I will take it.

When it comes to the “negative” methods of convincing patients like scaring them, the most commonly used scarecrow for menopause was the fear of osteoporosis. Telling women that they were going to lose their bones usually creates enough concern. One point to note here is the Turkish equivalent for the word osteoporosis. The colloquial term for osteoporosis in Turkish, aside from the more medical word *osteoporoz*, is *kemik erimesi*, which literally means “melting of bones.” This word is not the equal of bone loss, which would have been *kemik kaybı*, and the “melting of bones” created a quite powerful and scary mental image in most menopausal women's minds. Doctors sometimes tried to correct this image, but also sometimes resorted to it themselves. They contributed to the horror images of osteoporosis when they wanted to convince patients to take medicine or make the lifestyle changes to prevent osteoporosis after menopause. The most colorful example of this kind is a comparison of two middle-aged popular figures I heard two different doctors claimed to create for their patients. They both said that they would ask their menopausal patients whether they wanted to be like Ajda Pekkan, who is a pop singer famous for her plastic surgery operations and facelifts as well as her singing; or Suna Pekuysal, an actress who has a deformed back due to a bone disease sometimes called “bamboo spine.” When I asked why they used Suna Pekuysal as an example since she has a different problem than osteoporosis, the answer was, “we know, but this is a striking example.”

This conversation passed during my interview with Sultans of Menopause shows how Suna Pekuysal example trickled down to the social world of menopausal women.

Esin – You know we entered [sic] osteoporosis, me and Meral, there is a slight hunchback thing... Suna Pekuysal...

Sibel – But hers is different, it is a posture problem. Hers is something called sclerosis...

Even though they did not seem to believe in the example themselves and corrected each other, Esin and Sibel remembered the example, and the image that comes with it.

As patients used strategies of active and passive resistance against various convincing attempts of doctors, doctors developed ways to counter that resistance as well, or at least anticipate the kind of resistance and minimize its effects. Dr. Gözde was telling me why she was prescribing daily doses of calcium to all her patients:

I know from patients whom I tell to take it every day, I know it from my own mother, that the patients who use it every day are very rare. Because it is not easy to take medication every day. But you should still [prescribe], even if she takes it whenever she remembers, it is still something. I am sure that they are doing it that way, because [they have beliefs] like it gets accumulated in the kidneys, causes kidney stones, gets accumulated in the blood, things like that. My mom says that she takes it every other day, for example, because it disturbs her stomach.

The problems can sometimes start way before the prescription of drugs. Sometimes there would be a parallel flow of monologues between the doctor and the patient. Doctors would try to stick to their questions and get their answers as soon as possible, and the patients would try to tell them their story in their own pace and narrative. This ended up frustrating the doctors, and sometimes they ignored the patient's story and carried on with the task at hand. Below is a dialogue that passed between a family practitioner trying to note down the medical history of a woman in a menopausal clinic in a research hospital. The woman was in menopause for eight years, and according to the file in the doctor's hand she appeared to have taken Climara for one year, yet she was saying that she still takes it. After struggling to understand the HRT part for a while, the doctor moved on to ask her about other medication she takes:

Doctor - Are you taking any drugs?

Patient - I am taking nerve medicine.

Doctor - What medicine? For what?

Patient - I went to the nerve doctor, he gave it to me.

Doctor - What did he say when he was giving it? For what?

Patient - I was nervous.

In instances like that, where the doctor was unable to extract the name of the drug the patients were taking, they sometimes asked the patient to show them the drugs they are taking, and note down the names on the drug packages. Some patients carried the packages of drugs they regularly took with them, or just the part of the packaging that showed the name, to show the doctors. This especially happened when they asked the doctor to refill a prescription, which I believe to be a sign of familiarity with the medical system. This practice of asking for or showing the drug packaging was a way of facilitating communication between two parties that spoke different languages. In the arena of the clinic, both parties devised a way to circumvent the inability to understand the other in their own terms, and drug packages became “boundary objects” in that sense (Star and Griesemer 1989).³⁸

While patients learned the medical terminology and the rules of conduct in a hospital, doctors were also learning to understand what patients meant. There were instances where doctors and patients created a hybrid language of their own. The biggest astonishment I had in a hospital setting was witnessing a dialogue between an ob/gyn assistant and a menopausal woman, where the doctor asked the woman about her complaint, to which she replied by saying she had an operation and now came for a follow up visit.

- What kind of operation was it?

- Woman's diseases.³⁹

³⁸ Bowker and Star define boundary objects as “those objects that both inhabit several communities of practice and satisfy the informational requirements of each of them. In working practice, they are objects that are able both to travel across borders and maintain some sort of constant identity.” (Bowker and Star 1999)

³⁹ The colloquial term for gynecology in Turkish, *kadın hastalıkları*, can be roughly translated as “woman's diseases.” In this dialogue, I could have said “gynecology,” but I preferred to use the one-on-one translation for it sounds closer to the original.

At that point, I expected the doctor to get impatient and scold the woman, or at least ask for what kind of woman's disease the surgery was done. Instead, the dialogue went as follows, without any hesitation on the doctor's part:

- Did we leave one of the ovaries or did we take them both?
- Both.
- OK, proceed to the exam room, let's take a look at it.

Later, I discovered that when women talk about an operation of "woman's diseases," it almost always meant a hysterectomy or a hysterectomy and oophorectomy (surgical removal of ovaries). This was a language created mostly by women themselves, in their effort to cope with medical terms that they found impossible to understand. There is also a sense of pride in women that I interviewed in understanding the language of the doctors, and making themselves understood by them. Some referred to this as "being able to speak their language." Knowing the rules of conduct in a medical setting, like when to come in, what to bring to the exam (test results, for example), whether to come hungry or not (in case they request blood tests), where to make appointments for the ultrasound, was also part of the culture that some women seemed proud to have mastered. Those who had chronic diseases like diabetes that required them to visit hospitals frequently, those who cared for relatives who had such conditions, or those who have themselves had an operation were in a better position than those who only come for check-ups. Those who were the subjects of medical discourse (or be close enough to the said subjects) cultivated an expertise on understanding and coping with this discourse. Either they internalized the discourse, or they "translated" it into a language they can understand and communicate with.

Some of my participants mentioned the proper ways of conduct in a hospital setting, and criticized those who did not know how to behave. Most of these accounts involved acknowledging the hard working conditions of the doctors, necessity of being nice and courteous with them, and importance of being knowledgeable about one's conditions. There is an element of siding with the doctors and differentiating oneself from the ignorant, poorly-behaving masses of patients in these narratives. Below is Şeyda's description of the proper way to behave in a hospital setting.

For example, nowadays at least the patients perhaps became a little more careful. They started asking more questions, trying to further their knowledge...I'm not saying it for all the sections [of population], but at least half of them, or let me say even more than half improved their consciousness level, they ask more, they try to learn more, gain information. And I see some patients coming here, for example they prescribed something to her, she doesn't know, there are tests she has to have, she doesn't know. She comes and goes to the doctor, asks ten times, she [still] doesn't know. There are a lot of people like that, taking the doctor's time. About health, let me talk about myself, I constantly scrutinize. [For example I ask the doctor] "is it OK if I go here *hocam*?"⁴⁰ [Or I say] "excuse me"—I know how to say excuse me too—"excuse me *hocam*, I'm taking your time." *Hoca* is running around, I run around after him, [asking] "excuse me *hocam*, does that happen this way, that way." Now, when it is asked or told nicely you get nice answers. If you ask in a way that will annoy them, of course you don't [get nice answers]. They are right, too. I wouldn't want to put myself in their position. They are very right, they are very busy...Because I understand them, I know how to talk to them, like that.

Familiarity with the hospital culture is necessary to survive in a medical system with lengthy waiting lists for those who do not have the chance to go to private hospitals and need the service urgently. Hanife's husband had a chronic kidney disease in addition to many other health problems, partly due to paralysis—he had a stroke several years ago. Hanife was telling me the story of how she could deal with the late appointment dates and complicated health problems of her husband:

For example, I tell a lot of lies in the hospital. It was last week, we went to the [eye doctor], we had an appointment. Our doctor finished the exam, gave a test for peripheral vision, I went and made the appointments. I went to dermatology, there is fungus under his toes, I told the doctor that we came for the eye exam but my patient's situation is like this. I don't have an appointment, but can you please examine him if you are available? He said, OK, bring him. I mean, if I say it in a different manner he won't examine him. [I tell it] with a nice expression. Today I had him examined

⁴⁰ *Hoca*, while originally being a title for professors in Ottoman times, mainly teaching Koran and religious studies, became a way of addressing university professors in today's Turkey. Especially in the research hospitals that are related to medical schools, most senior physicians also hold academic positions, and both students and patients address them as *hocam*, with a meaning close to "professor." Patients, especially those more familiar with the medical culture tend to call almost all doctors *hocam* in public hospitals.

in dermatology without making any appointments. Then I went to neurology, but it is three or half past three, [the number of patients] is decreased...I went and talked to the neurologists, our doctor from previous time was there, he said, OK, bring him. That day I had him examined there too. Next door was psychiatry, I asked psychiatry, too. That day I passed from four clinics in two hours. Neurology said that they wanted an EMG, go make an appointment. I went to the [inpatient] service, because we had stayed in the there I know them all. They said that they don't have any more appointments for 2006, come in December so that we can give you a date for 2007. Now, I gave the name of my doctor, there was a specialist sitting next to him, I had read her name from her stamp, so I said, *Sinan Bey* and *Ayten Hanım* sent me, they said that you have to squeeze him in somewhere. There is no such thing in fact. (Did they believe in you?) They did. They do. I mean, I tell it in such a way, my patient, this and that, very urgently...He said OK, and gave me a date for a month later, or twenty days.

Although this is not an example related to menopause or even gynecology clinics, it shows the way women, who are traditionally in the position of being the caregivers, learn to move within the medical system. This familiarity is transferable to other instances where women came into contact with doctors and hospitals. For example, Hanife said that later on she used the expertise she gained through her husband's illness for her own medical problems, including seeking for help for her menopausal complaints.

An additional element in the clinic setting was the presence of pharmaceutical companies, mostly in the form of drug representatives who visited doctors regularly, and in a more material sense as small gifts bearing the name of particular drugs scattered around in the spatial realm of the clinic. The relationship of doctors and drug representatives during their visits constituted another clash of social worlds. Since this clash usually happened in the same physical place where doctors and patients come together, "the clinic" became a multiplied arena. Some hospitals attempted to limit the presence of pharmaceutical representatives by regulating the hours they were allowed in the clinics or requesting them to present an ID card they had to apply for beforehand. They generally came in to talk to doctors at quieter times of the day like close to the end of workday or early in the morning before the appointments begin, and those who came in busier hours were not very welcome. Usually they would come in, greet the doctors they already knew, meet the ones they had not seen before, remind them of the drug they are working on by a very brief presentation of the name of the drug, what it does, its

ingredients and administration, and sometimes leave brochures and small samples of the drug or little gifts like mugs, calendars, pens, or clocks. This practice, called “detailing” in the North American medical culture, is referred to as *ilaç çalışmak* by doctors and drug reps, which literally means “working (on) a drug” in Turkish, and the term is not used by anyone outside the medical circles. Almost always, and especially if they had some kind of rapport with the doctors, they asked whether they had any requests before they left. On several occasions, I saw doctors or nurses demanding certain things, mostly to supply the needs of the clinic for which the hospital does not have the resources. In one instance a nurse was asking the representative to have a stamp made with the name of the clinic; in another doctors were talking among themselves about asking for an air conditioner from a representative they knew for the exam room which would get really hot in the summer.

The influence of pharmaceutical companies falls beyond the arena of the clinic, as Dr. Rıfat indicated:

There is a very important issue in Turkey, unfortunately some international drug companies marketing hormones have doctor arms [branches] in Turkey and the companies are in an effort to conduct them according to their own interests. We have to also deal with that. This is of course something that is not unique to Turkey, but an ethical, moral problem seen in many countries. But unfortunately it became so widespread in Turkey.

Although I do not have fieldwork data to support his hypothesis, I heard many stories of doctors asking drug representatives for big favors and participants being presented with cash at the end of a meeting organized by an international drug company explaining the side effects of a new drug, in exchange for not mentioning this information outside. All of these suggest that both parties in the arena of the clinic came there with a certain shared knowledge of relations between medical profession and pharmaceutical relations, even though they had varying reactions to this relationship.

7.3 Conclusion

Analysis of the arenas and the intersections, clashes, negotiations and translations happening within them shows us how discourses of different social worlds interact and change each other. As the discourses change, so do social worlds and institutions. The general analytical framework of this dissertation, namely situational analysis, enables one

to explore the dynamic process of negotiations in the arenas of menopause and HRT in Turkey and the ongoing process by which social worlds shape one another. Although the argument of mutual shaping is important so as not to deny agency to those who are in subordinate positions vis-à-vis the traditional power sources, like patients in a doctor-patient relationship, I also want to draw attention to the direction of flow for the governing discourses and their relative effects.

The process of producing medical truth starts the production of clinical research that is eventually translated into clinical practice and used as a basis for administering treatments to individuals. Every step of the way, multiple “truths” are communicated, constructed, and shaped by various social worlds that carry their own perceptions, interests and values into the process, with differing degrees of influence. The main social worlds involved in the clinic were pharmaceutical corporations, clinicians, and menopausal women. Media, professional organizations, medical researchers, menopausal women who did not come to the clinic and their social circles constituted the implicated actors of the clinic arena. Although it is possible to talk about the influence of all of these parties in the meaning-making process and shaping of practices regarding menopause and HRT, the differences of influence cannot be disregarded. In every step of the way, from sponsoring the medical conferences to informing doctors via brochures and sponsored TSMO workshops, to public health conferences and news about their products, pharmaceutical corporations have a proportionately greater say in the shaping of discourse around menopause and HRT than anyone else. Part of this influence stems from their presence in a multiplicity of arenas, and part of it from their increasing power in a globalizing economy of privatized healthcare. They are faced with resistance in different arenas, from suspicious doctors to other pharmaceutical companies producing drugs that rival theirs (like osteoporosis drugs for HRT for example) to women who hold more traditional beliefs about menopause as a non-existent problem. However, all of these factors could not prevent the dissemination of a powerful global medical discourse with Western origins throughout Turkish culture. Interestingly, the same happened for the main dissent for HRT, as the WHI results trickled to other parts of the world as fast as the drug itself. In any case, reflection of Western discourses, whether pro or con HRT, seemed to be stronger than a genuine local resistance in Turkey.

8. Conclusion

A while later Doctor Ramiz came. His face was glowing with joy.

- It's done...he said. At first he resisted a while. But when I told him that you are a patient in my area of expertise he was convinced.

- But doctor, I am not sick... For God's sake... I told you.

Again, he stared in my eyes. With his most determined voice:

- You are sick... he asserted. Since psychoanalysis came out almost everyone is more or less sick. (Tanpınar 1961, 105)

This dialogue passes between Hayri İrdal and Dr. Ramiz in *Saatleri Ayarlama Enstitüsü*⁴¹, a satirical novel by Ahmet Hamdi Tanpınar criticizing bureaucratization and the modernization process in Turkey through the example of a group of people creating an institute (with state funding), which has the aim of calibrating all the clocks and watches around the country. The quoted part is told by the main hero, Hayri İrdal. The doctor in the dialogue with Hayri İrdal had just returned from Vienna, where he studied psychoanalysis, is very eager to apply this new approach on his patients, and feels frustrated working for a hospital administration that does not take his theories and treatments seriously. He is very happy to have found a patient with the arrival of Hayri İrdal to the hospital as a result of some court-related misunderstanding and who is willing to do anything to get out of there as soon as possible. However, Dr. Ramiz is not very pleased with his progress as a patient:

Maybe because he is tired and irritated, he didn't like the dreams I told him at all. He was accusing me of not having dreams that a guy who doesn't like his father and looks for a father for everywhere should have.

- How is this possible? he was saying. A person like you, not having even one dream fitting his illness! Can you at least make an effort from now on...

This last sentence was the beginning of a new phase in my treatment. That day, he did not talk until the evening, walked around the room nervously,

⁴¹ The name of the book literally translates as "Institute for Adjusting the Clocks," though it has been translated into English by the title "Time Regulation Institute," which I believe does not reflect the absurdity in the Turkish title.

almost ignoring me, then all of a sudden, he faced me like he made up his mind, and told me, in his most serious voice:

- I want you to have dreams that are more appropriate for your illness, do you understand? (114)

Written in 1961, Tanpınar's novel is still valid in explaining the dynamics and discourses behind medicalization, as well as the modernization project in Turkey. My overall argument for this dissertation is that the medicalization of menopause in Turkey became possible both with the changes that happened with privatization and globalization, like the spread of patient-as-consumer ideas; and with what has remained unchanged from the core of modernization ideals like the belief in Western science, and the privileged position of science, technology and medicine as part of a "modern" identity.

The continuity and change of discourses through time, and how they were exchanged by different social worlds and mutually adjusted to fit together within a globalization/privatization framework was the most important finding of this study, supporting the need for a more sophisticated categorization than the dichotomies of modern/traditional or modern/postmodern in social sciences analysis. Modern and traditional are not two separate worlds, as would be expected in dichotomies, but more like two currents that run parallel sometimes, and sometimes they got mixed in different degrees in different places. The more "fluid" nature of these concepts became apparent in many examples from the field.

8.1 Imported Empowerment Ideal

I have mentioned different frameworks of analyzing the effects of globalization in Chapter 1, Introduction. Before going into the "local" elements, I would like to turn to these globalization frameworks and the effects of globalization on healthcare worldwide once again.

At the ideological level, the most profound change in medicine happened with the spread of a neoliberal economic model that sees healthcare as a private good instead of a human right (Farmer 2005; Huynen et al. 2005; Reich 1994). The imposition of neoliberalism has resulted in increased inequalities in accessing healthcare, consumer-

oriented medical practices, decreased government spending and increased privatization, and changes in the structure of medical profession. Another aspect of the ideological shift coming with globalization has been increased institutionalization and rationalization of healthcare systems, and exclusion of religious or traditional medical practices (Turner 1995, 202)

In her unpublished doctoral dissertation Lorna Ronald showed how a neoliberal discourse of undertreatment and underdiagnosis of diseases constructed the “empowered customer” ideal in the process of lobbying for direct to consumer advertising (DTCA) in the United States:

The origin of DTCA in the 1980s and its explosion in the late 1990s and early 2000s is part of an increasing medical neoliberalism and commodification of health that has altered the ways in which healthcare is perceived, structured and governed in the United States, a model that has now been exported elsewhere. Health is seen as a result of products and services; public health as the sum of individual decisions to consume them; and patients as consumers who are responsible for monitoring and managing their own health” (Ronald 2006, 4).

According to this ideal of patient as the empowered consumer, consumer/patients should educate themselves about the diseases and drugs and demand drugs from the doctors, who now became both gatekeepers and relatively passive advisors, since “[g]overnance in neoliberalism works through autonomous individuals rather than in spite of them” (Ronald 2006, 5). These empowered consumers are not only encouraged to be informed about their healthcare, but also be demanding about treatments and drugs for their “conditions.” Supplemented with the language of preventive medicine and awareness about risks, and armed with their buying power, the empowered consumers — who are usually middle class and middle-aged citizens of the developed West— determine the direction of medical research.

The model of pharmaceutical governance through markets creates incentives for drugs that have large markets for relatively healthy people in Western countries, rather than for illnesses that affect large numbers of people in the developing world. Heath (in Moynihan and Cassels, 2005) called this serving the “rich well” rather than the “sick poor.” The increasing emphasis of the pharmaceutical industry on risk factors and conditions that are normal processes, such as balding and menopause, goes hand in hand

with its neglect of treatments affecting millions of people across the globe (Ronald 2006, 15).

As Ronald suggested, a separate language of fear and risk and the necessity to know the risks and protect oneself from them is another thread that is present in the idea of pharmaceutical governance. In *Risk*, Deborah Lupton examined the changing role of risk in modern societies, and argued that epidemiological risk strategies used to be directed at regulating environmental conditions for a healthier population in the nineteenth and early twentieth century. This emphasis on environmental factors, while not disappearing altogether, gave way to “a far greater emphasis on individuals’ ‘lifestyle’ choices in relation to health status,” expecting the individuals to “engage in self regulation” (Lupton 1999, 97). Lupton explained the way this mechanism of “encouraged self-regulation” as such:

Thus, for example, if a certain population group is identified through statistical calculations as being at ‘high risk’ of developing heart disease, based on such attributes as gender, age and diet, then members of that group are then encouraged to deal with the risk factors themselves. This process does not necessarily involve consultations and examination of individuals by health professionals, but rather often takes place through mass-targeted media campaigns which rely on individuals identifying themselves as being ‘at risk’ and taking steps voluntarily to reduce their exposure to risk (Lupton 1999, 97).

In this context, she defines risk as “a governmental strategy of regulatory power by which populations and individuals are monitored and managed through the goals of neo-liberalism,” (87) thus making the connection with the individualist focus on neoliberalism and ongoing management of populations by the government. In the case of risks that come with menopause, say, osteoporosis for example, there is an element of bringing risk upon oneself through one’s own actions. This can be generalized to the whole preventive medicine discourse. One is both the victim, and also responsible for the risk to a certain extent, for not conducting their life according to the guidelines or not submitting oneself to the surveillance of medicine. Lupton also mentioned Douglas’ theory on strategies of victim-blaming versus blaming an outside enemy at times of risk; where Douglas claimed that “Victim blaming facilitates internal social control; outside blaming enhances loyalty” (Douglas, cited in Lupton 1999, 49). Along this line it is possible to consider the shift to

individualized management of menopausal risks as a kind of discipline constructed through blame, responsibility and fear, despite the irony of putting the responsibility to avoid risk on women in environment of scientific controversy.

There is a very significant scope for improving the health of ageing women and thus ensuring that they remain a resource for their families and communities (Women, Ageing and Health, WHO Fact Sheet, 2000).

In examining concepts of risk and blame, Mary Douglas mentioned the way scientists take the individual as a focus for calculations of risky behaviors in the name of objectivity, disregarding their support group (Douglas 1992).

No one takes a decision that involves costs without consulting neighbours, family, work friends. These are the support group that will help if things go wrong. However, they tend to give conflicting advice. One of the interesting questions in risk studies would be to know how consensus is reached. Placing all the focus on individual cognition excludes the problem. The risk perception analysts say practically nothing about intersubjectivity, consensus making, or social influences on decisions (12).

Following Douglas' words, focusing on social worlds where social influences are created and arenas where consensus is attempted, and sometimes reached, gives a better picture of decision making about HRT use. As seen in the examples from the field, menopausal women tended to make a decision to take or reject HRT based on information they gathered from friends, family, neighbors, doctors and the media, and with varying weights of influence. In addition to decision making regarding risky situations involving one's own health, HRT case also presents decision making involving risk for others, which is the position of gynecologists. Their decision making was subject to similar concerns and inclinations that menopausal women have. Although there was a general claim of objectivity and following the medical truth, what happened in practice was that doctors tended to believe in and follow the advice of their colleagues, professors, or medical organizations they belonged to. In other words, they too followed those that are socially closer to them in assessing and taking risks, be it for themselves or for their patients.

This approach of assuming individuals to be rational and isolated decision makers is also thought to be part of the Western medical discourse, where the focus is on the body –or sometimes just a body part—of the patient rather than a holistic approach

locating the patient in a social environment. As opposed to the position of doctors in the West, Ayşecan Terzioğlu argued that Turkish doctors are more aware of the social and economic environment of their patients, partly because of the historical role of doctors in Turkey as important actors to shape social and political life; and partly because they are closer to the patients in terms of class especially after the heterogenization of the medical profession that led people from lower socio-economic backgrounds to enter medical schools and the high inflation rates and privatization policies of the 1980s and the 1990s that further decreased the life standards of doctors (Terzioğlu 1998). The historical responsibility of doctors to save the people and the country led to the development of a socially aware professional identity. This somewhat distant interest in the socio-economic condition of the patients took a different twist after medicine ceased to be an elite profession in the 1980s and 1990s. The private/personal experiences of doctors corresponded with those of their patients, decreasing the distance between two groups.

I agree with Terzioğlu's argument to a certain extent, even though I think there is still a split between the professional and private selves of doctors; and the professional identity still carries traces of class-based elitism. In their professional role, doctors saw patients as "rational individuals," and got upset when they did not behave as such. In addition, those who did not behave rationally according to doctors' standards were considered primitive, and to tie it to the thread of *bilinç*, lacking consciousness. Ironically, doctors themselves sometimes behaved the same way outside their professional roles, when they were in the position of a patient or a relative of the patient. As we were talking about regular gynecology check ups, one of the female assistants that I interviewed told me that she has never been to a gynecological exam despite the fact that she recently gave birth. Astonished, I asked her what kind of prenatal care she had during her pregnancy, and she said that she checked herself with the ultrasound machine in the first few months, and asked a gynecologist friend of hers who she was working with to do it for her in the later months. This attitude is quite at odds with what health professionals criticized in their own patients. Another example is a young male assistant telling me that he understands the female gynecologist preference of the patients, saying "In our culture it is normal that she demands a female doctor. Even I sometimes think that if it was my sister, or mother [I would want the same for them]."

Despite the fact that the private self of doctors brought them closer in the clashes and negotiations between doctors and patients, it did not prevent them from casting the patients as the “other” in need of being educated and disciplined. This sense of mission to heal the society as well as healing the patients became part of the professional identity of the medical doctors in the process of establishment of modern medicine in Turkey, giving them a sense of authority in commenting about what is wrong with the society and how it should be corrected. In my fieldwork, this idea of mission exhibited itself as a mission to educate and increase the consciousness of the society, either by educating individual patients (as also argued by Terzioğlu), or engaging in awareness campaigns for public health and/or using the media to distribute the “scientific truth.” As far as the menopause/HRT arena goes, the recent marketing strategy of pharmaceutical companies by increasing awareness resonated with the vanguard role of Turkish medical doctors in educating the citizens, and the discourse created by the media about the desirability of being young and “healthy.”

8.2 Fertile Grounds for Import?

The process of exporting this new understanding of healthcare, or “pharmaceutical governance” as Ronald called it, resulted in structural as well as discursive changes in most non-Western countries. In the Turkish case, the discourse of the transformed patient after neoliberal policies is not so much about “empowerment” but “being conscious” with an underlying assumption that it is one’s duty to others as well as themselves to be healthy. Although it carries the same moral obligation overtones, the Turkish construction of a conscious/aware patient is different from the neoliberal personal responsibility idea in its emphasis on the community/nation rather than the individual, and in its links with the older ideals of the “good citizen” that started to be formed in the early years of the republic. Unlike the political climate in United States, where the norm is the market and the professional institutions carry the responsibility to shape policies where the state acts mainly as a regulatory agency, Turkey has the tradition of a strong paternalistic state, responsible for the health and well-being of its citizens. In this historical and cultural environment, the consumer-oriented neoliberal empowerment discourse tweaked into the still modernization-laden, state-led meanings of

consciousness/awareness and the traditional burdens of women to take care of others before themselves.

The shift in discourse can be observed in multiple levels of my data, through the relevant social worlds and arenas where they come into contact. At the macro level, there are global pharmaceutical companies and the dominant medical practice and research, which is the main source of empowered consumer discourse.⁴² At the meso level, there are professional organizations, international and local, which try to influence clinical practice; and the local media reproducing or reconstructing the medical research results as well as popular understandings of menopause. At the micro level there are menopausal women and doctors negotiating over prescriptions of HRT and there are more loosely defined private networks of women form among themselves.

The tropes of modern woman and *bilinç* are threads that run through the social worlds in question, and interweave them. Both concepts change meanings in time and between social worlds, but they are nevertheless important elements ensuring continuity in the change of healthcare discourse. As the role of state and individuals were redefined with neoliberal healthcare policies, the meaning of these terms changed to accommodate the shift in responsibility for governance over women's bodies. A deeper analysis of these two main tropes, that of the modern Turkish woman and the conscious Turkish woman, can explain the change better.

8.2.1 Modern Turkish Woman and *Bilinç*

There are several degrees of how the exported empowerment discourse blended with the older “duty” ideas in the construction of menopausal women in relation to healthcare. On the one end of this spectrum there is the woman who needs medicine to continue “being” for others, like taking care of their elderly patients or grandchildren, or being able to go on having sex with their husbands. Examples of these have been demonstrated in Chapters 4 and 5 of this dissertation.

⁴² For a study of how global health practices negotiated and translated at the national level in Turkey on a different subject, see Yeşim Yasin's unpublished master's thesis on directly observed treatment strategy-short course (DOTS), a global treatment and control strategy for tuberculosis promoted by World Health Organization (WHO) (Yasin 2007).

With more input from the individualism ideas, there is the discourse of women who are empowered (or saved) enough to ask for relief from their symptoms, mostly with the help of awareness campaigns, even though they did not have that opportunity before. Historically, the portrayal of these women followed the line of enlightening and saving people through education by the Kemalist elite. It is important to note that the “empowerment in healthcare” was a more consumer-oriented change, for the nonexistence of a women’s health movement like in the United States. For that reason, it lacks the feminist aspect of empowerment present in the American discourse as explained in Chapter 3. Lastly, there is the ideal of a woman who is modern, urban, strong and self-aware, wanting to continue her independent life for herself and requesting the help of doctors for that reason. The example below, taken from my interview with Dr. Ali, summarizes this stereotype:

Today if our women in the cities don’t cry [about menopause] thinking they are old, finished; not perceive it like that and take care of themselves live a tremendously colorful and comfortable life...Now, if you have noticed, a person entering menopause at the age of 48-50 in Turkey still has 30-35 years to live ahead of her. Now, if that person accepts herself as finished and old, she really is going to spend this time as an old, sick person who does not enjoy anything. But someone who perceives menopause as normal and takes care of herself, regularly goes to her medical check ups will have neither bone loss nor premature aging, nor psychological disturbances. She lives a tremendously strong, colorful life with joy of living. And the Turkish woman, as I said, the Turkish woman living in the cities is aware of this now.

These different constructions of modern woman that came out of my findings make more sense when situated in a more general framework of gender identity formation in Turkey with the modernization project. In her article theorizing on the gender regime of Turkish modernization, Serpil Sancar argued that despite most studies on the field focus on the mechanisms of state and market, the project of Turkish modernization is constructed around the idea of creating a “modern Turkish family,” which in turn rests on the image of modern Turkish woman (Sancar 2004, 202). During the process of constructing an identity that is modern, yet different from the West; Turkish women became this “difference” from the West (205). The boundaries of this imaginary of Turkish women were drawn by the continuity of certain governing discourses. One of these discourses is

the discourse of “excessive Westernization,” defined with consumerism, idleness and a degenerate life style centered around sexuality, and including references to the life practices of an upper class femininity that might come up with demands of independence (206). Fear of excessive Westernization and consumerism were themes carried in to the 1990s and, according to Ayşe Öncü, have taken a new twist:

What has given the past decade a special twist is the way such themes have been taken over by the popular media, and packaged in commercial genres and forms of consumption by wider audiences...Pathetic narratives of girls who arrive in Istanbul to become television stars or singers and then drift into the trade in vice are of course classic, and have been around for a long time. But they have now been displaced, as favourite tabloid material, with stories about ‘children of affluence’, who wear designer clothes, frequent expensive restaurants, bars and discos, and celebrate promiscuity in sex and drugs, but eventually end up committing suicide, or are found dead of an overdose in some filthy basement, or fall into the clutches of some religious cult, as in a recent case, illustrating how ‘excess consumerism’ breeds ‘identity confusion’ because it is contrary to Turkish values and ways of life (Öncü 2002, 174).

While the discourse of excessive Westernization drew the boundaries of modern Turkish woman’s freedoms, the discourse of “traditional woman” separated it from lower-class femininities, acting as class-based boundaries for being a modern woman. Traditional woman, constructed as the “other” of the modern woman, was defined as both the symbol of ignorance, dependence and being oppressed, and the symbol of hard work and altruism (Sancar 2004, 207).

...[I]t can be argued that the definitions of modern woman and family reflect the imagination of middle class, urban, male founders supporting modernization. According to this imagination, *modern woman* is constructed in opposition to the extremities of upper class with her characteristics of moral uprightness, altruism and loyalty to the family; and in opposition to the lower class traditionalism with her characteristics of being educated, aware of her rights and having public presence (Sancar 2004, 207).

This construction of modern woman in Turkey can be put into conversation with other postcolonial examples, like the “new” Indian woman in the nineteenth century created by the Indian nationalist discourse (Chatterjee 1989). Chatterjee described similar concerns of defining the “difference” from the West while adopting its science and technology, women becoming the (spiritual) symbols of this difference, and the effort to differentiate

these new symbol women from the “degenerate Westernized” or “common vulgar” versions of femininity.

The new patriarchy was also sharply distinguished from the immediate social and cultural condition in which the majority of people lived, for the “new” woman was quite the reverse of the “common” woman, who was coarse, vulgar, loud, quarrelsome, devoid of superior moral sense, sexually promiscuous, subjected to brutal physical oppression by males...It was precisely this degenerate condition of women which nationalism claimed it would reform, and it was through these contrasts that the new woman of nationalist ideology was accorded a status of cultural superiority to the Westernized women of the wealthy parvenu families spawned by the colonial connection as well as the common women of the lower classes (Chatterjee 1989, 627).

However, the Turkish case differs from Chatterjee’s description in one important way: while the new Indian woman was defined as the protector of spirituality and religion in the process of modernization and encouraged to stay at home, the new Turkish woman was expected to appear in public sphere and be the protector of secularism. There is also an element of rural/urban difference in the Turkish case when describing the lower classes as the “other” of the modern woman, which seems nonexistent in Chatterjee’s analysis of the Indian example.

Serpil Sancar argued that this construction of modern woman, which took place in the 1930s, did not change too much despite political and social transformations of the 1950s and the 1960s, like the multiparty rule, ‘68 movement or new possibilities for employment and education for women. The imaginary of the modern woman became multiplied with these changes, but did not change totally. Furthermore, it created such a big social consensus around itself that the difference between the modern woman and its “others” got lost, for the same imaginary of modern woman has been internalized by the “others” (210).

Sancar’s astute analysis of the development of modern woman identity in Turkey shows the importance of this identity for Turkish women, however they define themselves in relation to modernity. I have observed the same effort to differentiate oneself from the archetypical “others” of this new woman throughout my fieldwork, in my interviews with menopausal women like the one below, where Zehra was telling me about her experiences with other patients during her visits to the hospitals.

Unfortunately Turkish society is traditional, those people who come from the East [Eastern Anatolia] are shy people. Especially when talking about gynecological diseases, even I, as an intellectual person, feel shy about gynecological exam. But obviously you tell your problems when there is an illness...After my operation I told the problems of many patients [to the doctors]. They get shy. They especially are shy when the doctor is male. Unfortunately there is still that kind of a sentiment, they cannot see him as a doctor. Even I have that, think about it.

Zehra portrayed herself against some other women she helped during her stay at the gynecology ward of the hospital after her hysterectomy. The “others” were traditional, did not know how to communicate their medical problems, and were potentially ignorant or uneducated women coming from “the East” which denoted the non-urban parts of the country. Although Zehra saw herself clearly different from them, she still referred to certain ways they were alike, like having similar sentiments about gynecological exams.

Here, it is useful to return to the concept of *bilinç* I introduced in Chapter 1. When the term was used by doctors, there was more emphasis to the reference to formal education and ability to communicate in the “medical language.” They also used the word to denote a particular awareness of and attention to one’s body and what happens to it. Doctors’ complaints of patients not having *bilinç* (*bilinçsiz*) involved stories of how these women do not have any idea about the last time they had their period or what kind of operation they had. Also within the meanings of *bilinç* as used by doctors was the propensity to demand medical attention and treatment. In this sense, the word gains a meaning involving awareness about one’s body, (right) knowledge about what should be done when there is anything wrong with the body, and a personal responsibility to have this kind of knowledge. In this sense, the word *bilinç* corresponds to “consciousness” in English, with the Latin root of the word literally meaning “with knowledge,” signifying the difference between those who have the “right” (medical) knowledge and those who do not.⁴³

The meaning of having the right kind of medical knowledge is adopted by some menopausal women, when they pointed out to the fact that they regularly come for follow ups, hence they are *bilinçli*. In this context, *bilinç* referred to the degree of being a disciplined medical subject. Constructions of a modern woman include having this *bilinç*,

⁴³ Ayşecan Terzioğlu, e-mail message to author, December 15, 2007.

although the definitions of what actually being *bilinçli* changes according to time and social worlds. The sub-meanings of being aware of one's rights and educating oneself are transformed into the individualized responsibility of the empowered consumer within the discourse of neoliberal healthcare policies.

Usage of the word *bilinç* and its derivatives in the media on menopause and HRT followed the medical definitions of the word. Some of the news stories and articles were direct translations from North American sources like Christiane Northrup's books, and news stories on the latest medical developments on treatment of menopause, and sometimes they were supplemented with the opinions of Turkish experts. In these stories, the word *bilinç* was generally used in the context of creating public awareness, or having the right attitude in menopause, which is consulting medical experts and arming oneself with knowledge on the subject.

8.3 What Have Hormones Got To Do With It?

If we focus back on the technology of HRT in the light of these concepts, we can see that both these concepts and their differing meanings were used by various social worlds. In Chapter 4, 5 and 6, these different meanings are explained in detail. To summarize, they included those circulate in the medical community, like HRT as a substance that replaces what is lost in menopause, HRT as a preventive treatment, HRT as a treatment that alleviates unnecessary suffering and HRT as a suspicious treatment that has to be administered carefully. There were different meanings observed among menopausal women like HRT as a drug to "cure" the symptoms they are having, once and for all, HRT as a drug that prolongs menstruation and postpones menopause, and HRT as an artificial and potentially dangerous substance entering the body. Lastly, there were shared meanings of HRT by the doctors and women alike, like HRT as a cause of cancer, HRT as a protection from osteoporosis and HRT as a drug that keeps one young. All these meanings influenced the prescription practices of doctors and willingness of women to accept hormones.

Another concept to discuss besides consciousness, modernity, and risk is the dichotomy between natural and artificial, and what constitutes as "natural." As mentioned in Chapter 4 and 5 briefly, the decision to refuse HRT sometimes rested upon its

perception as an “unnatural” substance; and doctors tried to refute this argument by making comparisons with other technological developments, other more accepted treatments like insulin for diabetes, arguing that menopause itself is not a natural period only happening because of increased life expectancies, or that HRT is actually just putting back the hormones that was and supposed to be in a woman’s body.

In addition to these meanings, in the increasingly globalizing discourse of health as a personal responsibility, HRT and the decision-making related to its usage became converged with the identity of modern citizenship:

If health today “has become a duty as much as a right of citizenship” (Porter 2002:201) and a new morality (Tiefer 1997), then a critical aspect of being a responsible late-modern citizen is to take charge of one’s somatic well-being by practicing healthy lifestyles mediated by the consumption of appropriate products and forms of expertise (Marshall and Katz 2006, 91).

In the case of HRT in Turkey this duty of modern citizenship became a confusing task, complicated by many layers of responsibilities menopausal women had in this regard. Women were expected to be conscious and modern consumers of healthcare, not fooled by misinformation especially when provided by the media, more accepting of medical explanations, yet still aware of the “bad doctors” as well. This *bilinç* was expected to become part of their modern woman identity, part of their duty to remain healthy for their families, and part of the newer idea of being an individual who enjoys life after menopausal years. The tricky part is, this conscious decision-making about HRT involved conflicting information coming from all directions. Despite the efforts of TSMO and the like to create a uniform front against the public, scientific controversy over HRT seeped out of the medical community, taken up by the media looking for sensational stories and got integrated into the even more complicated knowledge networks of women comprised of newspapers, TV, doctors, friends and relatives.

8.4 Looking at the Future?

Earlier, I quoted Celia Roberts on the necessity of finding a way to talk about a medical technology without essentializing women or rejecting the technology altogether. This seems to be a pressing problem for STS and feminist studies alike. Jennifer Aengst

and Linda Layne dealt with a similar question in their analysis of menstruation suppressing birth control pills (in press). They discussed whether or not pills like Seasonale are feminist technologies through the lenses of several feminist approaches such as liberal, radical, socialist, essential/cultural, eco-, existential, and cyborg feminism. Seasonale gave women choice and control over their own bodies, making it a feminist technology according to certain approaches like liberal feminism. At the same time it stigmatized and tried to regulate menstruation instead of trying to change the social structures that made menstruation a problem, making it an anti-feminist technology according to other approaches like radical feminism. The issue of choice and what it means to be forced (or convinced) to choose when there might be other options are questions in theorizing about gendered technologies. When it comes to menopause and HRT, the issue of choice also includes dealing with the idea of risk and scientific controversies.

My answer to Roberts' question, which I tried to explain in this dissertation, is to theorize women's bodies and technologies related to them while keeping the focus on several matters. One of them is to analyze and discuss who benefits from the technology and how. Determining who has a stake on the HRT arena helps us answer this question, and enables us to see the power relations within the arena. The second issue is to discuss whether or not there would be better alternatives that could and would be developed if multiple perspectives were taken into account, which is a common thread in STS literature. Thirdly, giving a voice to the "implicated actors" in an arena should be part of the analysis. I tried to accomplish this task by having menopausal women talk about their experiences instead of just talking about menopausal bodies. Finally, contextualizing the technologies in question is an important part of the study. The context in which the "choosing" occurs partly determines what it means to choose or refuse a technology. Aengst and Layne mentioned control over one's body is considered to be sign of "modern womanhood" (in press). For HRT, control over one's body is supplemented by the responsibility of protecting an aging body as part of the identity of a modern woman. In Turkey, discourses around the modern woman identity have been continually shaped and reshaped by the historical processes I described earlier on in the dissertation.

A persistent feminist critique of Foucault's understanding of power is that it loses sight of who has the power while keeping track of the ways power is produced and circulated. I believe in the importance of pointing to the places and institutions where power rests and *persists*. As I pointed above, during all that talk of risk and blame and consciousness and duty, menopausal women's voices are hardest to hear, despite the fact that their responsibility to calculate risks about their bodies and lives increases with the new era of pharmaceutical governance. In her book on women drug addicts and public policy on drugs, Nancy Campbell referred to the cultural assumptions that direct policymaking –yet go unnoticed—as “governing mentalities” (Campbell 2000). Similar governing mentalities are in charge in the medical and popular narratives on menopause in Turkey, some of which are carried from the globalized Western discourse on aging and women which are co-constructed with HRT, and some more “local” ones blended with the former discourses. Analyzing these mentalities which do not make laws but still affect women's and doctor's decision making is an effort in pointing out where the “power to define” rests and persists. It is useful to mention the concept of “contact zones” as another theory on instances of meeting and clashing in order to point to the power relations. In Mary Loiuse Pratt's definition, contact zones “refer to social spaces where cultures meet, clash, and grapple with each other, often in contexts of highly asymmetrical relations of power, such as colonialism, slavery, or their aftermaths as they are lived out in many parts of the world today” (1998, 173). In the context of HRT and menopause in Turkey, the clinic can be considered as a contact zone where the medical culture and the culture of menopausal women meet, as demonstrated on Chapter 6. What creates a power asymmetry between doctors and women here is that the knowledge claims of medicine are backed up by the legitimacy of science, which is very much revered in the modernization project of the Turkish Republic.

Following the threads of contact zone and governmentality, it is possible to make a macro-level analysis of medicalization of menopause in Turkey with regards to neoliberal policies after the 1980s and the increasingly prominent role of transnational pharmaceutical corporations. In their article on ethnographies of governmentality, Ferguson and Gupta defined civil society as the zone of contact between the people and state (2002, 983). They argued that state was perceived as both “above” society, and as

“encompassing” it, and these spatial perceptions helped legitimize state’s authority. However, with the move towards neoliberalism, “local” influences of transnational organizations and entities started to threaten this straightforward spatialization of state, creating a situation of “transnational governmentality” (989). Decrease in the authority of power did not necessarily bring “less government.” In Ferguson and Gupta’s words:

Rather, it indicates a new modality of government, which works by creating mechanisms that work “all by themselves” to bring about governmental results through the devolution of risk onto the “enterprise” or the individual (now construed as the entrepreneur of his or her own “firm”) and the “responsibilization” of subjects who are increasingly “empowered” to discipline themselves (989).

In this new modality of government, transnational organizations like Oxfam or Doctors Without Borders become “integral parts of a transnational apparatus of governmentality” which “does not replace the older system of nation-states...but overlays and coexists with it” (994).

Ferguson and Gupta did not mention professional organizations as part of the NGO’s they defined to be the contact zone of the spatial state and the governmentality apparatus of the new transnational system, but I would like to stretch their definition to include organizations like TSMO and EMAS. I already defined the role of TSMO as the intermediary between the dominant global medical knowledge and local professionals in HRT controversy on Chapter 5. In that sense, instead of being a contact zone between state and society, they were the contact zone between (local) doctors and the (transnational) pharmaceutical corporations and international professional organizations like EMAS. On the discursive level, as the role and influence of state in healthcare diminished, local medical organizations (interlinked with the broader international ones) took over the responsibility of “creating awareness” on healthcare matters, along with the power to define the discourse of awareness campaigns. In the arena of menopause and HRT in Turkey, they were the carriers of the dominant discourse.

As I mentioned in Chapter 1, the theoretical focus on situational analysis is the situation rather than the actions. This dissertation was an attempt to describe the situation of HRT and menopause in Turkey: social worlds, arenas in which they come together, and the backdrop against which dominant and subordinate discourses in the arena

contend. It is also a first step towards more sophisticated analyses of modernization and gendered medical technologies in Turkey, and the implications of these technologies for transnational feminisms and global health equity movements.

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Appendix 1
List of Initial Codes

List of Initial Codes

Doctor/patient relations

- Good/bad patient
(education, aggression, consciousness, knowing the medical/hospital culture)
- Good/bad doctor
(competency, trustworthiness, aggression, patience, informing the patient)

Menopause

- Experiences of menopause
- Meanings/definitions of menopause
(illness, aging, shameful, a natural process, a sensitive period, a biological event, osteoporosis, end of womanhood, having time for oneself, exploring oneself, etc.)
- Menopausal woman (meanings)
(doesn't have anything to do, talks a lot (empty talk), depressed, "menopausal patient", taking care of themselves to take care of others)
- Complaints
(hot flashes, fatigue, sweating, insomnia, nervousness, irritability, stress, headaches, dry skin, weight gain, etc.)

HRT

- Meanings of HRT
(replacing something that goes missing in the body, making the woman menstruate, postponing menopause, a necessity to go on with one's life, a drug (the doctor gave it to me), relaxing/comforting, something given from outside (not natural), a risky drug (not innocent), a way to legitimate the problems against the family, unnecessary, doesn't have a real alternative)
- Indications of HRT (reasons to use)
(protective: protects the heart, the bones, betterment: good for the skin, comforting, alleviating the complaints: hot flashes, sweating, nervousness, headaches)
- Counter-indications of HRT (for doctors)

(family history of breast cancer, CVD, smoking, “test results not good”, etc.)

- Concerns about HRT / side effects

(cancer, weight gain, causing hormonal imbalance, increase in body hair, etc.)

- Who to give and how

(according to the patient/person, to everybody, to everybody as long as there isn't a risk, under regular control, if the complaints are affecting the quality of life, before a certain age and for limited duration, in low doses)

- Alternatives of HRT

(herbal alternatives (black cohosh-Klimadynon), exercise, “brain power”, calcium, vitamins, milk/yogurt, other drugs that protect the bone, antidepressants, soy, omega3, primrose, milfoil/yarrow)

Medicine

- Differences between theory and practice

- Conflicts/differences in medical opinion

- Medical hierarchy

(between specialists and interns, between doctors and patients, between different branches of medicine)

- Informing/not informing the patient

- Problems in medicine

(privatization, lack of control/inspection after privatization, diminishing of quality in medical care, increase in number of patients, crowded hospitals, not enough money for health, political favors to those close to health ministry or government, patients becoming more demanding, less respectful, etc.)

Change

- Changes in medicine

(private hospitals, labs, diagnostic centers, switching to appointments instead of first come first serve queues, merging of public social security systems, plus all that I wrote in the “problems” section)

- Change/general (in society)

(urbanization, increase in visiting doctors/ob-gyn, change in life styles, nutrition, exercise, etc., some “taboo” subjects becoming more “talkable”, increase in the visibility of illnesses, the culture of going to doctor for annual/regular controls, not just when you have a problem)

Other (unclassified)

- education
- influence of the media
- pharmaceutical corporations
- hospitals
- gender roles/relations
- hormones
- the practice/habit of going to the physician (esp. for ob/gyn)
- natural/normal vs. unnatural/abnormal
- tests and other diagnostic tools

Appendix 2
Examples of Ordered and Messy Situational Maps

Ordered Situational Map – 08.23.06

INDIVIDUAL HUMAN ELEMENTS/ACTORS

Erdogan Ertungealp

Ob/gyn specialists

Other doctors

Menopausal women

Pharmacists

Drug reps

Derya Baykal

COLLECTIVE HUMAN ELEMENTS/ACTORS

EMAS

TMOS

TTB

ISMEK and other courses

Sultans of Menopoz

Pharmaceutical Companies

- producing hormonal drugs

- producing other drugs

DISCURSIVE CONSTRUCTIONS OF INDIVIDUAL AND/OR COLLECTIVE HUMAN ACTORS

“menopoz teyze”

myth of the menopausal housewife with too much time in her hands

“keeping busy” as a way of dealing with menopause

taking HRT to go on with your life and work

“educated/conscious” vs. “uneducated/unconscious” patients

suffering as an aggravating factor for menopausal symptoms

masculine culture of ob-gyn world

HRT as replacing what disappears in body

“others” as important for seeking relief from menopausal symptoms

“media terror”

Menopausal women talking too much and irrelevant

Doctors yelling at patients

Doctors as untrustworthy

Patients getting aggressive and demanding in time

POLITICAL/ECONOMIC ELEMENTS

Insurance coverage for drugs used in menopause

Rivalry between pharma producing different drugs (hormones vs. others)

Difference in socioeconomic status of menopausal women

Privatization causing the “father state” to disappear

Closing of SSK and agreements with private hospitals as AKP government’s attempt to benefit their own people

Lack of regulation for private hospitals

Different doctor-patient relations in public and private hospitals

TEMPORAL ELEMENTS

WHI Study

Merging of public health insurance (SSK hospitals becoming public hospitals)

Private hospitals

Declining public health spending/privatization of healthcare

Urbanization

Changes in life style

MAJOR ISSUES/DEBATES (USUALLY CONTESTED)

Menopause as natural vs. needs treatment

Menopause as a natural process yet still needs treatment

Menopause as the end of womanhood or start of a new period

Standard vs. individualized treatment

Risk benefit analysis

WHI Study results

The length and type of treatment

HRT for protection or symptoms

Expectations from doctor visits

OTHER KINDS OF ELEMENTS

The concept of time

Keeping track of patients: control?

Communication of risks and benefits

NONHUMAN ELEMENTS/ACTANTS

HRT

Osteoporosis

Menopausal symptoms

Menstruation

Mammography

BMD measurement

FSH/blood tests

CVD

Cancer (breast, endometrium)

Weight gain

IMPLICATED/SILENT ACTORS/ACTANTS

Non-menopausal women

Relatives, husbands and children of menopausal women

Friends of menopausal women

TV programs for women

Newspapers

SOCIOCULTURAL/SYMBOLIC ELEMENTS

Traditional gender roles

Employed women vs. housewives

“Shame” as an element in not talking about menopause

Gender segregation

Menstruation as a positive thing

SPATIAL ELEMENTS

Waiting rooms

Public hospitals

Private hospitals

University hospitals

Menopause Polyclinics

RELATED DISCOURSES (HISTORICAL, NARRATIVE, AND/OR VISUAL)

The need for education in Turkey

Successful aging

Quality of life

Medical hierarchy

Medical expertise boundaries (other docs scaring patients about HRT, etc.)

The ideals of modernization

The language of medical institutions

Messy Situational Map #2

02.07.06

time (waiting)
waiting rooms
modernization
Media terrain
dress-being covered
HFE study
husbands
surgical mas.
statistics
quality of medical care
trust
doctor-patient relations
aging
protection
employment
public hospitals
osteoporosis
sun exposure
weight gain
complaints
"menopoz teje"
private hospitals
other women
EMMS
children
menopause
pharmacies
quality of life
nurses
vasomotor symptoms
families/relatives of mas.
medical practice
HRT
Erdgen Erdgenly
menopausal women
talking too much/nonsense
education
CVD
medicalization of mas.
drug representatives
"shame"
friends of mas.
pharma companies
menstruation
ob-gyn specialists
documents
herbal treatments
menopause
risk-benefit analysis
breast cancer
"leaky lung"
TV programmes for women
"natural"
headache
other doctors
"sultan of menopause"
health insurance
"consciousness" (Sims)
off-label prescribing
"conscious" women
rivalry b/w. doctors
macrography
Socio-economic status (income, place, volume)
non-hormonal therapies
medical hierarchy
MED
mapping of public health issues
globalization/postmodernization
medical education
exercise
private practice
traditional gender roles
communication problems
"habul paini"
arts & crafts courses
misinterpretation