THE HEALTH-RELATED BEHAVIOURS OF WOMEN AT MIDLIFE

A QUALITATIVE INVESTIGATION OF THE HEALTH-RELATED BEHAVIOURS OF WOMEN AT MIDLIFE: PERCEPTIONS OF POWER AND CONTROL

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SALLY LANDON, B.A.

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AUTHOR: Sally Landon, B.A. (McMaster University)

SUPERVISOR: Professor V. Walters

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Abstract

This research examines women's ways of understanding health and illness as well as their means of maintaining wellness. It attempts a women-centred approach to explaining health behaviours. The research consisted of in-depth interviews with seven women from Southern Ontario between the ages of 50 and 70. A grounded theory approach guided the analysis. The study shows that perceptions of power and control may be at the root of many attitudes toward health care and various health behaviours. By researching health issues from women's perspectives, this research provides a glimpse of the way these seven women experience midlife, and suggests the existance of perspectives that differ from mainstream views on health and illness. It further demonstrates how theories of agency can be used to shift the focus of sociological research from over-socialized accounts of health-related behaviours to more empowering, woman-centred explanations. It shows that women strive to maintain control of their health and that they pursue wellness in a manner that enables them to keep that control.

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1. INTRODUCTION: WOMEN'S PERSPECTIVES ON HEALTH AND ILLNESS AS A STARTING POINT IN HEALTH RESEARCH

As researchers continue to unlock the mysteries of growing older, one thing appears to be certain: the choices that we make regarding our health greatly affect how we age (Doress-Worters & Siegal, 1987). Health choices are made within a social context which moderates and shapes them. Recently, health research has focused on the social and cultural barriers to good health but has glossed over the actual decision-making process from the patient's perspective. As women age, we may face challenges which typify the experience of being female in Western society. Chronic disease, as well as caregiving responsibilities, and insufficient income, to name a few, are conditions which often emerge during midlife and affect eventual health outcomes. Women actively navigate their way through this life stage, interacting with their environment and making decisions which have far-reaching effects on their health. At midlife, more than ever, researching women's health behaviours and the factors involved in the decision-making process are integral to improving our understanding of aging women's health as well as developing more effective health care services.

Some feel that the nucleus of women's health research is the belief that women's wisdom of their bodies is valid knowledge and we must question the assumptions of health care systems that tell us otherwise. In Canada and the United States, our medical systems have developed alongside the drug and technology industries. Emphasizing expensive cures and neglecting preventive measures has become the earmark of Western biomedicine. Although highly acclaimed in the area of saving and maintaining lives, our health care systems are not adept at promoting wellness. For Doress-Worters and Siegal (1987), women are:

> caught within the confines of an impossible health care system, filled with absurdities and based on an economic underpinning that distorts it into grotesque shapes (xii).

Midlife marks a time when many women re-enter the health care system; for some it is the first time since child bearing (Bidikov & Meier, 1997). The imposition of a medical model that speaks *for* women has bred mistrust and discontent. Promoting knowledge and wellness through this life stage must begin with an understanding of women's ideas of health and illness, how they manage their health, and what they desire from a health care system.

Currently, women's behaviours pertaining to their health are poorly understood. The medical literature limits its exploration of health behaviours to the issue of compliance. From a medical perspective, when patients choose not to follow a recommended treatment, it is an act of deviance and is considered a major problem in health care (Hunt, Jordan, Irwin, et al., 1989). Reasons found in the literature for patient noncompliance range from discontent with the recommended treatment and discrepancies between lay and professional understandings of health to misunderstandings in doctor-patient interaction.

Most doctors consider it a patient's duty to comply with the prescribed treatment and grossly underestimate the rate of noncompliance (Freund & McGuire, 1995). In fact, one study estimates that 20 percent of prescriptions are never filled and that 30 to 50 percent of medications are taken incorrectly (Freund & McGuire, 1995). What is missing from the literature is an explanation for these and other types of health behaviours from patients' perspectives.

Doctor-patient interaction is mediated by social forces which do not enhance the medical encounter for women. However, we know little about women's experiences in doctor-patient relationships and how this affects their choices to accept or reject medical advice. When a woman seeks medical attention from a physician, there is an 81 percent chance that her physician will be a man (Anderson, 1993). According to Anderson (1993), "[w]omen's health care is intricately interwoven with the power of men in medicine and with the profit structure of modern medicine" (208). She claims that the doctor-patient relationship is likely to emulate gender relations in society and that male doctors' views of their female patients are socially conditioned. For example, one 1970 study involving psychiatrists, psychologists, and social workers revealed that their concept of healthy women was that they are "submissive, non-independent or adventurous, unaggressive, easily influenced, excitable, easily hurt, emotional, conceited about their appearance, and not objective" (Anderson, 1993:209). Furthermore, studies have indicated that physicians prefer passive patients who unquestioningly accept their decisions (Ryan, 1994). It is reasonable to surmise that social conditioning has a direct effect on physicians' and other health care professionals' treatment of female patients and, conversely, on women's experiences with medical care.

In light of recent policy developments, it is especially appropriate at this time to research health concerns and needs from the viewpoint of the patient. Given that women access health services more than twice as often as do men (Rosser, 1994), policy change in primary care[1] could be considered a women's issue. Health care reform in Ontario will be initiated in the near future as a pilot project designed to test a new model for primary care delivery. According to OMA president, Dr. William Orovan, the new approach to health care is designed to strengthen the doctor-patient relationship which is the "fundamental linchpin of health care delivery and medical services delivery in Ontario" (Orovan, 1998). To do this, the OMA, in conjunction with the government, has developed a plan (called "rostering") whereby patients sign an agreement with their physician which entitles them to medical care and services including access to information via a 24 hour 1-800 number staffed by medical personnel. In return, patients must promise to seek "the overwhelming majority" of their health care services from the contracted physician. Physicians are to be the gatekeepers to all other health services, including alternative therapies. According to Orovan (1998), "physicians should be the health care navigators...to help guide patients

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[1] According to the Ontario Medical Association (OMA), 'primary care' is a service that promotes health and prevents illness. It may be delivered by such health care practitioners as physicians, nurses, dieticians, physiotherapists and others. It is considered the foundation of the health care system. Examples of primary care services include: breast examinations, health information, vaccinations, prenatal care, nutritional counselling, some mental health services, palliative care, and treatment and care in the physician's office. (OMA website)

through this, and...treatment should be based on scientifically based principles." In effect, the proposed reforms will bolster the authority and dominance of physicians and medical science, diminish the decision-making power of the patient, and place some alternative health services out of reach. Considering the impact that this new model of health care delivery may have on middle-aged women re-entering the medical system, research which focuses on patients' perspectives is important and timely.

My focus on health research is a result of working for a family physician in a primary care facility. My experience in a setting where health practitioners' endeavours to meet the needs of patients were structurally bound by the very tenets of mainstream medicine has inspired my interest in research down this path. My disappointment at the lack of interest in lay perspectives in medical literature combined with my feminist orientation and respect for women's ways of knowing and traditional healing has strengthened my resolve to initiate my own research. This qualitative exploration of women's perspectives on health, illness, and primary care is an attempt to fill some of the gaps that I have perceived.

This project began during my summer doing research for Walters. I searched the literature for information on women's health at midlife and I interviewed 7 women in order to understand their perceptions of health and illness. What fascinated me about the interviews was the complexity of the health management strategies that these women employed. My experience working in a medical clinic where patients present with symptoms and leave with a diagnosis and a prescription had not prepared me for the prevalence of this "hidden health care system."[2] I became interested in understanding why patients do not simply consult their physicians and follow the recommended treatments, and what informs their decision-making process.

I chose a grounded theory method in order to let the data direct the research. The interviews were designed to cover a broad spectrum of women's health issues and encourage the participants to talk about their own concerns, ideas, and health care needs. This method of discovery is revealing because it allows the voices of the participants to be heard; their words and language can reveal some attitudes and beliefs that other types of research miss. During the analysis, I focused on what I perceived as patterns of health behaviours which indicated that primary care services were only a small aspect of health modalities, treatments, and therapies that these women tap into. I directed my analysis at understanding these behaviours from their perspectives.

The women interviewed had many ideas about health and health care. Most interesting is that none of them defined health as the absence of disease, the definition that is associated with mainstream medicine. Furthermore, no one suggested that their physician should be their navigator through the health care system making decisions on everything from the treatment of disease to the use of alternative health modalities. In fact, if anything, the converse was true: the women desired enough information to make their *own* decisions on the health care approaches which best suited their lifestyles.

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[2] Freund and McGuire (1995:174) use the term "hidden health care system" to describe the health seeking process whereby patients attempt to maintain their health outside of health institutions.

This thesis looks at health care from the patient's perspective. It examines health behaviours from the standpoint of the women participants. It looks at issues of agency, power, and control from the patient's viewpoint and explores how these factors underlie the health behaviours in question. Further, it looks at how one sample of women responds to mainstream medical services currently, and considers their visions of optimum primary care delivery.

Chapter two provides an overview of several literatures which helps to frame the exploration of women's health behaviours. First, the literature on different aspects of aging covers medical research on the physiological and psychological risks to aging women, as well as the social influences on health at midlife. The medicalization literature discusses the underlying assumptions of mainstream medicine in its approach to women's health and the implications this has for women's wellbeing. The literature on agency looks at women's position in society in relation to mainstream discourses and how this is epitomized in the doctor-patient relationship. Finally, a brief look at a growing body of literature which frames women's health within the context of their lives is characterized in an attempt to illustrate how social factors affect the decisions women make regarding their health. Together, these literatures provide a backdrop for the focus on women's health behaviours.

The medical literature tends to focus on age-related physical and psychological changes in isolation from social factors. It looks at diseases that are common in aging women and discusses their frequency, etiology, and treatment. Coupled with this is a body of medical literature which frames women's health problems in a social context, discussing issues such as the links between aging, poverty and subsequent ill health. In general, this literature tends to emphasize the stereotype of maladjustment and ill health in middle-aged women. It also fails to adequately explore the scope of women's midlife experiences. Rather, it provides only a partial view of women as wives and mothers. Although there is a body of literature that looks at women's experiences of aging, I chose to use this medical perspective because it contributes to our understanding of the predominant views of aging in society insofar as medical science informs popular opinion. Secondly, since women's perceptions of power and control are often described in relation to their doctors, this literature contributes to that analysis by highlighting the disparity between lay and medical perceptions of aging. Thirdly, this body of literature includes studies which give us an idea of the types of ailments associated with aging.

The medicalization literature focuses almost exclusively on social structure, presenting a comprehensive and useful critique of mainstream medicine. In doing so, however, it underrepresents the role of women as resistors of medical dominance as well as agents in their own oppression. The literature on women's agency offers an account of women's ways of manoeuvring through life on the margins. It helps construct a vision of action and participation from women's position in society. Unfortunately, the theory of agency has seldom been applied to the doctor-patient relationship, thus limiting what this literature tells us about women's health behaviours. The articles on women's health vis-à-vis their social situations are excellent illustrations of the extent to which women's decisions regarding their health are influenced by their family arrangements and socioeconomic status. This literature demonstrates the importance of considering social context, but its generalizability is limited. To a great extent, these literatures fail to consider women's health behaviours and the decision-making process, thereby falling short of developing an understanding of this activity.

Chapter three provides a more detailed account of the methodology. Since my research assignment was to research women's health from their own perspectives, I began by conducting in-depth, exploratory interviews with seven women and recorded their responses verbatim. The women were between the ages of 50 and 69[3] and lived in or around small towns in Southern Ontario. They graciously gave of their time and provided rich, thoughtful interviews. It was the quality of the data which allowed me to pursue my own ideas in this research. In order to preserve the integrity of their insights, positions, and thoughts, I allowed the interviews to guide the analysis through the "grounded theory constant comparison method" (Glaser & Strauss, 1961) in which data is broken down into incidents or moments and compared until clear categories emerge. The categories are then used to explain the research question at hand. Quotes from the interviews are printed throughout chapter four in order to let the results of this research unfold through the women's own words.

In chapter four, the findings are presented in relation to the analytic themes I identified. These themes are characterized and illustrated with quotes. Although I strove to

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[3] Ages 50 to 69 are used in this research as the parameters denoting 'midlife' because they span the decades when women experience a number of transitions in their work and home life.

remain true to the women participants, this chapter, and the analysis in general, is a product of my interaction with the data and, as such, is permeated with my own conceptions based on previous experiences. I have attempted to capture the essence of the women's voices with many quotes in the hope of limiting my manipulation of the data.

Chapter five discusses issues of women's agency, power and control in relation to health. It looks at the social context of the doctor-patient relationship and the cultural biases in medical practice and attempts to explicate the health behaviours of the women participants in this light. It discusses the ways in which women strive to maintain control of their bodies and of their health, sometimes in opposition to medical recommendations, and how we can use the theory of agency to account for these health behaviours as well as offer more positive and woman-centred interpretations. Finally, the implications for future research and policy recommendations are explored.

Research on women's health needs to bring women's standpoint into the spotlight. Improving screening techniques and medical therapies does little for women who choose not to use them. Understanding how women decide on different courses of treatment is paramount to developing treatments that are of use to them. Additionally, understanding what women want in primary care is a necessary part of developing more effective primary care delivery. Medical research has focused on health care from a medical standpoint and neglected to consider the views of those it affects the most: the patient. Optimizing the health of women in midlife necessitates research from their own perspectives.

The value of this research is that it provides a glimpse of the ways in which women negotiate life from the margins. It provides a cross section of life from the perspectives of seven women allowing the reader to consider the underside of the social hierarchy, the ways in which women vie for control over their lives amid structures of power. It contributes to feminist and sociological literatures on women's health and adds to the accumulating voices in women's health research. Although its generalizability is limited, its value is that it adds a dimension of women's experience to existing research and may serve as a catalyst for future research in this area. It encourages further investigation into women's perspectives so that their insights and wisdom can inform and improve health care delivery.

2 REVIEW OF THE LITERATURES ON WOMEN'S HEALTH, MEDICALIZATION, AGENCY, AND CONTEXTUAL MEANINGS OF HEALTH

Several bodies of interrelated, overlapping health literature are relevant to the study of middle-aged women's health behaviours. First, the literature on structural and physiological factors affecting health at midlife includes medical and sociological research on etiology, disease, and social structures that are known to be important determinants of health outcome in aging women. Second, the literature on medicalization is comprised of sociological and feminist critiques of medical science and its history of pathologizing women's normal bodily processes. Third, the literature on women's agency involves general theories of the agency of marginalized people as well as literature on the agency of women as patients. Lastly, the literature on the contextual meanings of health and wellbeing looks at individual women's experiences and viewpoints regarding their health. These bodies of literature will be covered in an attempt to develop an understanding of the physiological and social processes influencing the health and health behaviours of midlife women.

The literature on physiological and structural factors reflects ongoing medical research on aging as well as sociological research on aging in a social context. The medical research covers morbidity, mortality, and the onset of chronic disease during midlife, while the sociological literature reveals that ill health does not occur in a vacuum. Ageism, employment discrimination, education, gender socialization, and societal expectations of women are shown to be important determining factors of health and wellbeing. This literature is important to enhance our understanding of the position of middle-aged women in relation to the various social conditions that may present themselves at midlife and how this plays out in terms of the choices they make concerning their health. And perhaps even more importantly, it exposes the myth of the normal aging process,[4] making it clear that all aging occurs within a social context and, for women, this context can be particularly treacherous.

The medicalization literature explains the unique position of women in relation to the medical system. It traces the development of Western medicine and the reasons for its rise to power. It explains that, as a male dominated system, it has constructed women as 'other' and pathologized the aspects of women's bodies that differentiate them from men. It argues that reproduction and sexuality have been targeted by medical science as aspects of female health in need of medical regulation and control. Feminists are critical of medical hegemony and its claims to knowledge of the female body. This literature embodies that strong critique. It is important in this research in order to understand the position of Western medicine on the female body, the social distance between women and their doctors, and the experience of being a woman in a male dominated system. It enhances our

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[4] Hunter and Sundel (1994) claim that negative images of aging have served to normalize social problems such as poverty and its associated ill health, thus leading to the myth that midlife is a negative life stage.

understanding of the ways in which the medical system might influence women's health behaviours.

The literature on women's agency is used here to balance the medicalization literature. It covers general theories of power and agency, suggesting that, by virtue of their position at the margins of a male dominated medical system and society, women adopt an agentic stance as a matter of survival. This literature also explores evidence which counters the myth that women are passive victims of medicalization. Indeed, we learn from this literature that women are far less medicalized than the medicalization literature purports. This literature is crucial to our understanding of women's capability to act and mediate their position in and around the social hierarchy. It is central to our understanding of the nature of women's health behaviours.

Finally, the literature which locates health in the context of women's lives covers a small but growing body of literature that is concerned with individual women's perspectives on their health. The studies reviewed here illustrate how social structures affect the health and life choices of different women. This review is helpful because each study shows how the social structures and physiological risks delineated in the previous reviews play out in terms of individual health, choices, and behaviours. Dimensions of women's lives not adequately mapped out by quantitative data are useful in helping us to understand how different women make the choices that they do. Although it is limited in size and generalizability, it is an effective illustration of how social context affects health behaviours.

SETTING THE STAGE: STRUCTURAL AND PHYSIOLOGICAL FACTORS AFFECTING HEALTH AT MIDLIFE

It is impossible to build an understanding of the health behaviours of middle-aged women without first having an idea of the conditions that are unique to this life stage. This body of literature identifies the physiological risks to postmenopausal women as well as the social and economic context within which health is determined. This review will attempt to present a well rounded picture of the landscape at midlife to give the reader an idea of the position in which women in their 50s and 60s find themselves. It is important to our understanding of health behaviours because it illustrates the circumstances under which women strive to maintain wellness. According to the literature, middle-age is a critical period in the life cycle because of the onset of chronic disease and structural barriers to healthy living that present themselves. How a woman navigates her way across this midlife terrain will have a bearing on her health and situation in old age.

From the literature on the health of aging women we learn that midlife is a time of changing economic, social, and familial relationships as well as a time of great physiological transformation. Retirement, divorce, aging parents, grown children, the death or illness of a spouse, and cultural views on aging are just some of the factors which influence women's experiences. Combine this with the physiological milestone of menopause, as well as the appearances of the first manifestations of chronic diseases such as arthritis and heart disease, and it can be gleaned from this literature that midlife is a pivotal stage in the life cycle.

Socioeconomic location is a significant determinant of health at midlife according to the 1990 Ontario Health Survey. As reported by Roberge, Berthelot and Wolfson (1995), the survey revealed that education is the strongest predictor of health for all age groups. Household income was also associated with health status, as was main activity. Those who were gainfully employed, according to the survey, reported better health status than those who were not employed. Hence, women whose main activity was housekeeping reported poorer health than women who were employed outside the home. Benefits of employment, however, are contingent on the type of work. Women in professional positions reported better health than women in both skilled and unskilled jobs. Although married people have a longer life expectancy than single people, older women (45 and over) who were single reported better health than married women. Roberge, Berthelot and Wolfson (1995) claim this phenomenon may be explained by the fact that single older women tend to have higher levels of education than married older women. Also, this category (single women) does not include separated or divorced women, who reported poorer health than their married counterparts. Although crossing many age groups, this health survey is helpful in delineating the connections between socioeconomic status and health. Looking at the socioeconomic conditions of middle-aged women, then, will shed light on the particular circumstances that impede women's pathways to wellbeing.

This body of literature reveals several factors which threaten the socioeconomic status of women at midlife making this life stage particularly perilous for some groups of women. According to Butler and Weatherley (1992), middle-aged women in general have lower rates of poverty than younger or older age cohorts. However, middle-aged women living alone have a significantly higher poverty rate than either the older or younger age cohorts. In fact, the numbers of homeless women in the U.S. have grown from 3% to 45% of the homeless population in just 3 decades (Butler & Weatherley, 1995). Unfortunately, the authors represent women as one homogeneous group, thus overlooking the effects of race and class on pathways to poverty and homelessness. We do not know to which women they are referring. In their research on homeless women, Butler and Weatherley (1995) found that life events common to women's lives can lead to poverty and homelessness. Marital separation, abusive relationships, illness, and employment discrimination were all found to be factors which led to the homelessness of the women they interviewed. Divorce, the death of a spouse, and job discrimination are obstacles particularly relevant to middle-aged women and threats to their socioeconomic status. The social conditions which threaten socioeconomic status emphasized in these studies are often associated with middle-age in the literature.

Women's socialization as caregivers, wives, and mothers, according to the literature, leaves them vulnerable to poverty in midlife. In research on age cohort and the "empty nest" by Adelmann, Antonucci, Crohan, et al., (1989) women growing up in the 'feminine mystique' era (1950s) were found most likely to have remained at home raising children than to have pursued a career and economic independence. Furthermore, midlife, in the literature, is portrayed as a critical time for married couples due to changes such as retirement and the launching of children. Consequently, according to Gullette (1995), many marriages end during midlife. From Butler and Weatherley's (1992) research, we learn that, on average, a woman's standard of living drops by 73% after divorce, while her ex-husband's increases by 42%. Women who have been married the longest, middle-aged women, are reported by Butler and Weatherley (1995) to suffer the most after divorce because of their lack of job skills and experience, and because of discriminatory hiring practices. Women brought up in the 1950s may face risks during midlife due to the infusion of nuclear family values which may have limited their education choices and influenced their vocational plans, thus leading them to marriage and economic dependence.

Additionally, women socialized to be wives and mothers can suffer from depression at midlife due to changing roles (Bromberger & Matthews, 1996). Findings in the research of Adelmann, Antonucci, Crohan, et al. (1989) also state that how middle-aged women experience the "empty nest" is related to their socialization or early influences. The emphasis on family values and the cult of motherhood in the fifties is implicated in the higher rates of depression, identity crises and deteriorating health of women in this age cohort. Women in the age cohorts ahead or behind them were found to fare better. Explanations for these observations offered by the authors are that women in the earlier cohort were encouraged to work outside the home during WWII, and women in the later cohort benefitted from the second wave of feminism in the sixties and subsequent liberation from the 'feminine mystique.' Interestingly, studies of personality across cohorts show more self-achievement themes in this later cohort of women (Helson, Stewart, & Ostrove, 1995). Adelmann, Antonucci, Crohan, et al. (1989) predict that women entering midlife now - the women whose early influence was the feminist movement of the sixties - will make a healthy transition through the empty nest and into midlife. But for older women, midlife may pose changes in social relationsips with which they are ill equipped to deal.

Women's socialization as caregivers also poses risks to their socioeconomic status as it affects their ability to perform other roles in the paid labour force and the community (Doress-Worters, 1994). One study showed that 20 percent of people between the ages of 65 to 74 need help with at least one household task. This increases to 33 percent and 55 percent for ages 75 to 84, and 85 and over, respectively (Doress-Worters, 1994). Services daughters provide to their mothers and mothers-in-law range from looking after financial affairs, making and taking them to appointments to keeping their houses and selves in order and giving emotional support (King, 1993). Caregiving consumes so much of women's time that an 8% drop in employment rate for women over 54 is directly attributed to only two factors: elder care responsibilities and discrimination in the work place (Doress-Worters, 1994). The toll this responsibility takes plays out in terms of women's health. Women often develop anger and resentment over what they perceive to be a sacrifice of their time and resources for their mothers (King, 1993). Guilt, stress, fatigue and anxiety are also commonly expressed feelings of care-giving daughters (King, 1993). Martha Keniston Laurence (1992) argues that women bear the brunt of insufficient health care funding and modalities of health care based on outdated, stereotypical female gender roles. There is a significant lack of health care funding for hands-on types of caring, and women find themselves filling the gaps. As women approach midlife, the chance that they will take on caregiving responsibilities for aging parents and in-laws drastically increases.

Studies have recently begun to dispel what they claim to be the myth of the depressed middle-aged woman maintaining that focusing on women's multiple roles and burden of caregiving may magnify the negative aspects of aging. The 1994-95 Canadian National Population Health Survey (NPHS), showed that the rates of depression actually declined with age for both men and women and that the lowest rates of depression were found among those who are retired (Beaudet, 1996). According to Woods and Mitchell (1997) younger women suffer higher levels of depression than midlife women, but because their depression does not coincide with any major physiological event, it has not received the attention that is given to depression around menopause. Furthermore, the authors contend, the stereotype of depression in midlife is a result of studies which show that depression in this age group often occurs around menopause. This has prompted research into hormonal changes as the source of the problem. Recent studies have shown, however, that changing hormone levels are generally not associated with midlife depression (Woods & Mitchell, 1997). Although the literature contends that there are many reasons for women to be depressed during midlife, some researchers are arguing that the data do not support the myth of the depressed middle-aged woman.

Based on the Seattle Midlife Women's Health Study, a stressful life context and poor health have the most explanatory validity for depression in midlife women (Woods and Mitchell, 1997). Stress alone is the main factor in predicting depression (Woods and

Mitchell, 1997). The National Population Health Study found that traumatic events in childhood or early adulthood were associated with higher rates of depression in both sexes, but when all other variables were controlled for, this was only found true for women (Beaudet, 1996). Determining whether depression poses a threat to middle-aged women is difficult from the literature. It is often contradictory, focusing on pathways to depression at midlife, yet producing data that suggests this focus is not warranted.

More tangible than midlife depression are threats to middle-aged women's marriages and employment which have real implications for health, according to the literature. Studies have shown that married women are healthier at midlife than unmarried women implying that marriage is beneficial to health. However, the effect of marital status on health is confounded by several factors. First, employment buffers the beneficial effect of marriage for women (Waldron, Hughes, & Brooks, 1996). When all other factors are controlled for, marriage was found to be beneficial to the health of unemployed women only (Waldron, Hughes, & Brooks, 1996). In other words, the material and social benefits of marriage are relevant only for unemployed women because their employed counterparts gain these benefits through work (Waldron, Hughes, & Brooks, 1996). Furthermore, it is found that widowhood, separation and divorce bolster the beneficial effect of marriage on health. Since women often suffer from poverty and the declining health associated with it after losing a spouse, marriage, in comparison, appears to have great health benefits (Waldron, Hughes, & Brooks, 1996). However, as mentioned above, it was found in the 1990 Ontario Health Survey that never-married women over 45 experienced better health than married women in this age group (Roberge, Berthelot, & Wolfson, 1995). These studies show that the beneficial effects of marriage are linked to financial resources and social support. When employment is substituted for marriage, middle-aged women report better health. Regardless of whether benefits to wellbeing come from employment or marriage, middle-aged women face threats to both due to caregiving responsibilities, age discrimination in hiring practices, interruption of career for childrearing, disability, the death or illness of a spouse, or divorce.

It is important to recognize that not all employment is beneficial to health. The literature reminds us that women's employment experiences are diverse. Health benefits from employment are contingent on many variables. For instance, personal control over the work situation or "mastery" as it is sometimes called, contributes to the health preserving effect of employment (Frankenhaeuser, 1991). This implies that women in managerial or professional types of jobs benefit from employment while women in lower income factory, service industry, or clerical types of jobs may not. Furthermore, since women's work in the home has remained relatively unchanged over the years, her total work load increases with full time employment (Frankenhaeuser, 1991). Without the stress-relieving effects of managerial or professional positions, women's double day merely increases the negative effects of role strain. Studies of upper-middle-class white women in professional, managerial, and administrative positions show significantly lower cholesterol and blood sugar levels (Kritz-Silverstein, Wingard, & Barrett-Connor, 1992) than studies which include working women from diverse socioeconomic, ethnic, racial, and educational backgrounds (Ickovics, Morrill, Meisler, et al., 1996). The benefits of employment must be considered within the context of women's lives. For some groups, employment offers social support and an escape from the stress of other roles. For poor, unskilled and less educated women, employment actually increases the risk of heart disease and obesity (Ickovics, Morrill, Meisler, et al., 1996). Additionally, it is believed that metabolic changes associated with menopause contribute to hypercholesterolemia in middle-aged working women (Ickovics, Morrill, Meisler, et al., 1996). The postmenopausal years see the need for changes in lifestyle which may not be possible for working women. The structure of the typical work place does not accommodate the exercise and dietary change necessary to keep postmenopausal workers healthy (Ickovics, Morrill, Meisler, et al., 1996). The health benefits from employment are contingent on the type of work, which is often contingent on the education level and socioeconomic status of the worker. For a variety of reasons already mentioned, finding managerial and professional types of jobs at this stage of life may be impossible, thus making pathways to wellbeing more difficult for middle-aged women.

The leading causes of death among 45 to 64 year old Canadian women, according to Wilkins (1995), are lung and breast cancers. Since lung cancer is largely preventable and 95% of breast cancers can be cured if detected early (Lee, 1995), social situation is important to understanding why middle-aged women die from these cancers. Many studies have shown that smoking, living with or working around smokers, poorly ventilated work environments, working with hazardous materials, the location of low cost housing near the industrial sectors of cities, education, and access to health care facilities and health information are all factors which influence one's chances of premature death due to lung or breast cancer. Wilkins' research does not speculate on connections between the cancers and socioeconomic status, but it is impossible to dismiss risk factors such as those mentioned above. The increased chance of poverty in middle-age for women increases their vulnerability to situational and environmental hazards.

Middle-aged women are not alone in terms of cancer risk, but what differentiates them from men is that they are more likely to be afflicted with one or more disabling chronic diseases as well, for example, diabetes, hypertension, arthritis, and osteoporosis (Danello, 1987). As a result, chronic pain is shown to take a drastic leap for women, Statistics Canada shows, in the 45 to 64 year old age group (Miller, 1996). Additionally, the 1994-95 Canadian National Population Health Survey showed a connection between chronic pain and drug use (analgesics, sleeping pills, antidepressants, tranquilizers, and narcotics) which consequently increases the risk of falls and osteoporotic fracture (Miller, 1996). Furthermore, women who are chronic pain sufferers report mental distress 44% more often, and sleep disturbances 30% more often than women with no chronic pain (Miller, 1996). Suffering from chronic diseases significantly complicates the lives of aging women and makes the midlife experience distinct from that of men.

It is clear from the literature that some doctors agree that women lack continuity of health care. Typically, women seek care during the child bearing years and then perhaps not again until they experience problems in midlife (Bidikov & Meier, 1997). By this time, it may be too late to intervene with preventive measures against chronic conditions. Bidikov & Meier (1997), doctors at New York's Mount Sinai Medical Center, recommend that all doctors use women's random visits for minor complaints as opportunities to identify risk factors and diagnose the early onset of chronic disease. Specifically, they suggest assessing younger women for the risk of osteoporosis, depression, heart disease, cancers, and domestic violence whenever the opportunity presents itself.

A survey of the health concerns of midlife women by the Midlife Health Center in Cleveland Ohio found that nutrition, weight, stress, menopause, osteoporosis, and finances were the primary problems middle-aged women worry about (Kennedy and Comko, 1991). Moreover, the women surveyed claimed that they visited their doctors for overt problems only and not for preventive care. In fact, they ranked their doctors second to books, the media, family, and friends for sources of health care information. The women reported that not having enough time, and not knowing what health services were available to them were the biggest roadblocks to obtaining adequate health care. Kennedy and Comko (1991) argue that there is a problem disseminating health care information. But like Bidikov and Meier (1997), they believe that women presenting to their physicians for disease care should be "captured" for preventive care. Research on the health behaviours of middle-aged women is important to understanding why women do not seek preventive care from their physicians and how they feel about the strategies developed by doctors like Bidikov and Meier (1997).

Nechas and Foley (1994) maintain that there is a bias in health research on older women's issues and that this is one explanation for the deficit of information on midlife women. They refer to the Baltimore Longitudinal Study of Aging (BLSA) as a typical example of women's exclusion from clinical research. Launched in 1958, this study involved approximately 1,400 male subjects only. Four hundred women were recruited some twenty years later but very few of them were over 40. The first report the BLSA published was entitled, "Normal Human Aging" although women were mentioned only once in a statement explaining why they were excluded from the study for so long (Nechas & Foley, 1994). This research indicates that since women live, on average, 7 years longer than men, make up 2/3 of the elderly population and nearly all of the people over 85 (Nechas & Foley, 1994), clinical research on the etiology of diseases that afflict and severely affect the lives of women beginning in midlife is critical to filling the gaps in knowledge about women's health.

For Rosser (1994), the recent attention given to research on women's diseases tends to focus on conditions which are analogous to the conditions which threaten men's health. She argues that this ignores or diminishes the magnitude of chronic, debilitating diseases that primarily afflict women. Women's cancers and heart disease research, for example, have recently received more equitable funding and great strides have been taken to identify the etiology and risk factors of these devastating illnesses (Rosser, 1994). Incontinence, a condition affecting almost entirely women, has received little attention, and until very recently, was considered an inconvenience or embarrassment rather than a medical concern

(Nechas & Foley, 1994). Research shows a strong connection between incontinence in later life and institutionalization (Statistics Canada, 1995). Chronic conditions like incontinence may be the deciding factors between independence and institutionalization (Nechas & Foley, 1994). Many women develop incontinence as a result of child birth, obesity, urinary tract infections, or side effects from medications. It is common, consequential, but virtually ignored in health research. When issues that pose threats to middle-aged women's health are glossed over by doctors and researchers, positive health outcomes for aging women are jeopardized.

From this literature we get an idea of the multi-faceted character of the landscape at midlife. The research described here attempts to identify the physiological risk factors middle-aged women face, as well as the structural conditions which shape and determine them. The medical literature outlines the problems associated with human female aging, while the sociological literature points to the social factors such as poverty and employment, sexism and ageism, that influence them. The psychological literature situates itself somewhere in between where it looks at the social factors associated with psyche development and the subsequent risk of clinical depression. This research sets the stage for further investigation into the health behaviours of women at midlife. Having constructed an idea of the circumstances under which middle-aged women find themselves pursuing wellness, it is fitting to consider the nature of the medical help they may enlist.

MEDICALIZATION

The literature on medicalization[5] makes up the bulk of sociological and feminist critiques of the mainstream medical paradigm in Western society. It is crucial to our understanding of the position of women vis-à-vis the medical system. Additionally, since this literature makes claims about the effects of medicalization on women, it indirectly, and sometimes directly, makes claims about women's behaviour and actions regarding their health. This review will characterize that research in an attempt to delineate the causes of medicalization, the implications for women's health, and the claims made about women's health behaviours.

The term 'medicalization' crept into sociological literature in the early 70s. It was initially used to critique psychiatry and the medical treatment of mentally ill patients. The process of medicalization became an important discourse in sociology about this time as many issues converged on this area. The literature reviewed here pertains to the development of medicalization and how it has affected women's lives. Several different but related explanations for the rise of medicalization are found in the literature. It is argued that medicalization is a result of the deliberate expansion of medical dominance by those in the profession within the larger context of the industrialization and bureaucratization of society, that people are now dependent on unnecessary medical care, that medicalization is

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[5] The term 'medicalization' was coined by Irving Zola and later popularized by Ivan Illich. See Zola, (1983) and Illich, (1976).

a means of social control, and that women's lives and bodies are subject to increasing medicalization because of the patriarchal structure of the medical system. Medicalization is by far the strongest critique of mainstream medicine and the largest body of sociological and feminist literatures on women and the medical system.

The literature on the origins of medicalization traces the rise of modern medicine over two centuries. Freund and McGuire (1995) state that it is easy to mistake the current "nature of medical practice as a cultural given," yet it is barely a century old (207). Along with Mitchinson (1988, 1991) they describe a radically different health care setting from the past: one hundred and fifty years ago, physicians were few among many lay and religious healers including midwives, barbers, pharmacists, herbalists, ministers, nurses, and bone setters. The practice of allopathic medicine, as it was named by the American Medical Association (AMA) in 1847, was characterized by invasive, heroic treatments such as leaching, bleeding, purging, blistering, and the use of powerful drugs (Freund & McGuire, 1995; Daly, 1978). Many people felt this approach to health was dangerous, and avoided it, opting for less drastic alternatives (Freund & McGuire, 1995).

Initially, allopathic medicine was not readily accepted. According to Ehrenreich and English (1973a), the very first health movement occurred between 1830 and 1870 as a backlash against invasive, heroic medicine. The movement emphasized prevention, hygiene, vegetarianism, education in physiology, and self-determination (Geary, 1995). The struggle between the new medical profession and traditional healers continued for a long time, with the latter, including female healers and midwives, gradually losing control over the management of health (Daly, 1978; Ehrenreich & English, 1973a; Findlay & Miller, 1994; Freund & McGuire, 1995). In their pursuit of medical dominance, the AMA perceived women's interests in practising medicine as well as alternative practitioners as threats to their integrity and barred them from entrance to medical schools (Geary, 1995). Patients were no longer referred to them and they were prohibited from practising in hospitals (Geary, 1995). Mitchinson (1988) recounts that in Canada, where few medical schools existed in the mid-nineteenth century, young men apprenticed with already established, licensed doctors for several years and then wrote their licensing exams. Because these orthodox[6] doctors had so much competition from a variety of other types of doctors (i.e. Homeopaths, Thomsonians, Eclectics[7]) and health care practitioners (i.e. midwives, traditional healers, etc.), they pressured authorities to legislate increased educational requirements for a medical licence. As a result, by the end of the century, licensing was limited to affluent urban men, since university was out of the question for the poor, the rural population, and for women. Although two Canadian universities began allowing entrance to women in 1883, the difficulties of procuring internships and setting up practice virtually ended women's pursuit of medicine. They were effectively kept out of the profession. These efforts created what Freund and McGuire (1995) called "internal

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[6] By 'orthodox' doctors, I mean those who adhered to the allopathic model of medicine which later became the dominant form of health care.

[7] According to Mitchinson (1988), a Homoeopath practices in diluted medicinal treatments, a Thomsonian in herbal remedies, and an Eclectic in a mixture of all systems, depending on which is most appropriate to the case.

professional cohesion and standardization" (p.208) and a relatively solid platform from which to denounce perceived quackery or any type of healing outside of their professional control. The AMA was so successful in their efforts that:

> ....in the early part of the twentieth century medical doctors had achieved virtually total professional dominance....[T]hey had successfully eliminated, coopted, or subordinated all competing health professionals, and had acquired a state-legitimated monopoly over the health care market in the United States (Freund & McGuire, 1995:207).

According to Mitchinson's (1988) account, the same could be said for Canada.

In the latter part of the nineteenth century, orthodox physicians bolstered their professional dominance by aligning themselves with science (Findlay & Miller, 1994; Freund & McGuire, 1995; Mitchinson, 1988).

> By defining itself as a scientific endeavour, then, medicine could claim privileged access to the truth about conditions and problems and argue that its approach alone was technical, objective, and bias-free. In short, medicine was able to share the prestige that contemporary society accorded to fields that presented themselves as rational, scientific enterprises (Findlay & Miller, 1994).

As increased knowledge of the human body became available, specialties developed which served to further fragment the human body and reduce it to the sum of its cellular parts (Mitchinson, 1988). This diversification and expansion of medicine was closely linked to the professionalization of medicine once it aligned itself to science (Mitchinson, 1991). Clearly, the prominence of the current medical paradigm with its focus on disease, intervention, and cures is a result of social, political, and economic processes. It is not the only approach to health yet it has become so entrenched in Western culture that it essentially determines health care as we know it and has major implications for how we experience health and disease.

According to Conn and Fox (1980), medical conditioning teaches us to view this biomedical model as a permanent fixture, not open to question. This conditioning reinforces the legitimacy of biomedicine as well as determines our approaches to health care. Advertising is one of the most powerful and insidious influences on our medical conditioning. Pharmaceutical companies have spent millions to make us think "ASA" when we feel a headache instead of searching out the cause of the headache or trying a relaxation technique. Doctors are influenced in this way as well. Pharmaceutical companies spend a great deal of time and money educating physicians about their drug cures while no one educates them about alternative or preventive therapies (Conn & Fox, 1980).

In the medicalization literature, it is argued that the widespread acceptance of the biomedical model has eclipsed our ability to appreciate other models including those that view the human body as a natural, healthy system (Conn & Fox, 1980). According to Conn and Fox (1980), when something changes or goes wrong, we revert to the biomedical model and seek the aid of medical professionals. We are conditioned to expect invasive, drastic measures that typically correct dysfunction quicker than letting nature run its course. Furthermore, Conn and Fox (1980) argue that drugs that must be regulated by law, dispensed by licensed professionals, and are costly, carry far more weight in a consumerist, capitalist culture than herbs that can be grown in the garden for pennies. It is also argued that this method of using strong drugs for therapy reinforces itself through the emergence of iatrogenic disease which in turn requires more drugs and intervention as treatment (Conn & Fox, 1980). Compound this with the increasing problem of drug-resistant bacteria, and we have a system which reproduces itself and augments professional authority at the same time.

In this literature, the biomedical model is portrayed as an ideology. It is described as a pervasive way of seeing the world that has definite repercussions. As a disease ideology, it locates the illness within the individual and develops its cures at the level of individual biology. One major outcome of this is what Ivan Illich (1976) coined the "medicalization of life." In effect, symptoms with social, cultural, and emotional roots lead not to change at the social, cultural, and spiritual levels; they lead to the medicalization of poverty, culture, the mind, etc. The physiological symptoms of socially produced ills are something doctors can treat at the individual level with drug cures and therapies, or Band-Aids. According to the literature, the underlying causes are typically never addressed. In essence, it is argued that doctors can treat depression, anxiety, and back pain, but they cannot treat the oppressive social conditions that may have caused them. This "disease ideology," as it is often referred to, is responsible for shaping the dominant approach to health in Western society, as well as the experiences of patients who choose to seek medical attention.

The literature agrees that when a condition becomes accepted by society as an illness and is moved into the sphere of medical control, medicalization has occurred. This expansion of medical jurisdiction is a process that occurs on the conceptual, institutional, and interactive levels, according to Conrad and Schneider (1980). They contend that, "conceptually", medicalization occurs when a problem is defined in medical terms using a medical model, for example, when a normal body process such as menopause is defined as a deficiency disease. 'Institutionally", medicalization has occurred when medical professionals legitimate an organization's work, acting as formal supervisors or gatekeepers. Alcoholics Anonymous (AA) is the example used by Conrad and Schneider (1989) to illustrate this level of medicalization. AA is an organization that is not run by physicians but is dependent on medical definitions of alcoholism to legitimate its operation. "Interactively", medicalization occurs when a physician gives a medical diagnosis for a patient's condition, or when a physician treats a social problem as a medical one. The example given is the prescribing of antidepressants for depression that is rooted in unhappy or oppressive family situations. Expanding medical expertise over different aspects of life, according to Findlay and Miller (1994), gave medical doctors the authority to speak on issues and matters previously not deemed medical territory. It gave them the authority to speak on issues of morality and behaviour such as birth control, sexuality, abortion, and social roles (Anderson, 1993; Daly, 1978; Freund & McGuire, 1995; Mitchinson, 1988 & 1991). Medicalization has significantly changed dominant perceptions of health and illness.

According to Findlay and Miller (1994), the values and organizational structure of Western culture make medicalization an effective tool for strengthening the cultural authority of medicine, increasing profits, and reinforcing physicians as agents of social control. The literature points to the rise of laboratory science in the first half of this century as the event that gave doctors the tools necessary to understand and define life events in terms of hormones, body systems, and cell activity (Freund & McGuire, 1995). This made the diagnosis and treatment of disease a skill based on privileged information and placed doctors in the esteemed and powerful position of defining what is healthy and what is illness, what is normal behaviour and what is aberrant. According to the literature, all that involved the body came under the control and authority of the medical profession which augmented its own dominant social status while reinforcing proper cultural behaviours through its treatment of health and illness.

The argument permeating this literature is that women's biology and subordinate position in society make them particularly vulnerable to medicalization, which makes this a feminist issue. According to Rosser (1994), in medical science men's bodies have always been considered the norm by which all bodies are judged. As a result, women's body differences are viewed as pathological and in need of medical control. Menstruation, child birth, birth control, and menopause have been coopted by medical science. Perceived psychological differences fell under the authority of medicine as well and, for Mitchinson (1988), this meant a great expansion of medical territory with inevitable consequences:

> [P]hysicians, who for centuries have claimed to be and have been accepted as experts on the body, are given enormous credence when they expound on the potential limitations of the female body and psyche (237).

As a result, women's lives more than men's have become "favoured territory for medical intervention" (Findlay & Miller, 1994).

Daly (1978) points out that the advent of gynaecological surgery coincides with the early stirrings of the first wave of feminism. She argues that this is no accident. In

Gyn/Ecology: The Metaethics of Radical Feminism, she traces the links between women's action for social change and developments in gynaecology:

> [I]n 1848, the year of the first Women's Rights Convention, Dr. Charles Meigs was advising his pupils that their study of female organs would enable them to understand and control the very heart, mind, and soul of woman. Clitoridectomy, "invented" ten years later by the English gynaecologist Isaac Baker Brown, was enthusiastically accepted as a "cure" for female masturbation by some American gynaecologists. In 1852, Dr. Augustus Kinsley Gardner let out a battle cry against "disorderly women," including women's rightists, Bloomer-wearers, and midwives. In the 1860s Dr. Isaac Ray and his contemporaries proclaimed that women are susceptible to hysteria, insanity, and criminal impulses by reason of their sexual organs. The year 1873 marked the publication of Dr. Robert Battey's invention of "female castration," that is, removal of the ovaries to cure "insanity."....Only after the establishment of body-gynaecology did psychoanalysis (the earliest form of mind-gynaecology) take over (227-8).

Fortunately for Canadian women, practitioners north of the border were more conservative than their American counterparts when it came to gynaecological surgery and matters of sexuality in general (Mitchinson, 1988). However, textbooks used in Canadian medical schools did recommend cauterization of the clitoris and removal of the ovaries (Mitchinson, 1988). As Ehrenreich and English (1973b) declare, the medical system is a tool of women's oppression. By using biological differences to fuel theories of male superiority, medical science has created justification for sexist discrimination in all of its forms.

Androcentric bias in medical research further puts women at risk. Rosser (1994), in her analysis of contemporary medicine, claims that everything doctors know about women was learned from studies conducted on men. Rosser (1994) found that medications, dosages, symptomatology, therapies, and treatments were developed by studies conducted on men and then generalized to women. She argues that the medicalization of women's lives puts women in double jeopardy since the medical care they receive may be second rate. For Mitchinson (1988), biased medical knowledge poses a threat to more than women's physical well being. She contends that doctors exert influence over all aspects of women's lives from sexuality, marriage, and child rearing to emotional and mental states. They have become "moral arbiters" (256).

In sum, the literature reviewed here is critical of medicalization because, as Anderson (1993) states, "the medical profession [is perceived] as unresponsive to women's needs and as treating women's bodies as objects for medical manipulation" (194). The medicalization of women's lives is understood as a condition brought on by a plethora of causes: the privileging of scientific knowledge over other ways of knowing, the inherent male bias in this knowledge, the control of medicine by men, the subordinate position of women in society, and the profit orientation of the medical system. This literature is important to our understanding of the historical development of medicalization and its particular relevance to women.[8] Medicalization, with its inherent androcentric bias and professional dominance, has informed health care practices to such an extent that it affects not only women's position in relation to their doctors, but it may compromise the quality of

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[8] For examples of literature which looks at specific aspects of medicalization, i.e. childbirth, menopause, premenstrual syndrome, menstruation, artificial insemination, see Bogdan, 1978; Lewis, 1993; Figert, 1996; Delaney, Lupton, & Toth, 1988; Wikler & Wikler, 1991, respectively.

care they receive. The critique offered in this literature is helpful in aiding our understanding of women's experiences. It sheds some light on the particular situation of middle-aged women, who may increasingly require medical treatment as they age. However, this body of literature implies that women have been, and continue to be, passive victims of medicalization. It does not allow for reciprocity of interaction between patient and physician, and it diminishes the capacity of women to act in their own best interests by avoiding medical manipulation. Theories of agency fill gaps left by the medicalization literature and illuminate the ways in which women resist medicalization.

WOMEN'S AGENCY: BEYOND MEDICALIZATION

The literature on women's agency focuses not on oppressive power structures, as does the medicalization literature, but on women's position within them. Focusing solely on power imbalances in social structures eclipses our ability to see women as subjects who interact with the social order. Consequently, as Davis and Fisher (1993) contend, "[w]e run the risk of treating women as if they are passive victims of repressive systems" (4) which leaves no space for:

> uncovering the subtle and ambivalent ways women may be negotiating at the margins of power, sometimes constrained by, but also resisting and even undermining asymmetrical power structures (6).

The literature on women's agency is used here as a response to the medicalization literature. By allowing us to glimpse the converse of the medicalization picture, this literature enhances our understanding of women's lived experiences within oppressive power structures, making their resistance visible.

Agency is described by Bakan (1966) as a strategy which reduces tension by taking control of the environment and changing the world around it. It is an expression of independence through "self-protection, self-affirmation and self-expansion" (Saragovi, Koestner, Dio, et al., 1997:593). Typically, researchers have found, it is associated with what American culture considers to be masculine characteristics (Bakan, 1966; Helgeson, 1994; Saragovi, Koestner, Dio, et al., 1997). As a result, the theory of agency in health research has been used mainly to understand gender differences in health outcomes (see

Helgeson, 1994). It is argued that women's socialization into femininity puts them at risk for increased psychological and physical distress. Although there is a rich literature inspired by the theory of agency, its use in explicating health related phenomenon has not been exercised to its fullest (Ryan, 1994).

Drawing on Foucault, theorists argue that power structures themselves produce resistance through a politics of exclusion. In other words, discourses create or produce various positions which enable the reproduction of that particular discourse, and for those located at the bottom of the power structure, resistance becomes a necessary means for survival. For example, under patriarchy, the right of men to keep all the power depends on the willingness of women to be compliant in their own oppression. However, this power structure, by casting women in this inferior role, has produced the occasion for its own resistance. As subjects regulated by this system of power, women, by virtue of being subjected to it, are defined and represented in accordance with the requirements of this system (Butler, 1990). This false representation is often legitimized by the invocation of a temporal 'before' in which women (any oppressed people, for that matter) were colonized for their own protection, are naturally subordinate, and in need of domination. The constant reaffirmation of this logic, while guaranteeing the perpetuation of the system, gives rise to a platform for resistance (Butler, 1990).

According to Butler (1990), these systems of power are not concrete structures but fluid, consisting of temporal acts which reinscribe their meaning through repetition. It is in this repetition that the occasion for resistance presents itself. In Gender Trouble, Butler (1990) argues that the logic of power structures is maintained and reinforced through the repetition of signifying acts. For her, agency "is to be located within the possibility of a variation on that repetition" (145). For Davis and Fisher (1993), power is both "everywhere and nowhere" (8). The hegemonic is maintained through micropractices which leaves no single focus for rebellion, thus it cannot be overthrown. "It depends for its very existence on the multiplicity of points of resistance" (8). Davis and Fisher (1993) contend that it is

> possible to investigate how power and resistance work in even the most routine micropractices....[w]omen continue to reproduce, but they also confront and discursively penetrate the practices of which they are a part (10).

From this literature we learn that language is part of the repetitive process that continually reinscribes the social hierarchy. Drawing on Derrida, Todd and Fisher (1988) claim that "we perceive reality through language. Anything said, whether written or spoken is already saturated with meaning" (6). Thus, medical discourse is particularly problematic because of its affiliation with science and science's claim to objective truth. Martin (1989) argues that the language of medical science is rooted in our specific form of social hierarchy. Usually "we only hear the 'facts,' and this is part of what makes science so powerful" (197). Fisher (1993) argues that "medical discourse does not exist in a vacuum...it reflects and reinforces broader social relations" (114). It is clear that science has been used to support a political agenda. Women have been prevented from holding certain jobs and positions of power based on 'scientific facts' about their hormones, their strength, their size, and their pregnancies (Martin, 1989). With the delivery of primary health care being "essentially a communication event" (Fisher, 1993:90), the occasion for the reinforcement of patriarchal ideology presents itself in myriad ways.

In her research, Fisher (1993) found that the "medical relationship is characterized by an asymmetry between provider and patient" (89) and that this relationship is a site for ideological and political struggle. She contends that during the medical consultation, doctors can "consistently reinscribe hegemonic discourses about the subordination of women" (117) under the guise of a medical consultation. In her study of doctor-patient consultations, Fisher gives the example of a woman who presented to her doctor with vague, non-specific complaints; she was married, worked part-time, and cared for an infant at home. The doctor immediately located her problem in her domestic arrangement, assuming and reinforcing the notion that a woman's sense of herself is tied to her identity as wife and mother. By narrowing the scope of his questions to her domestic arrangement, directing the inquiry and curtailing any discussion outside this sphere, the doctor had reinscribed cultural assumptions about women's place in society, the dominance of doctors and subordination of patients, and the asymmetry of power between men and women. Fisher (1993) claims that even when women openly challenge or resist these representations of themselves, they do not prevail:

> To prevail would be to challenge traditional discourses about the ways women are to be patients and the ways they are to live their lives as women. This challenge would undermine both the doctor's professional status and his dominance as a man (117).

Hence, the doctor-patient relationship continues to be a site of contested meanings and power struggles.

Martin (1989) argues that although science makes claims to the objective truth about the human body,

> women--whose bodily experience is denigrated and demolished by models implying failed production, waste, decay, and breakdown[9]--have it literally within them to confront the story science tells with another story, based in their own experience (197).

In The Woman in the Body: A Cultural Analysis of Reproduction, Martin (1989) claims that the ruling class may be oblivious to their oppression of others because they are either convinced by their own ideology or because they perceive the suffering of others to be deserved, inevitable, or chosen. The women in her study on reproduction, however, expressed consciousness of their position and their oppression in many different ways ranging from helpless lament to outright rebellion. She writes,

> What is striking about our interviews with women is the extent of their questioning, opposing, resisting, rejecting, and reformulating the ways in which they live and the ways in which the society might work (194).

She claims that women may be conscious of their position but chose not to speak out because of the perceived risk. She says they may do nothing or, "operating stealthily in the interstices of power, they may resist through devious ways of speaking and acting" (182).

In her analysis of "Body Narratives, Body Boundaries," Martin (1992) describes the existence of counter-hegemonic visions and practices. She disputes what she calls the

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[9] See Martin's (1989) The Woman in the Body for a complete explanation of how women's reproductive processes came to be seen in such negative terms.

"Swiss cheese" theory of hegemony which assumes that hegemony springs fully formed into being followed by resistance which squeezes through the holes left by its incomplete imposition. Instead she argues that resistance does not operate solely within the confines of the dominant discourse. If we look at how "resistance is built into the construction of the hegemonic...we can see that there are many coexisting and contending knowledges of the body" (418). This may not lead to rebellion or social change, but at least women can often "forge alternative visions of what the world might be like" (Martin, 1989:200).

In their study on compliance from the patient's perspective, Hunt, Jordan, Irwin, and Browner (1989) uncover counter-hegemonic visions and practices at work. Four months after receiving treatment from their doctors, 3/4 of the study group had ceased to follow their treatment regimen. What was deemed noncompliant behaviour from a medical professional standpoint, the authors contend is "logical and normative" behaviour from the patients' viewpoints. The authors claim that it is commonly thought that the reasons for patient noncompliance are the patient's misunderstanding of the treatment or the patient's different understanding of their illness. They found that this is not so. The patients they followed showed that their understanding of both treatment and illness were congruent with that of their physicians. What they did find is that:

> people base their judgment about diagnosis and treatment on their own experience and their interpretations of their bodily sensations. Whether or not a patient follows a physician's directions is not simply a matter of whether the patient can understand them but also a question of how those directions fit in with the rest of their thinking and their lives (323).

Furthermore, this study revealed that the incongruence lies in the reason patients sought medical attention to begin with. The physicians assumed the patients sought treatment in order to remain healthy and they prescribed treatment regimens accordingly. Most patients, however, "sought information they could use to restore themselves to a healthy state when they felt ill" (326). This incongruity led to the labelling of 3/4 of the 19 women involved in the study as noncompliant.

Interestingly, we learn from this literature that women's acts of resistance, in their various forms, are typically perceived as incompetence. Throughout history, women are depicted as content in their roles except for a few anomalies such as suffragists or feminists. According to Hoagland (1995), no behaviour is recognized or acknowledged as resistance within the confines of the feminine stereotype. Acts of resistance such as those revealed in Martin's (1989) study (women in labour delaying going to the hospital, unhooking fetal monitors, taking long walks to avoid medical intervention, for example.) are "used by those in power as proof that women have lesser rational ability" (Hoagland, 1995:178). The feminine stereotype does not support the capacity or desire of women to resist domination.

According to Hoagland (1995), "[i]f we operate in a conceptual framework which depicts humans as inherently dominant or subordinate, then we will not perceive resistance" (180). She gives the example of slaves, who were characterized as lazy, docile and clumsy, in part because they broke so many tools. This was not perceived as sabotage, Hoagland claims, slaves were merely believed to be incompetent. So deeply imbedded was the idea that slaves were natural subordinates, that running away was seen as a sign of pathology. "Drapetomania" was the clinical term for the disease which compelled slaves to run away. In the case of women, they are incompetent or crazy. For Hoagland (1995), acts of resistance signify more than the presence of counter-hegemonic practices, they help women to differentiate themselves from the will of those who dominate. She claims that acts of resistance help women to feel that they cannot be completely controlled or dominated.

As a complement to the literature on medical health at midlife and the literature on medicalization, this body of literature disputes the foregone conclusion that women are passive victims of oppressive structures. The literature on women's agency is essential to our understanding of women's position on the margins of power, and how resistance and agency are a necessary and inherent part of that life. Additionally, it illuminates the likelihood of co-existing bodies of knowledge, suggesting that women’s ways of knowing are important aspects of their lived realities and warrant emphasis in women’s health research. Using theories of agency to understand women's health behaviours adds a helpful dimension to the analysis of the ways in which women pursue wellness throughout midlife. Case studies on women who actively negotiate their way through this life stage provide good illustrations of women's agency in real life contexts. These are found in the literature on the contextual meanings of health.

EXPLORING HEALTH WITHIN THE CONTEXT OF WOMEN'S LIVES

More recently, there has been a small but growing interest in studying the meanings of health and illness from women's perspectives. This literature is a departure from the overwhelming focus on issues of reproduction found in sociological and feminist approaches to women's health research. Traditionally, lay perspectives on health and illness have served as a response to, and critique of, medicalization (see for example, Martin, 1989; Taylor, 1988; Thomson, 1986). However, by virtue of their biological clocks, postmenopausal women are omitted from representation in this literature. Research has traditionally been guided by what the researchers deem important (Walters, 1994), hence, my inclusion of this review, however small this body of literature may be. It is important to the development of this thesis because it looks at health in the context of the social realities of women's lives. By recognizing that women's lives occur within a context of inequalities and that these inequalities serve as structural and ideological barriers to good health, and by studying this landscape through lay women's eyes, this type of research can help us to understand the choices that women make concerning their health. Underscored here is the importance of context in theorizing about women's health behaviour.

In her analysis of a case study focusing on a woman and her family from South Wales, Yeandle (1996) highlights the degree to which family arrangements affect the life choices of her subject. "The extent to which constraining factors interweave with individual agency is demonstrated, and the significance of the analysis for policy-makers is noted"

(507). Yeandle (1996) maintains that it is important for policy-makers to recognize the impact of family on women's capacity for change. In this case study, Yeandle (1996) emphasized the extent to which family ties determined her subject's choices in life:

> The sources of authority, control and coercion in [this woman's] life have been important limits on her freedom to act independently and freely follow her own inclinations (519).

What we can learn from this research is that women's agency is mediated by structural factors related to women's traditional roles as wives, mothers, and caregivers.

A study of 11 homeless, middle-aged, American women by Butler and Weatherley (1995) points to much the same conclusions arrived at by Yeandle (1996). This research involved in-depth interviews over six months with the purpose of seeing the pathways to homelessness through the women's eyes. The authors conclude that structural factors such as marital separation, abusive relationships, illness, and employment discrimination - in effect, common aspects of life for many women - were the causal factors which led to the homelessness of these 11 women. It was found, contrary to myths about the homeless, that these women had travelled through the difficult terrain of their lives using common sense and hard work, like anyone else would have done. They were not less deserving or different from other women, just more disadvantaged.

Out of Butler and Weatherley's (1995) research comes many important insights. Learning that the women did not see themselves as victims and showed remarkable fortitude and resourcefulness in daily decision-making has implications for policy-makers. For example, one woman refused a bed at a shelter and chose to live in her car because she preferred to be independent. Seeing homeless women as victims informs the strategy of social policy and may, in fact, render it less effective. I include this study here for two reasons. First, I consider the issue of homelessness to be linked to health insofar as food, shelter, and clothing--the basic necessities of life--are threatened in a homeless situation. Second, I think Butler and Weatherley's (1995) research has some generalizability to primary care in that the congruity of physicians' approaches to health with patients' expectations are important factors in determining the outcome of medical encounters. As recognized by Freund and McGuire (1995), people seek medical help for a variety of reasons, only one of which is treatment.

In a similar vein, we can learn something about different women's health behaviours from each study in this body of literature. From England and Finch's (1991) investigation of aging, rural, South Dakota women, we learn that the theory of 'mastery' needs to be broadened to accommodate women's perspectives. Other studies have shown that having a sense of mastery or a sense of control over the directions life takes is negatively correlated with depression (see Beaudet, 1996). England and Finch (1991) contend that the women in this study were fulfilling their sense of mastery through the well-being of their families as well as through their own personal activities separate from their families - activities that were not formerly associated with mastery. King's (1993) study of middle-aged women who care for their aging mothers revealed a complex undercurrent of emotions ranging from guilt, impatience and stress to frustration, resentment and anxiety. By focusing on care giving from the care givers' perspectives, King

(1993) was able to identify a health care issue not recognized in health care policy: daughters, wives, and mothers routinely sacrifice their own health to fill gaps in the health care system. Blaxter's (1993) study of 46 Scottish grandmothers illustrates how these women had constructed models of health that were rooted in their social situation and life's experience. She contends that "[t]hese women's beliefs about cause could be demonstrated to have a direct effect upon their help-seeking behaviour" (69).

This brief review does not exhaust the literature on the context of women's health, but these examples clearly show how useful this type of research is for augmenting our comprehension of the relevance of locating health research in its social context. For middle-aged women in particular who have been left 'out of the loop' by contemporary health research, this approach is enlightening and beneficial, and adds to our understanding of the factors that influence the decisions women make regarding their health. This literature complements the literature on women's agency by giving concrete examples of the structural framework within which each woman must negotiate her position on the margins.

FRAMING THE RESEARCH QUESTION

The body of literature on women's health has grown considerably over the past 25 years but women in midlife remain underrepresented. This gap reflects the traditional medical interest in women's reproductive system and the sociological and feminist critique of this preoccupation. After menopause, women virtually disappear from the literature only to reappear once they become a gerontological issue. Because many chronic diseases first appear in midlife (Bidikov & Meier, 1997), and because there is relatively little research in this area, women may lack the necessary information they need to safeguard against disease and debilitation. Additionally, health care providers may lack the information they need about women in midlife in order to provide quality, effective care. What little information there is on middle-aged women has been presented or characterized here in an attempt to present a framework for the reserach at hand.

The medical and sociological literatures on health at midlife are, for the most part, based on the research interests and biases of predominantly white, male medical and sociological researchers. As a result, several problems exist in the literature to date. Studies often neglect social context and sever medical problems from their social setting. Studies which do recognize the social aspects of health tend to focus on male definitions of women as wives, mothers, and care givers, while women's own perceptions are ignored. Often studies are motivated by the desire to alleviate costs to the health care system rather than to improve the quality of life for the patient. Finally, there is virtually no research on the health behaviours of middle-aged women.

Life expectancy for women at age 51 is more than 30 years (Sarrel, 1991). We live a significant portion of our lives beyond menopause, yet little is known of women's experiences during the years between menopause and old age. What little we do know is narrow in scope. Hunter and Sundel's (1994) research reveals that contemporary views of midlife are narrowly defined in heterosexist terms. As a result, the only aspects of midlife women's experiences we hear are those related to their roles as wives and mothers. Aspects of women's lives unrelated to this assumption - career, public service, accomplishments - are ignored. Even feminist-guided research is guilty of perpetuating feminine stereotypes. The study by Adelmann, Antonucci, Crohan, et al. (1989), for example, which explores cultural stereotypes of depression and the empty nest are still guided by the heterosexist notion that women define themselves in terms of motherhood. Such narrow perceptions of midlife are demeaning and limiting, claim Hunter and Sundel (1994). There is a need to focus more attention on women in the middle years because, as the medical research suggests, chronic diseases have a tendency to present themselves at this time. Whether social or biological in origin, chronic ailments have implications for quality of life through the elder years. Understanding more about women's health behaviours is a way of gauging how women use primary care and may have implications for policy-makers for developing more suitable health care services.

Typically, medical studies neglect social context and look for biological links. For example, Woods and Mitchell's (1996) affirmation that the hormonal changes of menopause are not linked to depression departs from a tradition of locating the social causes of depressive illness within the individual, and more specifically, within menopause. The fact that a stressful life context has been found to be the main factor in predicting depression (Woods & Mitchell, 1997) exposes its social roots. By searching for biological links to depression at midlife, researchers have perpetuated stereotypes of menopause as a negative event, as well as depoliticized and individualized this socially rooted problem. In fact, when asked, middle-aged women do not consider depression to be a health concern during the middle years (Kennedy & Comko, 1991).

In Canada, heart disease is the leading cause of death for women over 64 (Wilkins, 1995), and lifestyle is a significant determinant. The focus in medical literature on healthy lifestyles is another way of severing the problem of heart disease from its social context. By emphasizing lifestyles, heart disease victims get blamed for their smoking, poor diet, lack of exercise, and stress. What is missing in the literature is an examination of structural barriers to optimum healthy living. A stressful or rigid work environment, the double day, elder care, domestic violence, poverty, and isolation all play a part in preventing women from living to their potential.

Both the medical and sociological literatures on women's health at midlife reflect the Western cultural stereotype of midlife as a time of increased vulnerability to depression, financial difficulties, and health risks. While this holds true for many women, Hunter and

Sundel (1994) insist that it is important not to overlook the advantages of midlife in order to give a well-rounded view of this life stage: something that is lacking in the literature. Hunter and Sundel (1994) emphasize that the persistent myth of midlife as a negative life stage serves to normalize the poverty, illness, and depression of aging women while ignoring its socioeconomic roots. They contend that it is important to hear how women experience their middle years in order to dispel the myths and better understand midlife as a potentially empowering and positive life stage.

The sociological literature on health at midlife points largely to socioeconomic and cultural factors as significant determinants of health. Characterized in this body of literature, midlife is a time fraught with peril due to everything from ageist and sexist attitudes which shape perceptions of midlife and inform health care policy to social and structural barriers which threaten women's economic independence and security. But Hunter and Sundel (1994) argue that to accept that midlife is simply a negative life stage is, again, to ignore the social roots of this assumption. The experiences of women at midlife are far from homogeneous. According to Hunter and Sundel (1994), studies show that women from middle- and upper-class white backgrounds experience a better quality of life at this time. Poor women and women of colour are far more likely to experience midlife negatively. For Hunter and Sundel (1994), it is impossible to ignore that it is sexism, ageism, racism, and poverty that hinder the experiences of many women during this potentially positive life stage. It does women a disservice to highlight only the negative aspects of middle-age, thus misrepresenting the midlife reality.

Hunter and Sundel (1994) have found that some studies show midlife is a time of increased self-esteem and self-acceptance for some women. Upper-middle-class working women, for example, tend to shift their focus from marriage, relationships, and family in early adulthood to the desire for personal growth and achievement of personal goals in midlife (Drebing, Van de Kemp, Gooden, et al., 1995). This shift - not in keeping with the roles society lays out for women - is associated with mental and emotional wellbeing (Drebing, Van de Kemp, Gooden, et al., 1995). Although the number of illnesses and chronic conditions increases, economically secure women report positive feelings and overall life satisfaction during midlife (Eronen, Rankinen, Rauramaa, et al., 1997). The postmenopausal years can be exceptionally freeing for women because they are typically associated with increased economic status, the launching of children, freedom from birth control and enhanced relations with friends and partners (Hunter and Sundel, 1994). Furthermore, there is more leisure time and freedom to pursue personal goals. This aspect of midlife is underrepresented in the literature.

Another typical strategy of medical research on middle-aged women is to focus on the importance of early detection in the struggle against chronic disease. Moreover, this approach is aimed at keeping older women independent, out of institutions and off state assistance. Some doctors have gone so far as to suggest that women be 'captured' for preventive screening and testing when they present to their doctors for unrelated, minor care (Bidikov & Meier, 1997; Kennedy & Comko, 1991). Apart from enhancing the potential of physicians to detect disease on a 'hit or miss' basis, this approach seems less than adequate for addressing the problem of chronic disease onset. While augmenting the authority of the physician, it does nothing to empower women with knowledge of their bodies, it does nothing to address the social conditions that contribute to disease, and it does nothing to understand how and why women do or do not seek primary care. It often seems that quality of life for individuals is of secondary importance in health care policy. The fact that there is little research on the concerns women themselves have about their health is a case in point. According to Crook (1995), a health care system that emphasizes disease and the role of physicians leaves women feeling that they lack the information they desire and the health care services they need. And this could logically play out in terms of how and when they access primary care.

The medicalization literature has made an important contribution to the women's health cause. It comprises the first grand scale critique of medical dominance and expansion, and androcentric bias in medical practice. However, with its focus on power structures, it overlooks the possibilities of agency within them, portraying women as passive victims of medical dominance. Since most of this literature has feminist roots, this is particularly problematic because it perpetuates sexist stereotypes of women, eclipsing the possibility of agency.

Although many sources recognize that medicalization was not simply imposed on women, that not all physicians agreed amongst themselves, and that many women, believing in the authority of science and medicine, participated in the process, the medicalization theory nevertheless portrays women as helpless victims or cultural dupes.

This literature stresses a structural viewpoint that minimizes the role of women as agents either for or against the process.

Most medicalization literature focuses on the medical cooptation of pregnancy, birth control, menstruation, and menopause. Ironically, by focusing so exclusively on the medical appropriation of women's natural reproductive functions and events to the exclusion of all other medicalization issues, this literature is guilty of ageist and sexist views of women. It defines women in terms of reproduction - vastly criticized in feminist literature for its androcentricity - and virtually ignores premenstrual and postmenopausal females. Medicalization issues relevant to middle-aged women, for example osteoporosis, have received considerably less attention. Rather than developing a literature on women's health stemming from women's own health perspectives, feminists and sociologists have established boundaries of health research which are little different from those already set in place by medical researchers.

Both the medicalization literature and the research which focuses on the social influences on health, although important contributions in their own right, are guilty of what Wrong (1961) calls "the oversocialized conception of man in modern sociology." Wrong (1961) is critical of the tendency of sociologists to overemphasize social structure and culture as explanations for human behaviour, thus denying the possibility that humans are anything else but completely socialized beings. He claims that the Hobbesian question, "How is social life possible?" has become superseded by a concept of conformity in which behaviour counter to society is seen as deviant and not the norm. He claims that theorists have become blind to the assumptions buried in their answers. For Wrong (1961), the model of human nature constructed by sociologists, which explains society in terms of the internalization of social norms and the motivation of individuals to achieve a positive self-image, has destroyed Hobbes' question. If these explanations are correct, the question must then be, and has indeed become, "How is it that violence, conflict, [and] revolution...exist at all?" (186).

Similarly, by explaining women's health in terms of medicalization and social structure, theorists underestimate the possibility of counter-hegemonic practices. They underrate the capacity for women to be anything else but completely socialized beings who have been victimized by a powerful medical ideology. It is assumed that women have internalized medical norms and have been duped in the process. If this explanation is taken for correct, the question then becomes, "How is it that noncompliance exists?" Predictably, there is a sizeable body of research dealing with this very question. By being blind to the assumptions buried in this explanation, the oversocialized conception of women keeps us from asking the question, "How is it that women seek medical care at all...and why?"

Wrong (1961) argues that the insistence of sociologists on the importance of social factors easily leads them to stress the priority of socialized or socializing motives in human behaviour. In sociology, "internalization" is thought of in terms of affirmation and conformity and not inner conflict between powerful impulses and superego control, the way Freud meant "internalization" (Wrong, 1961). According to Wrong (1961), Hobbes envisioned that the constant tension between the state of nature (the "war of all against all") and the social contract (the authority of "Leviathan") is what comprised society. For Wrong, these polar opposites coexist and interact in a dialectical fashion. Similarly, Wrong (1961) argues, human behaviour is a dialectic between human impulses and desires, and social structure. He stresses that sociology needs a theory of the individual to accompany the oversocialized conceptions of human behaviour, a theory that can address those seemingly irrational aspects of human behaviour that, so far, elude theorizing.

Some women's health behaviours are interpreted as noncompliance from a medical perspective, deviance from a sociological one. Following Wrong's (1961) lead, however, we can perceive noncompliance or deviance as evidence of Hobbes' state of nature coexisting and interacting with the Leviathan of modern medicine. From this viewpoint, women's health behaviours are far more significant than the anomaly of deviant acts within a sea of conformity. They represent the existence of a counter-hegemonic perspective.

The implications of Wrong's (1961) argument for women's health become clearer in relation to the literature on women's agency. This body of literature suggests that women are not medicalized (or socialized) to the extent that the critiques on medicalization would have us believe. The literature on agency introduces the idea that women's counter-hegemonic visions and practices coexist and interact with modern medicine.

Although some women's resistance to medicalization is wilful and rebellious (i.e. the alternative birth movement, the women's health movement), most women's position of resistance is structurally and contextually produced through power relations. In this latter sense, it is not intentional resistance, but agency. Most women's agentic, subjective stance is a means of dealing with their health within a hegemonic medical discourse that does not speak to their lived experiences. Specifically, we see women opting out of medical treatments, independently researching their health concerns, and looking for alternatives. And we also see them choosing to follow their doctors' advice. What we learn from the literature on agency is that women are not passive victims of medicalization, nor are they oversocialized automatons. They are thinking, acting individuals who make decisions and organize and coordinate their lives (and often the lives of those around them) within a social framework of inequality.

What is missing from this body of literature is more direct analysis of women's agency in relation to their health. Although the theory of agency is well developed, it has not been applied to health behaviours adequately to understand what form women's agency takes or how it is exercised. Without this angle on agency research, we are left with gaps in the literature which render us unable to fully understand the health care needs and desires of middle-aged women.

The small, but growing, interest in situating the health of women within the context of their lives has produced a body of literature consisting of small, mostly ethnographic studies. This research reveals how social structure is an important mediating factor in people's health. It is helpful to see how barriers and inequalities play out in the lives of individuals. However, although this research is generally carried out from women's own perspectives, the emphasis on social forces perpetuates the tendency in sociology toward overrationalized explanations for human behaviour. Women's health is explained in terms of their rational responses to their environment. Yeandle's (1996) case study shows a woman making rational choices based on her family situation even though they may not have been the best choices for her own health. Butler and Weatherley's (1995) homeless women lived sensibly but ended up homeless because of the adversity they faced. Study after study imparts the same message: women act rationally within various social landscapes and it is these landscapes which largely determine their health in the long run. Again, we see that women have not been controlled to the extent that the medicalization literature suggests. However, this literature does tend to reduce women's agency to a socially produced phenomenon.

Research on women's health is missing the exploration of women's health issues from women's perspective. There is a need for a theory on the behaviour of individuals on the margins, a general theory of human understanding that can be used to understand motives and actions that cannot be explained by looking at social structure. Women manage their health in myriad ways. Freund and McGuire (1995) have recognized that patients treat themselves, seek out alternative therapies, resist medical treatment, and constantly evaluate doctors' recommendations. They cite research which shows that doctors vastly underestimate the extent to which patients adopt an agentic stance in dealing with their health, and that many patients hide from their doctors this nonadherance to his/her orders. Research on women's health behaviours which attempts to uncover the wisdom and motivations behind actions will aid our understanding of what factors, other than the social factors already identified in the literature, guide their decisions. To date, research is shortsighted in its understanding of what type of health services middle-aged women seek, what kind of health care they desire, and what health information they need.

The current tradition of women's health research, especially the literature on health in the context of women's different life experiences, is a tapestry rich with lived reality. It connects the health status of women to class and race, education, employment, marriage, and age. It lends much to our understanding of the circumstances which restrain women's decision-making. A theory of human understanding based on deductive reasoning can help illuminate the things of which participants may not be cognitive. It can reveal patterns and traits that may not be voiced in qualitative data, and can add another useful dimension to women's health research.

The present study contributes to the literature by exploring these issues and looking at theories of agency which have previously not been applied to their full extent in health research. It attempts to illustrate how some middle-aged women access primary care, their thoughts and feelings on this care, and the strategies they use to get the health care and information they feel they need. It is hoped that this research will convince the reader that by exploring women's health behaviours, we can heighten our understanding of the dialectic between social structure and personal agency. This understanding may have implications for health care policy which could enhance the sensitivity of primary care services to the needs and desires of middle-aged women. Given that this is an important life stage in terms of onset of chronic disease, any improvement in the relevance of health care services to women is a step forward.

3 METHODOLOGY: SHIFTING THE FOCUS USING WOMEN-CENTRED APPROACHES

As discussed in the previous chapter, women's health behaviours (noncompliance) have been researched mainly from a medical perspective which allows physicians to develop better strategies for capturing patients for screening, testing, and treatment. Very little research exists which attempts to understand these health behaviours from women's own perspectives. This could be an insightful addition to women's health research.

Beginning with women's experiences is an important aspect of feminist research. According to Harding (1987a), feminists have argued that traditional epistemologies have excluded the possibility that women can be "knowers" or producers of knowledge:

> Androcentric biology and social sciences "proved" that women were biologically and socially inferior to men in myriad ways, and androcentric epistemology insisted that only men could be "knowers" and, therefore, legitimately question biological and social science claims (Harding, 1987b:187).

For Harding (1987b), if women were accepted as legitimate knowledge-makers, we would not need a specifically feminist social science. Reinharz (1992) contends that, traditionally, women have not been seen as playing "significant roles in the social settings of which they are a part" (51). Beginning with the experiences of women, for Reinharz (1992), is a necessary part of filling in those gaps left by women's exclusion from the sciences and public life in general throughout history.

According to Smith (1987), sociological research from women's perspectives contradicts the objectivity that sociologists have traditionally claimed for their work. When it is revealed that woman-centred research is different from mainstream sociological research, it becomes clear that "the subject matter of sociology is organized from a determinate position in society - a ruling class, white, male one" (Smith, 1987:84). For Humphries (1997),

> all research is value-laden and is inevitably political, since it represents the interests of particular (usually powerful, usually white male) groups. Neutrality is...problematic, arising from an objectivism which assumes scientific knowledge is free from social construction. What is required is research which 'brings to voice' excluded and marginalised groups as subjects rather than objects of research, and which attempts to understand the world in order to change it (2.6).

Smith (1987) maintains that in mainstream sociological research, women appear as fragments or accessories to the world occupied by men. She suggests that a shift in focus to women as subjects does more than recover what is missing from research. It changes "the values assigned to different aspects of the world" (85). This, Smith (1987) argues, is the key to developing a more representative sociology.

In recognition of the positionality of the researcher in his/her research, I have chosen a social constructionist grounded theory method for this research. As explicated by Charmaz (1990) in her article, "Discovering Chronic Illness: Using Grounded Theory," a social constructionist grounded theory views the research process as:

> dialectical and active, rather than as given in reality and passively observed by a trained observer. Hence, a social constructionist perspective assumes

> an active, not neutral, observer whose decisions shape both process and product throughout the research (1165).

She maintains that grounded theorists come from a "particular philosophical stance" and design their research questions "based on their assumptions and substantive interests" (1165).

Kirby and McKenna (1989) refer to "conceptual baggage," a source of information coming from the researcher that is used in research and often not reported. Like Charmaz, they claim that conceptual baggage places the researcher in the research and includes "thoughts and feelings, hunches and ideas about the research content" (85). Glaser and Strauss (1961) describe what they call "insights" as the root source of theorizing. They contend that the researcher's insights may develop during the research or they may be based on previous knowledge or experience. They may be borrowed from other people or existing theory, and they should be fostered throughout the research process because these insights can "enrich the theory by forcing elaboration and qualification" (253).

My own conceptual baggage, or insights, has shaped most aspects of this research process. Charmaz (1990) claims that different researchers take different things from the data. My interest in primary care played an important role in the focus of this research and my feminist standpoint has influenced both its direction and perspective.

RESEARCH DESIGN

Three goals of feminist research are mentioned frequently by feminist researchers:

> (1) to document the lives and activities of women, (2) to understand the experience of women from their own point of view, and (3) to conceptualize women's behaviour as an expression of social contexts" (Reinharz, 1992:51).

As a means of obtaining rich, detailed data, qualitative methodology offers the most effective approach to achieving this end. My purpose at the outset of this research was to uncover women's own interpretations of health from their own perspectives. My personal interests and background later led me to focus specifically on women's own understanding of, and explanations for, their health behaviours. Like Charmaz (1990), I believe that grounded theory is a useful research strategy for this type of research. In uncovering the meanings of chronic illness to patients, Charmaz (1990) claims that:

> [g]rounded theory analyses can then provide physicians with alternative understandings of patients' beliefs and actions than those readily available in clinical settings. Subsequently, physicians may use these understandings to improve communications with patients and to act on problems which patients define (1161).

Similarly, I believe that understanding women's health behaviours may provide different understandings of patients' actions which physicians could use to enhance the delivery of primary care.

The Interview

Semistructured interviewing was the method chosen for data gathering specifically because it maximizes the potential for discovering the viewpoint of the participant. According to Reinharz (1992),

> interviewing offers researchers access to people's ideas, thoughts, and memories in their own words rather than in the words of the researcher. This asset is particularly important for the study of women because in this way learning from women is an antidote to centuries of ignoring women's ideas altogether or having men speak for women (19).

The semistructured and unstructured interview are unique in that they permit interaction between the researcher and the participant (Reinharz, 1992). This is important because it allows for the clarification of ideas during the interview process, as well as the follow-up of certain tangents or threads not included on the interview schedule but nevertheless meaningful to the participants' perspectives.

The interview schedule was designed by Walters for use in her research on the health concerns of women at midlife. Its purpose was to cover a broad spectrum and encourage participants to discuss their views on a variety of health matters (The interview schedule may be found in Appendix A). The questions were open-ended in order to encourage a conversational tone to the interview which, according to Reinharz (1992, quoting Raymond, 1979), "maximizes discovery and description" (18). The questions range from an exploration into what the participants feel are health concerns and social problems to women in their age group, what they feel are their own concerns, how they feel about their doctors, and how they deal with specific health matters, to how this life stage differs from previous ones. In many cases, the discussion veered from the questions at hand as the women enriched the interview with many relevant thoughts and experiences.

Interviews were informally structured and conducted in the participants' homes in hopes of causing as little disruption as possible in their lives and to promote a safe and egalitarian environment. The "feminist ethic of commitment and egalitarianism in contrast with the scientific ethic of detachment and role differentiation between researcher and subject" (Reinharz, 1992:27) informed every aspect of the interview process. Rather than 'extracting' information from the interviewees in an exploitative manner, I strove to be a good listener and learn from the experiences of the participants. Ultimately, it is their views that underpin this research. As Reinharz (1992) comments, by being sincere, taking participants' words at face value and establishing a kind of relationship with them in which they feel safe to disclose, participants are encouraged to share their views in more depth. Interviews were taped - so that I could give my full attention to what the participants were saying, as well as to preserve their words - and later transcribed for analysis. With respect to participants' privacy and feelings, it was stated at the beginning of the interview that the tape could be shut off or questions skipped if the subject matter became uncomfortable. Fortunately, this did not happen and participants consented to keep the tape rolling through, in some cases, very sensitive topics.

The interviews lasted from two to four hours in length which allowed a rapport to develop that facilitated discussion. Rather than limit the interview to one hour and return on subsequent occasions for second and third interviews, as some researchers choose to do, I believe that the long, in-depth interviews which characterize this research lend a richness to the data that may not have been possible under different circumstances. Additionally, since this research does not involve "following" the participants through a life experience such as a pregnancy or chronic illness, follow up interviews may only have burdened the participants unnecessarily. The purpose of the interview in this research was to allow the researcher to listen to different women describe their perspectives, providing a temporal view of these participants' lived realities. To that end, the long, in-depth interview was successful.

The Sample

Snowball sampling was used to find the seven women who participated in this study. Initially, I mentioned to several friends, family members, and acquaintances that I was looking for women interested in partcipating and I asked them to mention it to their friends, family members, and acquaintances. My intent was to begin the snowball with third party contacts and this is indeed what happened. The sample size is small because, ultimately, the goal of this research is to understand health behaviours from different women's perspectives. To do this requires rich, detailed data. It was never my intention to test a hypothesis or make generalizations. This study makes no claims to be representative. In fact, the number of health problems among the seven women seems rather high. A representative sample likely would not look like this. However, I do believe that these women's views and experiences are echoed elsewhere and that their contributions are important to furthering our understanding of women's ways of knowing and women's lived realities.

The seven participants are heterosexual, white women of European descent between the ages of 50 and 69. They live in, or around, small towns in southern Ontario within two hours of a major metropolitan city. Although not representative, this sample does offer some diversity. One woman is without children, the remaining six have raised and launched children. Two of them raised their children alone. Three of the women are professionals, and the others work(ed) in clerical, retail, or service type jobs. Although all of the women expressed feeling relatively secure financially, their annual incomes [with spouses] ranged from barely above what Revenue Canada considers "low income" up to six figures. However, the two single women did mention having to budget carefully in order to support themselves into old age.

Not intended for statistical generalizability, this sample size and research design is best suited "to illustrate an idea...to show the limits of generalizations, to explore uncharted issues...and to pose provocative questions" (Reinharz, 1992:167). The manageable size of the sample permitted in-depth exploration of the women's views, something that is largely absent from the literature.

For the purpose of continuity, I have provided short profiles of the seven participants. To ensure confidentiality, small details are changed and all names are pseudonyms.

Annie- Annie is in her late fifties and works as a school teacher. She lives on her own and is generally happy at this stage in her life. She divorced her husband several years ago and continued supporting their children until, upon reaching adulthood, they moved out. During my interview with Annie, I felt that she had achieved a sense of inner peace after coming through some difficult transitions.

Jen - Jen is in her mid fifties and has recently retired from service-type work. She looks forward to having the time to do some of the things she enjoys, such as gardening. She divorced her husband many years ago and raised and launched a child on her own. She feels blessed with the arrival of grandchildren with whom she loves to spend time. During my interview with Jen, it became apparent that she is a survivor who has experienced some challenging times yet feels she has acquired the strength to face whatever the future holds.

Betty - Betty is in her mid fifties and lives in the country with her husband. A school teacher by profession, Betty now works part-time at bookkeeping and as an artisan. She feels that this is a positive time in her life, characterized by more confidence and less stress than at earlier stages.

Vi - Vi is in her early sixties and works as a school teacher. She and her husband have raised three children. They enjoy the freedom to pursue interests and hobbies that midlife now affords them. Vi feels very young and likes to keep active. During my interveiw with her, I had a sense that she was somewhat rebellious toward succumbing to what she perceives as the "little old lady" stereotype of aged women. She jokingly claims that she plans to age *dis*gracefully.

Sarah - Sarah is in her mid sixties and works part-time in an office. Her husband is retired and she feels that the past ten years have been the most enjoyable years of her married life. Their children now live nearby and have established families of their own. Sarah has a sharp sense of humour which set the tone of the interview but didn't necessarily transcribe well. Although facing some serious threats to her health, she claims that finding the humour and absurdity in any situation is what makes life worth living.

Kate - Kate is in her mid fifties and worked as a school teacher until falling ill several years ago. Her husband runs a small business with their sons who live nearby. During my interview with Kate, I sensed that she has a very spiritual outlook on life and that she values wisdom and inner peace. Learning to live with her chronic illness has taught her to enjoy life one day at a time.

Marj - Marj is in her late sixties. She and her husband have raised several children and are now retired from the family business. Marj believes in embracing life, having a positive outlook and good frame of mind. During my interview with her, I could not help but notice her wisdom, pragmatism, and strength. She feels that through life's experiences she has arrived at age 68 better equipped to handle what the future holds.

ANALYSIS

Since my goal was to discover explanations for women's health behaviours from their own perspectives, it was necessary to let the women's voices be the focal point of analysis. The constant comparison method of analysis developed by Glaser and Strauss (1967) was designed to generate detailed information and possible theories about the research question by organizing the data into categories and looking for connections between them. Kirby and McKenna (1989) have adapted this approach to reflect the feminist values of "intersubjectivity: an authentic dialogue between all participants...in which all are respected as equally knowing subjects," and "critical reflection on the social context" which involves an awareness of the participants' social reality and its impact on their lives (129). I chose to start with the original text by Glaser and Strauss (1967) and enrich it with Kirby and McKenna's (1989) adaptation.

According to Glaser and Strauss (1967), the constant comparison process involves separating the data into incidents, coding them according to their main property or properties, and then organizing similar incidents into categories. Kirby and McKenna (1989) refer to an incident as a "bibbit" and describe it as:

> a passage from a transcript, a piece of information from the field notes, a section of a document or snippet of conversation recorded on a scrap of paper that can stand on its own but, when necessary, can be relocated in its original context (135).

"Bibbits" or incidents are coded according to themes or characteristics located within them and then sorted into groups of similar themes. These groups become categories which can then be described according to their content (Kirby and McKenna, 1987). Eventually, these categories help generate substantive theory as explanations to the research question are derived from an analysis of the categories and comparison between them (Kirby and McKenna, 1987). For Glaser and Strauss (1967), this method is a "continuously growing process" (105). The constant comparison of bits of data in a category and between categories generates

> a full range of types or continua of the category, its dimensions, the conditions under which it is pronounced or minimized, its major consequences, its relation to other categories, and its other properties (106).

In accordance with this method, I arranged the women's voices into incidents, listened for themes and common properties, and slowly began formulating categories.

Initially, it had been my intention to look for the women's own explanations for their health behaviours. After transcribing, I felt that the interviews were rich with explanations. However, my first attempts at analysis proved this assumption wrong. Although many incidents surfaced which described women opting for alternative therapies, researching health issues, rejecting and accepting medical treatment, and avoiding primary care as well as diligently seeking it, there did not seem to be any direct explanations from the women themselves for these behaviours.

At this point I continued to code and categorize, allowing the data to speak. Many categories quickly emerged while coding the first interview and I feared that with subsequent interviews the number of categories would become unmanageable. However, these fears quickly subsided as fewer and fewer categories emerged with each subsequent interview until, by interview four, no new categories presented themselves at all. With the same themes repeatedly emerging throughout the coding process, several categories became "saturated" with data. According to Kirby and McKenna (1989), saturation occurs "when added information does not reveal new understanding about relations or abstractions" (138). This is extremely helpful to the research process because, "[w]hen categories are saturated, there is enough information to make statements with a comfortable degree of certainty (Kirby and McKenna, 1989:138). However, if no saturation occurs, statements are made in terms of "tendencies within categories or links between [them]" (Kirby and McKenna, 1989:138) rather than statements of certainty.

Through the constant comparison of incidents in and between categories as well as looking back through the literature, my original 21 categories were continuously redefined and reorganized in a process designed to generate explanations.

For Glaser and Strauss (1967),

> [a]s his [sic] theory develops, the analyst will notice that the concepts abstracted from the substantive situation will tend to be current labels in use for the actual processes and behaviours that are to be explained, while the concepts constructed by the analyst will tend to be the explanations (107).

For example, the category, "fear of cancer" was derived from the descriptions and words used by the women. Further analysis and comparison between categories led to the renaming of this category, "loss of control," which offers an explanation for why the women feared cancer. Similarly, categories were shifted, combined and renamed until just eight categories remained. The saturation of several categories led to their central position in the analysis.

What developed from the analysis is a model of explanation for women's health behaviours which centres around women's awareness of their position on the margins of scientific medicine, their agentic standpoint, previous experiences - both good and bad - with medical encounters, their resulting trust in medicine and physicians, and the health information they acquire. At the centre of this model is women's agentic standpoint. Arrows to all other categories originate from here. The research, thus, came to focus on women's perceptions of power and control in managing their health, seeking primary care, dealing with medical care/treatment, and coping with illness.

4 FINDINGS: PERCEPTIONS OF POWER AND CONTROL

The voices of the women participants were permeated with a sense of agency and punctuated with various statements pertaining to their position on the margins. The literature on agency, which focuses on women's position within power structures, insists that agency is discursively produced by the hegemonic discourse and, from the women's perspectives, is simply a way of life. From the interviews, it is discernable that this sense of agency guides the daily activities and health behaviours of the participants. Furthermore, far from being passive recipients of primary care or passive victims of medicalization, the participants were actively involved in the management of their health and, in some cases, the health of those around them. This chapter is divided into sections which describe the categories that I perceived in the data, as well as illustrates how agency plays out in terms of behaviours and attitudes toward health and where it clashes with hegemonic perspectives.

Beginning with the category, 'agency,' I trace the various behaviours and sentiments which signify what I have interpreted as an agentic standpoint on the part of the participants. In subsequent sections, I explore how this standpoint influences their health care related experiences, how it shapes their health-seeking behaviours, and how it may affect their attitudes toward health and illness.

AGENCY

This category is by far the largest compilation of incidents or snippetts of data from the interviews. It is made up of several subsections and describes a spectrum of positions, behaviours, attitudes, beliefs, and perspectives which, in total, comprise what I have interpreted as an agentic standpoint. Themes of self-control, body-management, and self-reliance make up the bulk of this category. In sociological literature, these are often referred to derogatorily as 'self-survaillance' types of behaviours and indicate the internalization of dominant ideology. I feel it would be a disservice to these women to represent them as over-socialized beings incapable of acting in opposition to, or independently of, the social structure. The internalization of social norms is inconsistent as an explanation here because it cannot account for sentiments and behaviours that are counter to the dominant ideology, for example, non-medical understandings of health and refusal of medical treatments. Theories of agency provide more empowering and woman-centred interpretations as well as a better fit with the data.

Responsibility and Self-Reliance

Overwhelmingly, the women participants believed that ultimately, they must each be responsible for their own health. Regardless of their relationships with their doctors or their feelings toward medical treatment, this sense of responsibility underpinned many of their health behaviours.

> Jen: ...what I do to my body is my responsibility, you know, and if I don't take care of it, well it's my responsibility.
>
> Marj: You are responsible, ultimately, for your own health, aren't you?

For Marj, this means being fastidious over medical follow ups and routine check-ups:

> What I do is I go once a year and I have my physical and I go as many times as the doctor says he wants to see me since I've had this [new condition], now mind you, I wasn't seeing much of him for a while because I was handling my [chronic illness] and everything, but I go now. He says, "I want to see you in two months," and he gives me a requisition for bloodwork and I just bring it home and stick it away and take it when the two months is up.

Most of the women expressed feeling responsible for their own health in terms of living a healthy lifestyle or relying on themselves for the treatment of minor illnesses in order to avoid needing medical treatment.

> Kate: I'm trying to eat the right foods. I'm not always eating the right foods....I quit smoking, quit drinking; you make major lifestyle changes and I guess that's probably why I feel like I'm a healthier person...than I was 20 years ago.
>
> Marj: I don't smoke, I'm very careful about what I eat, I get lots of sleep, I have wine sometimes, but I don't drink very much, I exercise....

> Jen:...I only go [to the doctor] when he tells me I have to come back and see him, you know. I don't--if I have an ache or a pain or something, I just take a Tylenol and hope it goes away....I'm not the type of person that if I have a toothache or a headache or something I don't go right away...

There is a sense that if one is suitably responsible for her own health, then there will be no regrets later:

> Annie: ...I feel somewhat guilty that I didn't push him [family physician] and say, "I want this [test] done."
>
> Betty: I think maybe I should have taken more responsibility. My own doctor, I think would have actually...he was willing to press more for it. It was the surgeon I felt the pressure was coming from.
>
> Marj: By gosh, if I die young, it's not going to be my fault. I'm not going to lie up in that hospital and say, "if only I hadn't smoked, if only I hadn't gained 50 pounds, if only I had exercised, if only."...I'm doing all I can do...I think you have to do the best you can do, then you don't have any regrets.

This sense of responsiblity can be seen to underpin many health behaviours related to lifestyle.

Controlling, Regulating and Managing

Being responsible for one's own health is tied in with ideas of actively managing one's own health, and notions of control and power. Furthermore, the women in this study tend to incorporate information, diagnoses, and treatments into their lifestyles and continue to manage health in keeping with individual subjective ways of knowing and seeing the world. In her research on the meanings of illness to 46 Scottish grandmothers, Blaxter (1983) notes that:

> People have to inhabit their bodies, and their physical identity is part of themselves. Particularly as they grow older, they have a need to account for this identity, to draw together all that they have experienced (69).

Similarly, in this research, as women in midlife encounter the onset of age related changes or chronic disease, they tend to understand them in relation to other events in their lives rather than in medical terms, and they tend to appropriate treatments and make them their own.

Interestingly, none of the women sought cures for their various ailments. Overwhelmingly, the women's responses to ill health were to seek ways to control and manage the condition, not cure it. There was a general need to be on top of things, to keep the illness controlled so life could go on as normal. For Marj, the feeling of being slightly out of control occurs during the course of normal hormone treatments:

> When I'm off of the estrogen for a week, about the fifth day after, I start having nightmares--my sister, too--oh terrible nightmares, and hot flashes, so I'm certainly not ready to go off it....Oh and I don't feel--I don't have the energy and--oh, I really need that hormone.

Being able to predict precisely when and how the disruption occurs, however, is in itself a method of regulating and managing the symptoms. In describing the nightmares in relation to her sister's experience rather than in terms of hormone levels, she demonstrates a subjective understanding of this disruption rather than a medical one.

For Annie, being unhealthy is equated with being out of control:

> Six to ten years ago, I was a mess. I went through that period when I was not healthy emotionally, physically, mentally in any way....I feel much more in control of my life now....I certainly feel more balanced. I probably feel healthier now than I did ten years ago.

She and others consider themselves conscientious when it comes to using medications. Here, again, is the sense that a cure is not as important as a means of keeping the condition under control:

> Annie: I go to [opthamologist] very regularly and it seems to be under control. I take...eye drops every 12 hours and I guess I'm very good about taking my medications....But I am very good about my medications. I don't miss.
>
> Marj: Well, so many of us have it [hypertension], and there again, it's not a good thing to have. I guess it's alright if it's controlled, though.
>
> Jen: Just once in a while I used to get dizzy or, you know, as long as I stay on my medication--don't forget my medication--I'm fine...It's just keeping on it and regulating myself to put myself on it at the same time...
>
> Sarah: As long as that's under control [heart condition], I can do and go all day.

Annie feels that being diagnosed with a chronic condition is in some ways better than having mild, unexplained symptoms. Although the medicalization literature states that once a medical understanding is used to explain a condition, medicalization has occurred, in many cases, there is a positive outcome. A diagnosis indicates a specified course of treatment - a means to control and regulate the condition:

> I almost was relieved. I thought, "Oh good, this is what's causing it all." ....So I went merrily along thinking, "Oh good, she's going to--" because I've heard with thyroid, it responds very quickly to medication and you feel great. And I went for the next blood test and they phoned and said, "Everything's normal," I said, "Oh shoot."

In other cases, prescription drugs are to be avoided if at all possible. Sometimes when the women choose to follow a medical treatment involving prescription drugs, it is perceived as "giving in" or relinquishing control:

> Marj: There's another one [prescription medication] I don't like taking. I try not to take it every night. If I have a couple of bad nights, I take it. I really try not to take it every night. It's a very small dosage.

In several instances, however, the participants on prescription medications incorporated these drugs into their own treatment regimes. They no longer spoke in terms of the doctor "putting them on" a medication, or "having to take" their pills, they made it part of their own health management practices. For example,

> Vi: I think it was diet and medication. Oh I may have tried to relax a bit. Every once in a while it'll flare up and this last year I'd take an antacid, chew a tablet or something like that....I did go back [to the doctor's], I got some more pills.
>
> Betty: I did go on the estrogen on a mid [between the lower and higher dosages] dosage. I was on that for about a year, then I cut down to the next dosage.
>
> Kate: *I'm* taking estrogen for the hot flashes. [emphasis added]

Kate also altered the prescription instructions to suit her needs. In Jen's words, the doctor "gave" her a medication for her arthritis, but it upset her stomach so she stopped using it, suggesting that she had not yet incorporated the treatment into her own health regimen.

There is evidence to support Blaxter's (1983) findings that women formulate their own beliefs about the causes of illness and that this affects their help-seeking behaviour. In many instances, women dealt with ailments in ways that did not involve medical treatment or help, thus indicating the presence of alternate ways of understanding illness. For example:

> [How do you cope when you feel depressed?]
> Betty: Get out for a day, go do something, get away from what you've been doing....sometimes a long walk can be the best thing you can do.
>
> Jen: I kept getting a lot of pain with that [elbow] so I just decided that I had to do something about it. So I heard someone say that if you take vitamin B6, that that will help, so I started taking that about two or three years ago.
>
> Annie: I think, "Why am I feeling this way? What am I upset about? What's happened, what's triggered this?" And sometimes if you think about it, there's a reason, and sometimes there's no explanation, you just ARE, and then it goes away. Or if there's no reason, go for a walk or phone somebody, or put on the boob tube--although, I don't find a lot there that helps--read a book; music helps a lot.
>
> Marj: I'll get in the car and I'll go down and get a movie--an old movie....It always makes me feel better, if I feel like I can't really get out and exercise, but you have to do something, you know.
>
> Kate: I just rest. Like tonight we'll have supper and--which is an easy supper because it's leftovers--but, you know, you plan like easy--I think that's one thing from when I was teaching. Because when I cooked on weekends I always did a bunch a meals and so I always have the emergency meals for when I don't feel like it.

For Kate, running a household and working full time taught her to manage her time effectively. Now that she is retired, she utilizes these skills to manage and cope with her chronic condition, thus fitting her illness into patterns of living she established over a lifetime.

All of the women, to some degree, expressed regulating, controlling, and managing types of behaviours. When speaking about their experiences with illness, the participants offered their own perspectives and understandings of the illness. Sometimes their models of cause incorporated medical views, sometimes they perceived their illnesses only in relation to their previous experiences or those of their siblings/parents. Several women referred to their menopause as "the change" and spoke of this experience in relation to their own mothers' experiences rather than in medical terms of hormones and menses cessation. Although some used hormone replacement therapy to control symptoms, this did not alter their interpretations. This is significant in light of the medicalization literature. There is evidence here that, although menopause has been appropriated and pathologized by orthodox medicine, women are not passive victims, nor cultural dupes of medical manipulation and claims to authority. Additionally, repetition of the term "the change" is evidence of the resistance of medical definitions of menopause. The meaning inscribed on this life event by using the term "the change" resists medical definitions and understandings. It suggests an experience that is continuous through familial ties, 'bloodlines' if you will, and entails something more meaningful to these women than "menopause."

Independence, Disability, and Productivity

Concerns of being disabled and dependent on others for care was a common thread throughout the interviews. The women participants valued being productive and able to do what they want to do. At this stage of the life cycle, future mobility is often threatened by the first manifestations of disabling diseases such as arthritis and osteoporosis. Devastating diseases such as Alzheimer's and stroke seem more tangible now than they were perhaps at 45.

Most of the women mentioned stroke as an event that they most wanted to avoid in later life:

> Betty: I don't like the idea of strokes, I guess. The disabling part of that, basically....If I'm going to have one, have one that's strong enough to just end it rather than go through that.
>
> Jen: I've seen people that have had strokes, and I just don't want that to happen to me. And I think I should get off my butt and do something about it instead of, you know--get my will power going and do something about it. I don't really want to have a stroke. I think that's my concern. I mean I've been through a lot. I've been through the cancer and a lot of other things but it's just, you know, I think that would be worse. Being disabled and having someone to look after me...I'm a really independent person and I like to do my own thing and, you know, I think that's what it is to me.

Diseases that limit mobility were often mentioned as health concerns:

> Sarah: I don't know if it's the osteoporosis so much or the arthritic sort of thing where people just don't move as well as they want to move....I think, you know, that you still want to be able to get up and go out.

For Annie, Alzheimer's was the disabling disease she feared most:

> But when you don't have family there's sort of no blood there to take over the reins and um...depending on how long I live, you know...And as long as I have my mental faculties, things will be fine. I mean, I can put up with anything physical, you deal with that. Maybe you don't like it, but you can deal with it--as long as this is working [points to head].

In all cases, the common denominator is a fear of losing control over one's life, a fear of having to be dependant on others for care, and a fear of losing the ability to be self-determined. I think these fears embody the presence of an agentic standpoint.

Along with the fear of being disabled comes the value placed on productivity or the ability "to do" things. Being "well" in the interviews is associated with being productive or being able to exercise one's will in terms of physical tasks. Given the production-oriented nature of industrial society, this is hardly surprising. However, when taken within the context of the "agency" category, I think there is more to it than being socialized by industrialization. The desire to act on one's behalf, produce, and exercise one's will are also expressions of agency:

> [What does it mean to be healthy?]
>
> Vi: It's about being able to get up and get going and do things....to be able to enjoy life and what you want to do.
>
> Jen: It must be a really good feeling to be healthy, you know, like you can uh...you can do anything....but not to have the aches and pains and be able to do everything that you want to do.
>
> Kate: I can do a fair day's work myself, now...and this sort of thing....It's hard to do things, you know, like go on a trip, sit some place, it's very difficult to do things if you don't feel healthy.
>
> Annie: I don't get sick. I don't miss days from work due to illness.

I have attempted to characterize the sense of agency permeating the interviews while illustrating the standpoints of the women participants. In keeping with the literature on women's agency, this section has focuses on women's position as self-determined beings rather than over-socialized automatons. It illustrates an agentic standpoint as described by Bakan (1966): is a strategy to reduce tension by taking control of and changing one's environment. In this case, agency is expressed through the control and regulation of health related behaviours, taking responsibility for health, and expressions of independence and self-reliance. Subsequent sections in this chapter reveal the effects of interaction between women operating at the margins of power, and power structures in society.

PERCEPTIONS OF GENDER INEQUALITY

There were enough expressions of various sentiments regarding women's location in society to warrant this category. It becomes clear in some instances what influences various women to take control of their own health, seek alternative treatments, and actively research their health concerns. The viewpoints expressed here are important to developing an understanding of women's health behaviours from their perspectives. Some embody the accumulation of experience in a sexist world, others represent awareness of women's social roles and the implications for health. This section emphasizes the extent to which the women participants oppose aspects of our medical system. It underscores the significance of what it is to be female in a male-oriented system, and it illustrates how an agentic standpoint exists alongside, and is produced by, the hegemonic or dominant ideology.

Four of the women made statements to the effect that women's health issues are secondary to men's or that women do not receive the calibre of care that men do. Although Marj considers her doctor one of the best, she maintains that this is not the norm and that, in general, women do not receive equal health care:

> I really don't think a lot of women get proper diagnosis. I really don't. I think that women don't get the health care that men do. I've always felt that, that they don't--doctors don't really listen to them. I just love my doctor because he's always listened to me and I think that it's put a--you know they just kind of pat you on the head and say, oh I'm getting older or something.
>
> Kate: They will have a cure for prostate cancer long before they'll have one for breast cancer.
> [What makes you say that?]
> Because it's a men's world....It's a men's system.
>
> Betty: I do think in women's health they have to look at more or do more with some things that are a concern just to women. I think a lot of health has been geared more to the general population: the male, the research and everything else. And I think we could use more on the women's side. It's always a male thing you hear about. But where is the same kind of money into the research for say breast cancer or into the research for these other things? You can't steal from the one because the other one is more important to the so-called experts or male doctors, male researchers.

For Sarah, who has survived a heart attack and triple bypass surgery, treatment for women's heart disease is seriously undermined by sexism:

> [Why do you say that women don't worry about heart disease?]
> I think it's because they're not educated to it. I think heart disease is a man's disease. You know, like if he has a heart attack, "Oh, my God, I can't go to work." Or when you see a man go like this [clutches chest], everybody

> goes, "Oh my God, he's having a heart attack, someone call an ambulance." You see a woman go like that and, "So?"
>
> But there is a look, and there is a, it's a complaint about the way a woman says, "I've got this..." You get a man in there who says, "I've got this..." and before he can get the words out of his mouth, he's up there [hospital].

In keeping with feminist critiques of medical care, several women felt that, too often, women's complaints are not taken seriously or are treated as psychiatric problems:

> Kate [before she was diagnosed with MS]: Then they sent me to a stomach man, that it was a virus. And then they sent me to have my head scan thing done. And then they sent me to all these different tests, and every time you had a test, like in between you had to wait for two or three weeks before you got to see this doctor. And in the meantime, they're telling you, "It's in your head." At this point I said to [family physician], "If it's in my head, let's get me to a psychiatrist and we'll get this dealt with." That appointment happened REAL fast!
>
> Marj: I think there are still so many old fashioned doctors that kind of pat women on the head and say, "Oh, you can live through this."
>
> Sarah [re: being given antacids and tranquilizers before her heart attack]: ...And I'm not arguing that. I'm not saying he should have known, you know, right away what it was, but if I'd been a man, I'd have been having an ECG and the whole business. But women don't. They get the tranquilizers and the whole bit first, and then if that doesn't work, they get an ECG....They're a normal treatment for a woman, or for something that they can't see exactly what it is at the moment, so their first avenue is tranquilizers. But not for men.

Both Kate and Sarah mentioned the connection between sexism in medical practice and the sexual division of labour in society. They understood that the value placed on paid labourers plays out in terms of unequal treatment and that women's paid work is trivialized and their unpaid work unacknowledged:

> Sarah: I think with men it's their...work. Something will happen to their work. But women...they only work for their entertainment, or so people think.
>
> Kate: This is the other thing with being on this disability pension...I will go to the doctor and because it's like you're treated like a second class citizen, type of thing. "Well, you're not working." [My husband] gets sick, he gets instant care... But he's also the man, and all of a sudden, "Well, you're just--you just stay at home, you don't have to do that much."

Attitudes of doctors play a part in discouraging women from seeking medical care. Sarah's experiences stem from her treatment for heart disease:

> [What would have helped?]
> The doctor talking to you like you were a human being and not just some idiotic menopausal woman--well, I'm not meno--I'm past that--But that's just the feeling I get, it's just like, "You idiot! What do you want now? What are you doing now?" And you think, "God, what did I do?"...
>
> And yet, if he would think about it, I've never gone to the doctor for a cold. I've never gone to the doctor for, you know...And then you think, "Oh well, I'll change," but you know they're all like that.
>
> And I think, too, you get to feeling that you don't want to go. You know you're being treated like that. And you think, "Oh, I've got something...Oh well, I'll just...."

A hysterectomy that was apparently unnecessary, based on the biopsy report after the surgery, has shaped Betty's opinion. Additionally, the issue of medicalization is apparent here. Betty could be seen as a victim, but never passive. Coercion, appeals to authority, and control influenced her decision to consent to surgery. The devaluing of women's reproductive parts once they are of no use to men is an issue in feminist critiques of medicine, and is evident in this case:

> At that age that I was at, this doctor is looking at, "These are useless organs, now. The old ovaries are going to shut down in the next few years anyhow, and the uterus is of no use any more." They're looking at it as a useless thing. It doesn't matter that you've still--they've cut you wide open, and you know, and basically you're some time getting over it, what you can and can't do. But those organs have become useless to them.
>
> I don't think I was given enough time to even think about the other and if I'd had maybe a woman, or even a--not necessarily a doctor--just to say, "Okay, we've got a woman that can talk to you about this," or...they don't even tell you what you were in for, basically until after it's all over with. Then they say, "Oh, by the way, now you can't do this, this and this for this long or high, and you shouldn't, you know, this." ...Like none of it is up front, kind of thing. You don't really know what you're getting into, basically. Like it's almost like, "Oh this is this patient, this woman that I've got to deal with. She isn't going to be able to make a choice, she's not educated enough in this or doesn't know enough about it." So they make the choice for you in a way.
>
> I mean, you yank the tonsils out and it doesn't seem to make any difference really, but they don't do that as readily as they used to. They've become, you know, they realize--we don't know these parts of the body, basically. Plus every surgery is a risk. But they have to make the money some place, too. I imagine hysterectomies pay pretty good.

Betty wishes she had taken more responsibility and not listened to the doctors who urged her to have the surgery immediately. She regrets not having the time to make an informed decision, but also recognizes that the surgeon was using his authority to pressure her into consenting:

> ...these are all male doctors, every one of them I had was a male doctor. I think if I'd read up on it a little bit more I maybe would have delayed it and said, "Lookit, I want to make sure."

Feeling cheated out of her right to make an informed choice, even recognizing that her decision may have been to go ahead with the surgery anyway, Betty was not to be cheated out of the last word:

> And I'm not a person to have people make choices for me...So I think I always felt like, "Hey, if you just let me think about this for about a week..." And I think I was a little scared enough to think, "No, I've got this growing and I've gotta have this done and that's that." Then afterwards, when they came back, "Well how were the tests?" "Oh fine, everything was fine." Well, I said to the surgeon, "Well, then it was an unnecessary surgery, wasn't it?" ...He did not appreciate that remark at all.

Encountering sexism in medical practice had the effect of discouraging some women from seeking medical treatment, reinforcing self-reliance, and fostering distrust of physicians. Individual experiences with mainstream medicine further shape women's attitudes toward, and use of, primary care.

This category in particular allows us to glimpse these women's counter perspectives. It shows how women may embody standpoints that oppose the dominant ideology by virtue of their position in an androcentric society. And it lends to our understanding of why women might take control of their environment and attempt to change it.

CONFIDENCE IN DOCTORS AND MEDICINE

Women's experiences with doctors, medical knowledge, and treatments shapes their attitudes toward, and trust in, allopathic medicine. But what constitutes a positive experience from the patient's perspective may be altogether different than what doctors expect their patients want. In organizing the "bibbits" of this category, I have attempted to understand the positions of the women participants' on primary care.

In keeping with previous research, all of the women claimed to use a number of sources for their health care information: television, newspaper, radio, magazines, Internet, library, pharmacist, friends, family, and family physician. Information is valued. Some women are suspicious of the extent to their doctors' knowledge:

> Kate: ...and that's where I have gotten the majority of my information, not from the doctor. And even on these tapes, they say doctors, they get what, an hour and a half of training on nutrition, and that is not enough. It isn't at all.
>
> Betty: I don't know that a modern doctor, though, once they get through their schooling and everything else, I don't think that a lot of them have time to read up on all of this stuff. I think it's a lack of time to read.

From Annie's perspective, medical knowledge is temporal, and listening to one's body may prove healthier in the long run. She has questioned whether erroneous medical advice during her child bearing years has contributed to her osteoporosis.

> Annie: I was pregnant at the time when, my goodness, you didn't dare gain any more than 20 pounds--that's it--20 pounds. And the doctor just preached and preached. I remember my doctor with [my first] saying, "Isn't it unfair, Mother Nature has given you this wonderful appetite and we're

> telling you not to eat." And after [my second] was born, I was overweight by about 10 pounds and I never went to the doctor. He wasn't going to say to me, "See I told you, those are those 10 pounds I told you not to gain." You know?...And now when I look back, I think that makes no sense. It doesn't make any sense at all. You know, even at the time you think you're doing the right thing [by following your doctor's advice] and then later on you find out you've been doing exactly the opposite.

In medicine, knowledge or information is power. The cultural authority of physicians is derived from his/her access to privileged information. Disseminating that information, then, must be done with reservation in order to preserve power and control. In her research on agency in health care, Ryan (1994) claims that information is the most important component of health care to the patient, that doctors typically withhold information, disseminate information selectively, and prefer passive, unquestioning patients who accept their decision making. It is not surprising then, that most women expressed positive opinions of doctors who readily answered questions and gave information and allowed them to be part of the decision making process.

> Vi: Oh, he's helpful. He will answer my questions. And that's helpful.
>
> Annie: Now mind you if I had a question he'd stop and answer it but I always found he's in and half way out the door. I'd say. "Just a minute," you know, and sort of come back. But I always felt I was sort of infringing on his time. Whereas with her, she pulls the stool up, she has your file and she sits down and, "Here, this is what this says and this is what this means. This is here--" and any time I've gone to her, I'll bet she's spent a good half hour. She's phoned me with test results, apologized for calling at meal time and took the time to talk to me. I appreciate that.

Interestingly, when Annie discusses medical treatment from her woman physician, she uses the pronoun "we," indicating that she and her physician worked together to develop the best course of treatment.

Conversely, when women feel that doctors don't give them the information they need, they express negative sentiments:

> Betty: They just, "Okay, one more case." That's all you are, one more case. You're not an individual to them, basically....[H]e was headed out the door when I basically stopped him and said, "Hey, just a minute, I've got a few questions I want to ask." And it was almost like [makes surprised face], "You're what?!" By his facial expression, it's just like, well they just don't have the time for you or just don't take the time for you. So, I think, ah....they have to stop and look at the individual person.
>
> Kate: And you see, I'm used to the old doctors who you go to when you're not feeling well, and the caring part? The caring part is all gone. The real care is really missing. And you are meat, you are. So what, you die. You know, who cares. And it's so much, "Here's a pill, this will make you feel better." I don't like that.

Like Kate, several women felt that primary care leans too heavily on drug cures because they are fast and simple. Doctors are too busy to take the time to work through a problem with a patient and develop a treatment plan that best suits their lifestyle. However, I did get a sense from the participants that they feel that medical science is a very good thing when it is needed or wanted, but that medications are prescribed unnecessarily for minor complaints.

For the most part, what women wanted from their physicians was a reliable diagnosis and information. Typically, the women researched their health problems on their own but relied on their doctors for a diagnosis. A good diagnostician, like a good mechanic, is one who makes a reliable diagnosis, does not withhold information, and puts the needs of the client first.

> Jen: I can be really thankful that [family physician] found the cancer when he did, years ago, and uh...I'm pretty lucky that he called me and told me about it and the whole bit and, "Get in here so we can do some more tests," and everything, and I'm lucky about that, you know, and I have confidence in him...

> Vi: Oh, I rely on him quite a bit. You know...now he's always ready to say, "Whoa, get a specialist," or like with this knee, I haven't been back to see him since he prescribed _________. Well, I haven't been back to him. I'm waiting to get my cholesterol down, too, so he can do it all at the same time.

> Sarah: There's a new internist up there and he looks about 7 years old. And he said, "It's not your heart. We've done all the tests and blah blah blah. And it's this, and the inflammation comes from here," and he drew a little picture, "and this is how it happens," and you say, "Well why do you think--" and he'd say, "Well because the pressure on the thing and da da da..." Fine. Good bye...It's not that you can't put up with the discomfort, it's just you're terrified of what it is....But not, "It's not your heart. Here's a tranquillizer, good bye."

Having the desired information empowers patients to make decisions about their health. Some choose to follow the doctor's recommended treatment. Others research the condition further and choose alternative therapies. Either way, the women participants in this research, in keeping with findings by Ryan (1994), value information from their doctors, and this aspect of their primary care experiences influences their feelings toward their doctors in general.

SEEKING HEALTH INFORMATION

As already mentioned, the women in this research all actively seek health information from a variety of sources: the media, books, pamphlets, various health care practitioners, information seminars, lay people and family. Information affords patients the ability to take control of health problems, thus ensuring that these problems will be managed in what the patient considers to be a satisfactory manner.

In some cases, women use a doctor's diagnosis to self-diagnose later on, or to learn how to regulate and control the illness:

> Jen: It was just a routine thing. And he took my blood pressure and he says, "Do you know your blood pressure's up?" "No." I know NOW when it's up...I can tell it now because I get headaches, or....I don't use the salt shaker at all. I try to stay right off it. Boy, I can really tell if something's really salty, I just....not immediately, maybe the next day.

From her doctor's diagnosis, Jen learned to recognize the signs of high blood pressure so she could control it with diet as well as medication. In a similar situation, Kate learned to identify elevated blood pressure. She, in turn, learned to control it without medication.

A common theme of this category is the incorporation of one's own and others' experiences into causal explanations for illness as well as management strategies. Women learned about their bodies through various experiences and developed understandings of their illnesses that were, as Blaxter (1983) states, perhaps different from medical explanations, but "no less logically derived" (69).

Marj developed a system of work and rest at two hour intervals while learning to cope with fibromyalgia:

> I've been one of these people, I charge into the day and I just go til I drop. But I can't do that any more. That's what I found out with the fibromyalgia, because the next day, I hardly can--the head is full of cotton wool and I'm weepy and I don't have any energy and every place hurts. I feel like I got hit by a truck everywhere.

She connects the onset of fibromyalgia to an accident she sustained right before the first of symptoms:

> I had a bad fall just before this was diagnosed and had surgery on my shoulder, and that's why it--that sometimes does start up fibromyalgia.

And she associates the exacerbation of symptoms and the onset of other problems with a stressful life event: the loss of a granddaughter:

> I seemed to start having some more problems at that time and they don't know enough about it to know whether this sort of thing triggers....Stress triggers a lot, I really believe. I had a big flare up of fibromyalgia after that...But everything is balanced, now.

Jen made the connection between her ongoing digestive problems and the radiation treatments she endured for cervical cancer some 30 years earlier by talking to other women who had also undergone radiation for cancer in the lower abdominal region. Comparing stories with three other women led all four to conclude that the radiation had hampered their ability to digest specific foods.

> I don't think they [the doctors] really knew. I don't think they really knew about it because, like I was talking to a woman before--she had radiation, too, and I was telling her about the things I couldn't eat and she says, "Well, I had radiation, too, and I can't eat peanut butter and stuff like that." But I've had it ever since they gave me the radiation....And my girlfriend that I

> told you about in the beginning? She has the same thing. And she says, "You know, when I eat different things--" and I said, "Peggy, I can name off a few things that I--" and she said, "Well, that's what I have," she said, "These things bother me." Like, she's still on the radiation. I said, "Well Peggy, it's got to be the radiation that's doing it to you," you know, that's making her sick that way. So she said she never even thought about that....So that's three people that I've talked to and they've all had radiation...

Her doctor eventually concurred with her self-diagnosis. By drawing on their own experiences, and networking with others, the women were able to make sense of their illnesses in ways that allowed them to control the symptoms and carry on with life.

The issue of trust appears to be a factor in women's health information seeking behaviour. Several women made statements which indicate that they are not willing to accept their doctors' word without finding more information or getting a lay opinion.

> Kate: Well, it's like...like they could give you a shot of cortisone...and it might work and it might not. But then I opted out for that because I talked to different women and they said, "No, they wouldn't work," it wouldn't work. And then I talked to this one girl...and she had them [shoe inserts]...and she said how she got the form things and that it did help.

Subsequently, Kate rejected medication and chose orthopaedic inserts.

> Marj: I go to the library, I research everything. Before I take a pill I go to the library, and half the time they don't have the newest books because if he gives you a new drug, it isn't in it.

> Annie: [re: her decision to take medication for bone loss] I have a friend who has been in an osteoporosis study group through Women's College Hospital in Toronto. She said she was on this for a while at the beginning of the group and she did have some increase in bone mass.

Considering other sources of information assists the women to make decisions with which they are comfortable.

Another common theme is what Blaxter (1983) found to be the second most frequent explanation of 'cause' after infection. Namely, heredity or family traits are incorporated into women's understandings of illness. In Blaxter's (1983) study, this type of explanation was "given much more weight than medical science would give it and was applied to a very wide variety of diseases" (63). During the interviews, women made strong connections between current health problems and family tendencies or heredity. In fact, in most instances, as we discussed each health concern, the participants invariably mentioned family.

> Vi: Well, I got a phone call and it was the doctor and he said he wanted to talk to me. And I thought, I bet it's cholesterol. So I must have had an idea maybe because of my dad.
>
> Jen [re: arthritis]: All I think is it's, you know, hereditary like. That's why I got it.
>
> Kate: I remember my mother had a heck of a time when she went through her change, and of course you didn't talk about it then. But every day I came home from school, she was crying. And I'm thinking, "Oh my God, this is what I'm going through!"
>
> [What makes you healthy?]
> Betty: Probably genetics is a good part of it...
>
> [Why do you think you had heart trouble so young?]
> Sarah: I think it was--well, my family history, because it was my grandpa and my grandmother, my other grandfather and my aunt, my mother....Um..I think it was smoking. I started to smoke when I was 16. And I smoked, I wasn't just fooling around. I smoked at work all day in those days, I smoked in the hospital when I had my heart attack....And I

> went on the birth control pill when it was first invented, I think, when the dose was [real strong], and I stayed on that until, God, I don't know....But I think it was the smoking and the birth control pill and a life of heavy stress.
>
> Annie: I'm just glad to be alive because my parents--like, my mother was dead at my age. My dad died at 59 and my brother at 43 and I'm just glad to be alive and functioning.
>
> Marj [re: cholesterol]: Definitely, I think it's an issue. I don't know why somebody like me--slim with--it's my family history. I have a terrible family history....I eat very little fat. I'm a health nut as far as food goes, according to my family. My husband weighs over 200 pounds; he's a big man. They don't have heart trouble in his family, his cholesterol is fine. He eats bread with butter and ice cream. It's very annoying.

The inclination to understand illness through family lines is more continuous and less individualistic than medical understandings of health. It exemplifies the emphasis patients put on lay perspectives. Although, from a medical science perspective, heredity does have implications for health, the key here, as Blaxter (1983) argues, is the *emphasis* put on heredity as an explanation for health. The women participants tended to weigh family quite heavily in their understandings of health. Along with the tendency to seek information and not rely solely on medical advice, it is perhaps indicative of counter-hegemonic beliefs at work.

REJECTION OF MEDICAL TREATMENT

Aversions to prescription medication may be in keeping with women's general sense of alienation from medical science, their need to independently manage their own health, as well as the influence of lay perspectives, and the results of their own research. Also, many women mentioned side effects of medication as reasons for avoiding it. There is a general reluctance to take medications prescribed by a physician, yet a seeming affinity to remedies that are perceived to enhance the body's own natural healing powers. Allopathic medicine approaches illness from a 'search & destroy' standpoint. Medication is designed to oppose pathogens in the body and fight them instead of working with the body and reinforcing its natural ability to fight the pathogen itself, which is the purpose of homeopathic and many herbal remedies. Women's aversion to allopathy and affinity to homeopathy was expressed in terms of the rejection of prescription medications and the search for alternative treatments:

> Annie: I don't like taking a lot of medications. I've had prescriptions--picked them up, brought them home, and gotten rid of them.
>
> Marj: Well, I think you're always concerned if your cholesterol is high. Especially if your family history has a lot of problems in it because it certainly isn't a good thing to have. And then it just adds one more pill. I hate them. Yet, I take vitamin B [laughs], ginseng, and garlic [laughs], but those are....
>
> Kate: Instead of going and asking for a prescription, I tend more to go to something that's natural.

> Jen: I just told him I didn't want to go on pills. I didn't want to get onto Valium or stuff like that, you know. I'm not one to take pills, I just--you know, like I take one pill--vitamins--right now. I mean, if I had to, I would, but...

Most of the women willingly take herbal medications and tonics recommended by alternative health practitioners as well as friends. One possible explanation is the incongruities between allopathy and traditional methods of healing used by women for centuries. Folk cures tend to be homeopathic in nature, assisting the body to cure itself. Perhaps the women learned from their mothers how to manage minor ailments and, as a result, find "natural" remedies more in keeping with this wisdom.

Many different ideas about prescription medications presented themselves in the interviews. Terms like, "invasive" and "side effects" were used in conjunction with "prescription medication." Some women felt that pills are not a real cure, they merely mask the symptoms and don't get at the real roots of the problem. Fruend and McGuire (1995) contend that patients generally tend to view health more holistically than doctors, seeing the social causes of ill health as important aspects of health care, and this could account for these sentiments. There is also the notion that a prescription drug deals with the problem for you, it does not help you to deal with the problem yourself. Furthermore, in many instances, women saw taking pills as "giving in" to the disease. Taking medications is associated with being unhealthy. This is hardly surprising since our health care system, with its downstream, Band-Aid approach is really designed to cure illness, not to keep people healthy. It is designed to be used when illness strikes, not during wellness. Even "preventative" strategies like mammography, Pap smears, and bone density testing are designed to detect disease, not to prevent it. Managing medical conditions with natural remedies and therapies instead of prescription drugs may mean the difference between maintaining "wellness" and being "ill" from a subjective standpoint.

The decision to reject prescription medications and medical treatments is determined by myriad factors. Trends in society toward natural remedies is most certainly an influence, especially given that women actively seek out health information; natural products are a booming business. The idea that alternative remedies are not as dangerous as prescription drugs, in terms of side effects and addictive qualities, has women adopting that, "it can't hurt" approach to trying different treatments. But apart from social trends and media, women's agency and lay understandings of health--specifically women's accumulated knowledge of their bodies--is an underemphasized component of the decision-making process.

ALTERNATIVE THERAPIES

Information about health, experiences with physicians and medical treatments, ideas about conventional approaches to health, and self-determination all influence women's decisions to seek alternative therapies. For reasons mentioned in the previous section, women seek alternative and natural treatments. Massage therapy, Shiatsu massage, Tai Chi, yoga, inspirational tapes, and herbal remedies were mentioned by the women. Most of the interviews revealed holistic understandings of health which incorporated emotional, spiritual, and mental facets with physical health. Some women felt that primary care deals with only one small aspect of health: the physical. Alternative therapies are one way to fill in the gaps.

> Annie: I go to her once a month for Shiatsu massage...and um...part of that I go for is um... because I don't experience human touch any more? And I think that's important for your wellbeing...
>
> Marj: I find that if I go to a massage therapist for the upper part of my body, if I get into bad shape, that that really works.
>
> Kate: ...like the oil of primrose, that helps. And...now I used to take Tai Chi and they used to have a class down here in the afternoon and it did help...I find that if it's really bothering me, that I will do it when I ahh...get up, like I'll just do the basic warm up exercises and that'll help cope with it. But I don't take--occasionally I'll take medication. I started taking a tonic that this girl recommended and it--because I was having an awful time with my hips last fall--and I take this tonic every morning...It's expensive, too, but it seems to help. It's just this tonic that has all these vitamins and all this natural stuff. It's all natural.

Seeking alternative therapies was closely linked, in the interviews, with information seeking behaviours and the rejection of medical treatments. Because of their agentic standpoint, women formulate their own ideas about health and health care, and choose a course of action which best suits their needs.

LOSS OF CONTROL

Every woman mentioned fearing cancer. Initially, I named this category, "fear of cancer," until I found that a similar fear was expressed for other conditions of equal gravity. Then it became a "fear of terminal illness." However, listening to the voices, I began to hear something else. No one expressed a fear of dying, in fact, some women claimed that they preferred to die suddenly rather than undergo cancer treatments. The fear of cancer is more accurately directed at the treatment for cancer, not the disease itself, and not dying. This makes sense because there was never any mention of fear of any of the myriad chronic illnesses that women face--save for stroke, and that fear was directed at losing control of one's body and mind. As long as they had enough information and were able to manage and control their ailments, most women generally claimed to be healthy. Cancer is different.

> Annie: I have friends who have had the treatment, you know, the hair loss...a mastectomy--the body mutilation is...I guess it's the mutilation...just the whole business of cancer I find repugnant. I just think it's such a horrible, horrible disease and, although they are making headway according to recent reports; we're doing a lot better than we did. But I guess if I had a fear, although it seems as if heart disease is the disease in my family--that's taken most of my family, still cancer is the one that I--if I had a worry--is the one that--if I have to go, I'd rather fall down tomorrow with a heart attack than--...And it isn't even so much having the disease and the dying, it's the horrible treatment, you know.

Cancer is one disease that most people take seriously enough to default to medical science for treatment. There was no criticism of the way cancer is treated, denoting a general acceptance that this approach is the only way to deal with it. A diagnosis of cancer, then, means that the patient effectively gives up control and management of the illness, puts herself in the hands of her physician, and undergoes a treatment that many find more horrifying than death.

Cancer itself is cell-division out of control. Fear of not knowing its form or degree of severity, fear of not seeing it, and not feeling it as it grows inside are fears related to being unable to manage something that is out of control.

> Jen: I was afraid, you know. The first time I had it, I was really afraid because I thought, "Oh, am I full of it?" or, you know, "Is it going to come all over the place?" or, you know, "Is it going to come back after 30 years," eh?
>
> Sarah: I don't know. It's just very scary, I think. And I think that, unfortunately, I think of all the people, when they find breast cancer, it's Latin for, "there's more."

The mysteriousness of the disease, according to Blaxter (1983), is partly responsible for the terror. In her study of the concept of disease and causes, Blaxter (1983) remarked:

> Cancer had replaced TB as the incurable disease, the disease to be dreaded, the disease to be mentioned without any discussion of its cause. Cause was unknown, and speculation not only fruitless, on the whole, but also uncomfortable (67).

In this research, issues of agency and control are very much a part of the equation.

COPING STRATEGIES

I include this category in order to round out the findings and answer some questions as to the consequences of approaching life from the standpoint that you are ultimately responsible for your own health. It was Freud who claimed that one's sense of responsibility is positively correlated to one's sense of guilt. During midlife, when most chronic diseases begin to manifest themselves, how do women avoid feeling guilty over every health problem they encounter? And how, in general, do women cope with the onset of age-related[10] ailments? This category developed as a repository for sentiments that seemed out of alignment with what I perceived to be an agentic standpoint. Upon organizing the data into themes abstracted from the substantive situation, I came to understand them as coping strategies rather than contradictions.

Improving With Age

With maturity comes a certain wisdom about life that fosters a more accepting outlook. Most of the women expressed increasing confidence during middle age, less stress, fewer social pressures, a stronger sense of self, and a mellowed disposition.

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[10] By "age-related," I mean related to age in a social context. I do not mean to imply that the body is naturally prone to things like osteoporosis or heart disease as it ages.

> Betty: You get to the point where you think, "Hey, if you don't like it...tough!" You quit having to prove yourself to the rest of the world. I've become a great deal more accepting about things.
>
> Kate: Well, the self-confidence--yeah, I wish I had some back then. I must have some now, otherwise I wouldn't feel this way and sort of accepting things.
>
> Jen: I think about 30 years ago when I was divorced and I was making maybe $1.19/hr and supporting my daughter. And I made it. So, it doesn't matter what I have to go through in the next few years, I know I can do it. And I figure if I have to go through cancer--another operation on my face, then I'll go through it and I'll get through it, you know?

For some, a sense of inner peace and more relaxed approach to life characterize middle age. In general, these changes in outlook make women more resilient and better capable of dealing with life's pitfalls.

> Marj: I can remember thinking when I was young and somebody would lose their husband and I would think at that time, why would they want to go on, you know?
> Where, when you get older you would feel terrible, I don't have THAT feeling any more. Because one of us probably--unless we both go down on an airplane--one of us is going to go first. We've had so many friends that have gone.

Taking Things in Stride

Taking things in stride is a natural outcome of accepting life's risks and easing one's expectations of self, others, and life in general. This coping strategy is characterized by the recognition not only that illness, pain, loss, and pitfalls will inevitably happen, but that they, too, can be dealt with in stride.

> Kate: I'm reading this book and it says, "Don't worry about it now, wait til it happens, then handle it." And you know, that changed my life. It's learning to deal--recognizing your fears then learning to deal with them.
>
> Jen: I just, you know, take it as it comes. I guess I'm a person that can put up with a lot of pain....It's there, you know, what can I do about it?
>
> Vi: I'm not concerned about my health. I think that...ah...you know, I don't drink milk and..ah...if I get sick, then I'll look after that.

Accepting physical change and incorporating it into one's lifestyle is a method of taking things in stride:

> Jen: ...But I just put up with it. I just, you know, if it took me a while to get going, I would just say--everyone says, "Well, are you okay?" and I'd say, "Yeah, I'm fine. Just give me a minute to get going."

Blaxter (1983) notes in her research that, in general, women were willing to accept poor health as a "natural feature of the aging process" (65). However, when discussing specific diseases, they were not inclined to dismiss them as normal age-related ailments. Similarly, in previous discussion of specific health concerns, ideas of cause were sometimes very complex, and disease was rarely attributed solely to age. The idea that ill health inevitably happens then, should be taken more as an indication that women have prepared themselves to deal with whatever they may face in the years to come.

> Kate: I think this is something people go through in their life, because it can't be all rosy, dammit! [laughs] If it was, it'd be boring.
>
> Annie: And if I don't have to deal with anything worse than osteoporosis and a thyroid problem, I'll count myself lucky. I said if these are the ills of age that I'm going to be dealt, I'll take my hand gladly. Very gladly. I'm very very fortunate. I'm not even going to let money worry me. I always say when it's gone, it'll be gone. If it's not there any more, it's not there any

> more. Plant a garden...As long as I can keep clean and tidy...fed and clothed...warm and dry...what else do we need, eh?

Fatalism

Finally, fatalism is a strategy that works to alleviate personal responsibility in the event of illness as well as a coping mechanism for life's mishaps.

> Marj: I think I'm more fatalistic and more pragmatic and I think that I'm able to look at my life as a whole, you know, instead of, when you're young you don't kind of--you're just looking at the next year? I think that I have become much more pragmatic. I think the more people close to you that you lose, you become much more fatalistic and this is all part of the big picture.

> Betty: I think that anyone, as you get older, you sort of wonder what's down the road for you, especially if you're around seniors a fair amount. You go into these nursing homes and look around and say, "Oh my goodness, is this what's going to be in store for me?" But I can't say that it's anything that I sit and worry about. I mean, if it's going to happen, it's going to happen.

> Kate: I guess I'm one of these believers that things happen because they happen. I don't know if it's a faith or a philosophy or something, like, on my life.

Faith in God is a form of fatalism. For Jen, religion has been a source of strength in times of adversity, as well as a comfort from day to day:

> I think maybe my faith has really done a lot for me. It's brought me through a lot of things. It's brought me through the cancer, it's brought me through--even though there was a time there I didn't go to church, but it was always there. It was always at the back of my mind that I knew I could go to Him anytime I wanted to and it's--and that's one thing that's really brought me through....and it doesn't matter how much time I have left, I'll still have that faith to take me through whatever I have to go through.

> You do worry to a certain extent, but if you spent all your days worrying about things, like me--I just put it in the Lord's hands and think, "Well, if it's going to happen, it's going to happen," you know.

Together, these coping strategies work to absolve women of the guilt that might result should they fall ill while embodying such self-determined and self-reliant outlooks. They are another piece of the puzzle which helps us to understand their health behaviours.

In this chapter, I have attempted to delineate and characterize the categories that I perceived in the data as well as to indicate the direction my analysis took. What I understand to be the most significant finding is the degree to which women's sense of agency influences their health behaviours and attitudes. Furthermore, these findings do not reflect the stereotype of the maladjusted middle-aged woman that the literature projects, nor do they indicate that women continue to be victims of medicalization. Rather, these findings suggest the existence of counter-hegemonic perspectives which are only discernable as "noncompliance" in health research from a medical standpoint. What we find when women's perspectives are the focal point of research are ways of knowing, resisting, and navigating a world which is not our own. Restrained by social structure, women make their space in the interstices of power, operating alongside the hegemonic, tapping into available resources in attempts to maximize their health outcomes.

5 DISCUSSION: IMPLICATIONS OF WOMEN'S PERSPECTIVES ON HEALTH

We have seen that in order to explain the health-related behaviours of women at midlife we must first understand something about the social context within which health decisions are made. Through the eyes of the women participants, we are able to glimpse an aspect of women's lives not generally found in health-oriented literatures. Specifically, we are able to see how certain women perceive health and illness in ways that are different from dominant medical perspectives. We are able to see how these counter-hegemonic perspectives sometimes clash with dominant medical views and attitudes. And we are able to see how this play out in terms of health behaviours. Exploring health behaviours from women's perspectives provides a critical standpoint from which to view primary care services. Perhaps most importantly, however, it affords an empowering and woman-centred approach to women's health research.

Beginning with women's perspectives, we must consider the roles that patriarchal social structure, agency, and control play in health care decision-making and eventual health outcomes. These aspects of health and health care are missing from medical research and health care policy yet lend much to our understanding of women's health. Recognizing that women actively make choices regarding their health and that these choices are made within a context of inequality is a step toward uncovering the dialectical relationship between women and mainstream medicine. Understanding this decision-making process is integral to the development of a primary care approach that not only meets women's needs but empowers them to make informed decisions on health treatments which suit their lifestyles. For aging women, the need for more woman-centred primary care is doubly important for maximizing health outcomes from chronic disease.

Western orthodox biomedicine is limited in its capacity to promote wellness among men and women because of restraints that are an inherent part of its structure. Since its inception 150 years ago, biomedicine has struggled with the contradiction arising from its identity as a *healing profession*, an incongruity that has significantly affected how society has come to experience health care. For Ehrenreich and English (1979), developing a male dominated profession out of healing marked the end of woman-centred care:

> While the female lay healer operated within a network of information sharing and mutual support, the male professional hoarded up his knowledge as a kind of property to be dispensed to wealthy patrons or sold on the market as a commodity. His goal was not to spread the skills of healing, but to concentrate them within the elite interest group which the profession came to represent....[T]he triumph of the male medical profession...involved the destruction of women's networks of mutual help--leaving women in a position of isolation and dependency--and it established a model of expertism as the prerogative of a social elite. (34)

This legacy, according to Ehrenreich and English (1979), has diminished the power of healing by removing it from its context and making it separate from "the web of human relationships which connect the healer and those she helps" (45). Consequently, women often feel marginalized and frustrated by a system that constructs a hierarchical relationship between healer and patient - magnified when the doctor is male and the patient is female - and depends on *not* sharing information.

As a male dominated field, medicine has often ignored or misrepresented the health concerns of women. Research agendas have been set by male researchers, consequently, women's interests are underrepresented and men's interests in women's health, such as reproduction, are overemphasized. Furthermore, government funding decisions are often made by small groups of elites who determine how health care and research dollars are allocated. Middle aged and older women, and the aging process are frequently left out of the loop (Doress-Worters & Siegal, 1987). Androcentric bias in medical knowledge is a result of research conducted on male subjects and then generalized to women. According to Rosser (1994), the absence of women in clinical trials has resulted in drug dosages that are developed for men but used on women without taking differences in metabolism, size, muscle to fat ratio, or etiology of disease into account. This same logic is behind the deficit in medical knowledge of the ways in which diseases such as AIDS and heart disease progress in women. Until fairly recently, it was assumed that disease etiology was the same across gender.

The social context of biomedicine is recognized in the medicalization literature as a determining factor in the organization of medical practice. The women who participated in this research were generally attentive to the politics which frame our health care services. Some expressed concerns that women's health needs are not represented and that women often face sexist discrimination based on stereotypes of women as unproductive members of society or as emotional and irrational beings. For these particular women, diminished trust in medicine plays a role in their decision making. It strengthens the resolve of women like Betty and Kate to manage their health on their own as long as their problems are not life threatening. For women like Sarah, however, the avoidance of medical treatment borders on aversion and influences to a greater extent how and when she enlists the help of a doctor. Explanations for patient noncompliance to medical regimes need to consider the effects of social context on women's decisions to reject medical models of health.

The doctor-patient relationship is the "most immediate context in which power relations can be seen in medicine," according to Anderson (1993:208). Because women are more likely to consult doctors and because most doctors are men, the doctor-patient relationship embodies gender-role stereotypes in society (Anderson, 1993). According to Anderson (1993), the stereotypical attitudes of male doctors toward their female patients is consistent with images of women presented in medical textbooks and advertisements by pharmaceutical companies. She claims that cultural stereotypes of women as nurturing, domestic, glamorous, passive, powerless, depressed, and afraid have influenced doctors' images of their female patients and encouraged the prescribing of psychotropic drugs to women. In short, for Anderson (1993),

> the problems of women's health care are manifested in the doctor-patient relationship but, ultimately, have their basis in the power of men in medical institutions and the profit structure of the medical profession (210).

Thus, social context and cultural views on health and illness create a climate in which health care itself can be a hostile environment for women.

Rather than succumb to victim status, the women participants exercise control over the management of their health as the literature on agency predicts. They shop for health information, and choose remedies and treatments that are best suited to their lifestyles and their beliefs about health. In many cases they incorporate their doctors' diagnoses and advice into their health regimes, making them part of their own health management practices. It is not so much the biomedical information that women reject, but the paternalism associated with medical practice. Adopting an agentic stance is a means of resisting hegemonic perspectives, but it is also a normal aspect of unequal conditions. The women participants did not perceive their health behaviours as resistance, but merely logical, sensible acts. They are evidence of the presence of Martin's (1992) counter-hegemonic visions and practices which coexist indiscernibly until they clash with the hegemonic. At these junctures, counter-hegemonic practices are considered deviant acts, as when a patient discards a prescribed medication. Freund and McGuire's (1995), assertion that doctors vastly underestimate the extent that patients devise their own treatment regimens and do not follow recommended treatments, suggests the pervasiveness of contending knowledges of the body.

From women's perspectives, given what we know about medicalization, androcentric bias in health research, sexism in medical practice, and the invasiveness of the allopathic approach, the tendency to not rely on biomedicine and to opt for non-medical treatments is understandable. This type of research leads us to question the efficacy of a primary care system that drives women away. For women reaching midlife, health information and health services can be crucial to wellbeing. If women find primary care a distasteful adjunct to Western medical hegemony, then it fails in its purpose of promoting wellness and preventing illness. Listening to the women participants describe their health concerns, practices, and beliefs, has provided insights into what kind of primary care would best serve their needs:

Policy Implications and Recommendations

The proposed reorganization of primary care services in Ontario will have far-reaching affects on patients and, as suggested by this research, will significantly affect the ways middle-aged women experience health care. The proposed changes involve elaborate plans to develop a rostering system whereby patients must pledge allegiance to a family physician in return for his/her, or a designate's, 24-hour availability, information, and preventive services. From a medical perspective, these changes will result in more continuous health care for patients, a more cost effective system, and it will strengthen the doctor-patient relationship. Additionally, it will place medical doctors in the position of health care "navigator" to the patient, and gatekeeper to other health modalities since, as Dr. Orovan (1998), president of the Ontario Medical Association, states,

> "Physicians are the best trained and the best equipped to co-ordinate that care and to deliver that care. So we think especially in times when there are constraints on the amount of dollars available, that the dollars should be spent on therapies that have evidence of efficacy. And I think that they should be channelled through the physicians" (A9).

According to Orovan, scientifically based principles will guide the decisions to accept or reject alternative therapies. For women who already feel marginalized by a system that imposes its discourse and speaks for them, the proposed changes will not be an improvement.

As we have explored from women's perspectives the reasons they accept or reject medical models of health, utilize alternative therapies, and seek health information from a variety of sources, several matters have come into focus. In this research, women's agency has presented itself as the most reasonable explanation for their health behaviours. Agency is an expression of independence which works to reduce tension by taking control of and changing the environment (Bakan, 1966; Saragovi, Koestner, Dio, et al., 1997). It exists within power structures as a means of resisting the hegemonic and as a means of exercising one's own will in opposition to the hegemonic. The agentic stance of the women participants is characterized by their health behaviours. They sought health information so that they could make informed decisions. They valued doctors who shared knowledge and encouraged them to participate in the development of treatments. They resented doctors who withheld information and made decisions without consulting them. They also valued modalities of health care that were in keeping with their beliefs about the body and methods of healing. In short, these women had developed their own understandings of their bodies and of health and healing based on lay wisdom, experience, and science. They controlled and managed their health through a variety of health modalities, only one of which is biomedicine.

Physicians cannot continue to deny what women's experiences and bodies are telling them: that science is only one approach to health and that lay wisdom, folk cures, and alternative therapies are important aspects of health management to women. They will continue to seek ways of dealing with their health that are in keeping with their values and beliefs. By developing a treatment with the patient, by being open to modalities of health outside the realm of science, and by sharing information, physicians can be more effective in empowering women to develop health strategies that work. Midlife is an important stage in the life cycle for women. For maximizing health outcomes, women navigators need co-pilots who are flexible, informed, and accommodating.

Implications for Future Research

Literature on middle-aged women's health tends to focus on negative aspects of aging. It appears to be influenced by cultural stereotypes of the elderly. Physiological risks are emphasized, perilous social factors such as poverty and maladjustment are overrepresented, and medical treatment is characterized by the theory of medicalization. Perpetuating myths of midlife as a negative stage serves to depoliticize and naturalize the social and cultural context which influences women's midlife experiences. Furthermore, the literature tends to represent women as oversocialized beings, presenting social and cultural factors as the only explanations for health. Finally, women's perspectives on health are underrepresented.

This research contributes a glimpse of women's thoughts on health from their own perspectives. It provides an understanding of how these 7 women navigate through the landscape of midlife amid the barriers of social and cultural factors. It explores the impetus behind their actions and decisions, and looks at health behaviours as the key to understanding what women want from a primary care system.

Further research on health behaviours from the perspective of the patient can be used to develop a better understanding of the ways that patients understand and treat themselves in illness, how they utilize primary care and other health modalities. This type of research has implications for health care policy, specifically, modifications to primary care that will enhance its usefulness to middle-aged women.

Additionally, this research takes the theory of agency out of the theoretical realm and applies it to every day life. This theory has much to offer in research on women's health behaviours. It counters oversocialized views of women, and advances an empowering research perspective. Further research can refine the application of the theory of agency to health behaviours adding a helpful dimension to the literature by making health research from the patients' perspectives more generalizable. This research has attempted to gain an understanding of middle-aged women's agentic standpoint, and how this plays out in health behaviours within a patriarchal context.

Conclusion

Women's health behaviours tend to be noticed only when they clash with the hegemonic. These glimpses of women's counter ideologies are considered deviance in the mainstream. As long as health research is done from a medical perspective, or an over-socialized viewpoint, women's choices and actions will not be taken into account in health research. Applying theories of agency to women's health research helps to correct imbalances in the literature and fill the gaps with women's perspectives.

It is important that the experiences of women inform future health research and health care reform. Understanding women's perspectives will aid in the development of a primary care system that is more in tune with their needs and desires. Proposed primary care changes that bolster the authority of the physician and diminish the decision-making power of the patient through rostering is antithetical to understandings of women's health needs as developed in this research. The findings suggest that some women may avoid primary care if they feel that it does not suit their needs. For the seven women who contributed to this research, and for other women whose experiences are echoed here, knowledge of the body based on experience and lay wisdom, as well as a sense of agency inform the ways in which wellness is pursued. Primary care that delivers information, flexibility, participatory care, and empowerment will optimize health outcomes by becoming a valuable resource for women to tap.

Appendix A

WOMEN'S HEALTH INTERVIEW GUIDE

FAMILY BACKGROUND:

1. Does anyone live with you?

   Probe for partner/husband, children, their ages, older children who left home, whether parents/in-laws, grown up children live nearby.

   If anyone lives nearby, ask: Who? Do you see them often? On what sorts of occasions?

2. Can you tell me if you have a job?

   If YES: Probe for what sort of job, what it involves, hours of work (full-time or part-time), length of time in job, whether this is the type of work they have always done, whether they like it, etc.

   If NO: Probe for when last employed, what job, hours of work, why did you give it up? Do you consider yourself unemployed? If yes: what effect has this had on you?

3. Can you tell me when you left school? How old were you?

   Have you got any qualifications? If yes: what are they? Have you had any education or training or done any courses since you left school?

4. What about other people who live with you? Do they go to work, or go to school or what?

   Probe as for partner's job if appropriate.

HEALTH:

5. What do you think are the main health issues of concern to women in their _______?

For each health issue mentioned ask:

Why do you think this is of concern to women?
What makes you say that?
What do you mean by that?
Do you know anyone who has experienced it?

6. Would you say you are healthy?

Why/why not?
How would you rate your health?.....Excellent? Good? Fair? Poor?
What do you think makes you healthy/unhealthy?
What do you think it means to be healthy?

7. Can you tell me about any health problems you've experienced recently?

When was this?
What was it like?
Can you tell me about the last time it happened/you had this?
How has it affected you (at home, at work)?
How long have you experienced this?
How often do you have this? How severe is it? Can you anticipate when it will come on? What happens? How do you cope? What helps? What makes it worse?
Do you talk to anyone about it?
Do you have any idea what causes/caused it?

Are there any other health problems you have experienced recently?

Use probes as appropriate.

8. Are there any health issues you WORRY about?
(This might include things already mentioned.)

For each health issue mentioned ask:
What? Why does it worry you?
Have you experienced it? Has any member of you family?

Anyone you know?
Are there any other issues you worry about?

If women talk about broad health issues (eg: pollution), ask if they worry about their *own* health and probe for what they worry about and why.

9. Do you think these sorts of problems - that you've experienced or are concerned about - are common for women of your age?

   Why/why not?

10. There are some issues that women sometimes mention in interviews, and I was wondering whether any of them have concerned you at all? For example:

    (Go through list asking about issues that have not yet been mentioned. Use all relevant probes from Qn.7)

    Tiredness
    Stress
    Disturbed Sleep
    Anxiety
    Lack of Confidence
    Depression
    Loneliness
    Lack of time for yourself
    Migraines/headaches
    Arthritis
    Breast cancer
    Cancer in general
    Alcohol
    Smoking
    Lack of exercise
    Weight (Are you happy with your present weight? Why/why not? Are you dieting right now or have you ever watched you weight? Why? Why do you want to lose/gain weight?)

11. What is it like to be in your _____?

12. Do you think your health problems are different now than before?

13. Do you think you have changed or has your image of yourself changed?

14. As you reflect on earlier periods in your life, is this one any different?

15. To what extent do you rely on your doctor? Is he/she helpful?

16. Where do you get your health information? (Specific examples?) Is it helpful?

17. What do you think are the main social problems facing women in their _____?

    In what ways do you think this is a problem? What makes you say this? Any other issues/social problems?

18. And what about you? Have any of these affected you?

    In what way is this a problem?
    Could you tell me more about it?

19. Some women have mentioned unemployment. Have you ever been unemployed or worried about it? (Probe: could you tell me more about that?)

20. Some women have mentioned money problems. Has that been a problem for you? (Probe: could you tell me more about that?)

21. Do you think any of these (answers to Qns. 18-20) have affected your health? How? Could you tell me more about that?

22. Would you like to have had help for any of the various problems we've talked about?

    What would have helped? (Information? Financial support? People to talk with? Anything else?) Who is best able to help women in that situation?

MORE BACKGROUND:

23. Finally, so we have an idea of the range of women interviewed, could you tell me when you were born?

    Where were you born?

24. What are the main sources of income for you/your family?

__own employment __spouse/partner's employment
__spouse/partner's & own employment
__social security __pension
__other______________ __don't know
______________ __no response

25. We don't need an exact figure, but could you tell me which of these broad categories your household income falls into before taxes and other deductions?

Less than $10,000 p.a.
$10,000 - $19,000
$20,000 - $29,000
$30,000 - $39,000
$40,000 - $49,000
$50,000 - $59,000
$60,000 - $69,000
$70,000 and over

Is there anything else you feel we should have discussed about women and health?

THANK YOU VERY MUCH FOR YOUR HELP AND FOR
GIVING UP YOUR TIME

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