

# A Matter of Perspective

With this issue of *Menopause Management*, we introduce a new department, "A Matter of Perspective." This department will feature articles on a wide variety of menopause-related topics that present the personal opinions of individual authors. We invite you to respond to previously published articles, or to write articles on topics of your own choosing, and submit them to the journal for consideration. We look forward to receiving your contributions and a lively dialogue! See the end of the article for information on how to submit your work to this department.

*The viewpoints expressed in "A Matter of Perspective" are those of the contributors, and not necessarily those of Menopause Management or NAMS.*

## Understanding the Gap Between Research Results and Clinical Experience

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### Introduction

Since the publication of findings from the Women's Health Initiative (WHI), which challenged deeply rooted beliefs about the preventive effects of hormone therapy (HT), clinicians and women contemplating menopause have questioned how such a great disparity could exist between our beliefs, often grounded in our clinical experiences, and the research data concerning HT.

We clinicians have seen women benefit from their use of HT, particularly those who were having difficulty with severe hot flashes, experiencing trouble sleeping, and becoming irritable and depressed. With HT, many of these women were able to enjoy a sense of well-

ness that they'd experienced before their symptoms began. Many investigators and clinicians were puzzled about why the WHI findings differed from those of earlier clinical trials for symptom management that were associated with positive health outcomes and the positive results of retrospective studies of HT use and heart disease. The findings of the WHI cast doubt on the validity of these observations by introducing concerns about the long-term consequences associated with HT: heart disease, breast cancer and stroke.<sup>1,2</sup> Many well-informed and well-intentioned clinicians were shocked by the results of the WHI and the gap between their own clinical knowledge and the trial's results. The publication of several papers concerning the primary outcomes of the WHI HT trial prompted several professional organizations to update treatment guidelines for clinicians treating women during the menopausal transition and postmenopause.<sup>3,4</sup>

How could we have failed to anticipate the results of the WHI? How can we make sense of this growing body of evidence that challenges our beliefs about HT and its associated health outcomes? Why were the results of a prevention trial with healthy, volunteer women between 50 and 79 years of age so different from our own clinical observations and expectations of HT use by women during the menopausal transition and postmenopause?

### Considering "Situatdness"

This paper seeks to contrast the differing views of menopause among community-dwelling women and clinicians as a basis for understanding the dissonance introduced by the WHI's recent research findings on the prevention effects of HT. I will focus on the contrasting perspectives of clinicians, and women themselves, of the menopausal transition, and will consider the concept of "situatdness," as it can help us understand our different perspectives.

The concept of "situatdness" is useful in helping us understand and integrate divergent perspectives. Used frequently in writings on women's studies, situatdness refers to an individual's view of the world and reminds us that where we sit influences what we can see. The clinician who sees mainly women seeking care for menopause symptom management has a different view of menopause than does a midlife woman in a community-based environment. A woman in such an environment sees that while a few of her friends may actually have extremely distressing symptoms,<sup>5,8</sup> a majority of women in her age group who are experiencing the transition to menopause are asymptomatic or have symptoms of low severity. In contrast, clinicians see women each day who are seeking care for symptoms such as hot flashes, sleep disturbances and depressed mood. The majority of the women the clinician sees are symptomatic and require some type of help to manage their symptoms. Most women seem to respond well to HT and suffer no adverse health consequences during the first few years of therapy.

Women in the general population view menopause as a normal developmental event. They see menopause as the end of their periods and fertility, a time of hormonal change and a marker for their own aging and changing life roles—an end to parenting and a beginning of a new stage in their lives.<sup>9</sup> Recent research points to the accuracy of this description, with some data indicating that there are only a few symptoms that seem to be linked to the menopausal transition: hot flashes, night sweats and sleep problems.<sup>5,6</sup> Sleep problems seem to increase in a linear fashion with age, and vaginal dryness becomes more prevalent after menopause, as do other sexual symptoms.<sup>5,6</sup> Severity of symptoms increases as women's cycles become very irregular.<sup>8</sup> Problems with depressed mood, urinary control, cognitive functioning,

and joint and muscle aches and pains do not vary across the menopausal transition stages, suggesting that there is no temporal relationship to the menopausal transition.<sup>5</sup>

For clinicians who treat women during the menopausal transition, it seems to be a time of distressing symptoms and increased risk of disease. The prevalence of chronic illnesses seems to increase around the time women are seeking help for symptoms they associate with menopause. Recent studies of the menopause transition reveal that distressing symptoms are transitory in nature and most are mild to moderate. However, there are not yet data from longitudinal studies that estimate the persistence of symptoms such as hot flashes over the postmenopausal years.<sup>5-7</sup> In contrast, some clinicians have daily experiences with patients who are severely distressed, some chronically troubled by severe hot flashes and sweats, sleep disturbances, and depression and irritability that persist for many years.

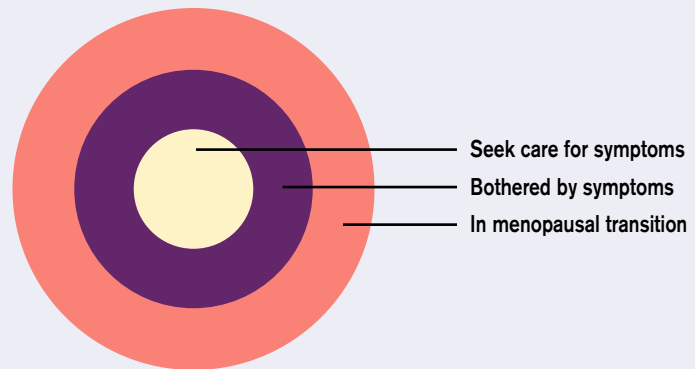
In opposition to the experience of many clinicians, data from longitudinal studies of menopause imply that menopause does not have a profound effect on quality of life.<sup>10,11</sup> Indeed, the WHI data suggest that HT is not associated with an improvement in quality of life.<sup>12</sup> In contrast, clinicians hear women's testimonials about how HT has enhanced the quality of their lives, and they've witnessed that HT restores a sense of well-being for women who were troubled by their symptoms.

Finally, the WHI data indicated that HT does not prevent the diseases of aging, such as cardiovascular disease, as had been believed. Yet clinicians witness that the women they see in their practices who have used HT for many years seem to experience robust good health.

### Reconciling Two Perspectives

Can both perspectives be valid? How can we reconcile the disparate observa-

## Who seeks care for symptoms during the menopausal transition?



Selection of women into health care provides clinicians and community members contrasting points of view.

**Figure.** Influence of selection of women into health care (whom we see in the clinic) on clinicians' perspectives.

tions? One answer lies in a consideration of the differences in how women in the general population experience menopause versus what clinicians see in their practices. A classic study of the ecology of medical care provides a valuable reminder to clinicians about who becomes a patient. In 1961 White and colleagues<sup>13</sup> provided a helpful framework for distinguishing the differences among different groups in the general population: those who experience illness or injuries, those consulting a physician and those admitted to a hospital or referred for other care. An updated view of these relationships reminds us that of 1,000 persons living in a community, 800 report symptoms, 327 consider seeking health care, 217 actually visit a physician's office (113 of these to primary care), 65 visit a complementary or alternative medical care provider and 21 visit a hospital outpatient clinic.<sup>14</sup> It is important to appreciate that the subset of women who find their way to clinicians for care for menopause-associated symptoms are a special subset of those women in the general population; they perceive symptoms, are bothered by them and are motivated to seek care for a variety of reasons (Figure).

### Summary and Conclusions

How can such a great disparity exist between our beliefs, which are grounded in clinical experience, and the results of research? Using the example of the WHI, the results of which have challenged prevailing notions of using HT for disease prevention, I examine the concept of situatedness to explain the gap between what clinicians experience and what research can reveal. Situatedness refers to individuals' view of the world and reminds us that where we sit influences what we can see. The concept can explain how our experience shapes what we perceive, and may help us to make sense of the turmoil that women and clinicians alike have felt since the publication of the WHI findings. ■

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Dr. Woods has received grants from the National Institute of Nursing Research and the National Institutes of Health.

Submitted: August 26, 2005. Accepted September 1, 2005.

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