

Menopause, revisited: Who's still afraid of hormones?

Night sweats, insomnia, hot flashes, mood swings, brain fog—these are just a few of the symptoms people with ovaries may experience with menopause. While I teach medical students that the depletion of ovarian reserve and the decline in estrogen production in midlife are physiologic, I always emphasize that physiologic does not mean painless.

It now appears that, after decades of women suffering in silence, the topic of menopausal hormone therapy is back in public conversation—in a meaningful way.

Three years ago, in an editorial for the *BCMJ* [2023;65:76], I wrote “Menopause: Is the media going to set the record straight?” I was referring to the fear that followed the early termination of the Women’s Health Initiative (WHI) hormone therapy trials in 2002 and 2004.^{1,2} As many will recall, the group of women assigned to combined oral conjugated equine estrogen (Premarin 0.625 mg/day) and oral medroxyprogesterone acetate (Provera 2.5 mg/day) for more than 5 years experienced a higher risk of invasive breast cancer, 8 cases per 10 000 woman-years in absolute risk terms. Yet it was the relative risk of 1.26 that dominated headlines and, alongside concerns about coronary heart disease, led to the conclusion

that the risks outweighed the benefits.³

In the years since, there have been reanalyses of the WHI data, further research on hormone therapies, and meaningful shifts in prescribing trends, including a preference for transdermal estrogen. New therapeutic options have also emerged. In November 2025, the US Food and Drug Administration removed the black box warnings related to breast cancer, stroke, dementia, and cardiovascular disease.⁴

Current consensus holds that menopausal hormone therapy is the most effective treatment for vasomotor symptoms and genitourinary syndrome of menopause, with additional benefits for bone health. For most healthy symptomatic women younger than 60 years of age and within 10 years of menopause onset, the benefits outweigh the risks.⁵

We have exited the post-WHI fear era. Are clinicians keeping up?

Following the sharp decline in hormone therapy use after 2002, many physicians who trained during that period had limited exposure to prescribing it and little demand to build experience. The result is a persistent knowledge gap at a time when patient interest is resurging. This is an ideal

moment to re-engage with the evidence. For a condition that will affect over 1 million women in our province, this is continuing medical education time well spent.⁶

There are many excellent resources to support clinicians who are updating their knowledge; a few of my favorites are listed in the **Box**.

A growing number of virtual menopause clinics have also emerged in recent years.^{7,8} Their success—offering both private-pay and provincially covered visits—speaks to the unmet demand for timely menopause care in Canada. BC Women’s Hospital and Health Centre recently opened the Complex Menopause Clinic for patients whose needs cannot be met by community providers.⁹

Menopause: The social movement

Menopause is no longer just a medical diagnosis; it is also a social movement. It is part of a broader cultural shift in which women are rejecting stigma and passivity in favor of openness and empowerment.¹⁰ Increasingly, they are not waiting for physicians to come around. Instead, they are driving menopause into the mainstream themselves.

Consider Melani Sanders, a social media personality (@justbeingmelani on Instagram) and founder of the We Do Not Care Club, who has given voice to thousands of women navigating menopause and perimenopause. Her widely shared reflections—on everything from unmade beds to arm fat—capture a growing irreverence toward expectations that once kept women silent.¹¹

Menopause may be having a moment, but for patients, access to informed, individualized, evidence-based care still lags. As physicians, we can close that gap by bringing the openness, curiosity, and confidence to menopause care that our patients are already demanding. ■

—Caitlin Dunne, MD

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BOX. Educational resources for physicians.

- **UBC CPD: This Changed My Practice:**
 - *Menopause: Don't Sweat it: Part 1 – Symptoms*
 - *Menopause: Don't sweat it: Part 2 – Therapies*
- **BCMJ articles:**
 - “Managing menopause Part 1: Vasomotor symptoms” (2022;64:344-349)
 - “Managing menopause Part 2: Hormone therapy and breast cancer, cardiovascular disease, and premature ovarian insufficiency” (2022;64:350-353)
- **Canadian Menopause Society: Menopausal Hormone Therapy (MHT) Products in Canada** (www.canadianmenopausesociety.org)
- **MQ6: Interactive Treatment Algorithm** (<https://mq6.ca/mq6-interactive-algorithm/>)



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Shining light on permanent daylight saving time and health

“British Columbia is going to change our clocks just one more time—and then never again.” Premier David Eby delivered this announcement on 2 March 2026, just ahead of the annual springing forward of the clocks, which had been implemented in British Columbia for decades.¹ And indeed, early on the morning of 8 March 2026, BC timekeeping permanently moved from Pacific Standard Time to Pacific Daylight Time.

What does this mean for our health? Evidence shows that twice-yearly time changes can disrupt sleep.² This is hardly surprising to anyone who has struggled to get up in the morning the day after springing forward each year. Lost sleep

due to time changes in the spring has been linked in some research to increased rates of motor vehicle crashes, while impacts on mental health have been observed following time changes in both spring and fall.³ Premier Eby’s announcement asked that we think of the children, observing that “every parent knows that changing clocks twice a year causes a significant amount of chaos on already busy lives.”⁴

Researchers studying the issue largely agree that a policy to eliminate time changes is a good move from a health perspective. But why a move to permanent daylight saving time, rather than permanent standard time? After all, standard time, as the name suggests, is the default. For the most part, under standard time, we see the sun at its highest point at noon, keeping midday aligned with its intuitive noontime correlate. The popularity of daylight saving time is linked, in large part, to there being additional daylight hours in the evening during the affected months—an extra hour for outdoor sports and recreation, time spent in parks, and safer outdoor play for children. It is easy to see the appeal of an extra hour of evening daylight during the winter.

But wait—stop the clock. Just hours after the announcement of permanent daylight saving time in BC, news coverage began to explore the dark side of this policy. Annoyingly enough, that extra hour of daylight in the evening comes with an extra hour of darkness in the morning.⁵ Under permanent daylight saving time in Vancouver, for example, sunrise will come after 8 a.m. for almost 4 months of the winter and later than 9 a.m. for about 1 month. The effect will be even more pronounced in communities farther north. This will mean a lot of dark mornings for BC residents.

Sleep experts have described health harms that may arise as permanent daylight saving time decouples the timing of waking from the sunrise. Our circadian rhythms rely heavily on exposure to morning light to start our days,² and disruptions to sleep patterns and related impacts on concentration and mood are important impacts. Many experts suggest that the healthy way to eliminate twice-yearly time changes would be permanent standard time rather than permanent daylight saving time.⁵

It is challenging to quantify the health benefits of an added hour of sun on a beach, baseball field, or balcony, let alone to tally up the apples and oranges of social and recreational gains versus circadian rhythm disruptions. Reaching public-health consensus on these options, let alone general public consensus, may be as hard as reaching consensus on a preference for sunrises or sunsets. Where we do have strong agreement is that an end to changing our clocks will be welcome and positive for health. As a society, we should anticipate, study, and mitigate specific harms and make the most of that extra daylight. ■

—Michael Schwandt, MD, MPH, FRCPC

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