

Menopause: Closing the knowledge gap

Claire Denness

IT WAS CIRCA 2007. I was in my late twenties, feeling invincible, without a grey hair or wrinkle in sight. *Take That* were back in the music charts, and, having made the switch from physician training, I was on my first general practice placement, in an urban practice in North Yorkshire, and could occasionally be heard singing along to ‘Rule the World’ driving to my home visits.

My supervisor had asked me to compile a list of topics I wanted to learn more about – ‘admitting to your blind-spots’ he’d (ironically) called it, and he surveyed the list of topics I had jotted down. At the top was ‘menopause and HRT’ (hormone replacement therapy) – my medical school education on menopause had started and ended with a definition of menopause, framed as ‘failing’ ovaries. My supervisor frowned, stroked his beard, and replied: ‘HRT? Well, that’s an easy one’, he chuckled, crossed his index fingers and held them up as warning, ‘don’t prescribe it, it causes breast cancer! And menopause–? Well, I don’t really do any of that women’s health stuff. OK – what’s next on your list...?’

The national general practice curriculum at the time was similarly sparse. And a year later, another supervisor dismissed menopause as a natural life stage, warning against ‘hormones made from horse urine’. As a young doctor, most of my consultations were with women my own age, focused on contraception, sexual health and pregnancy. Perhaps, I thought, menopause wasn’t ‘in’.

Two decades later, the landscape of my practice has shifted. My patients, like me, now have grey hairs and wrinkles, and most of my women’s health consultations centre on menopause and perimenopause. But medical education, it seems, has not shifted.

A 2021 Freedom of Information request revealed that 41% of UK medical schools lacked mandatory menopause teaching.¹ And in Australia, a 2024 Parliamentary

Inquiry heard testimony from women about the consequences of healthcare professionals’ gaps in knowledge and skills, noting that many medical undergraduates still receive minimal or no education on menopause. The Inquiry emphasised the urgent need for comprehensive menopause education for all healthcare professionals, across every specialist medical and surgical college.²

This gap is striking when we consider that menopause will affect more than half of the population, with symptoms lasting an average of 7 years³ – often longer. Underpinned by deeply ingrained gender inequity and stigma, menopause remains under-taught, under-discussed and under-researched. Women frequently turn to social media for guidance, risking medical misinformation with physical, psychological and economic consequences.

Against this backdrop, the *Australian Journal of General Practice* will publish two focus editions on menopause in 2026. Written primarily by general practitioners (GPs), with contributions from other specialties such as endocrinology, cardiology and psychiatry, these editions aim to make menopause consultations achievable for every GP at every stage of training. This first edition provides practical guidance on conducting a menopause consultation, prescribing menopause hormone therapy (MHT) safely, and selecting non-hormonal therapies for women who cannot or choose not to take MHT. It includes an update on the 2024 guidelines for premature ovarian insufficiency – affecting 1% of women and carrying elevated risks of osteoporosis, cardiovascular disease and dementia, if untreated. It also addresses perimenopausal depression, reminding us of the higher suicide rates among women aged 45–55 years.⁴

Reflecting on this statistic, I remember Tanya*. It took her a long time to trust me, to allow me glimpses into her early-life experiences that had shaped her complex mental health presentations over the years.

After hours of building trust, of time spent sitting quietly, listening and holding her distress and anxiety, she told me softly one day how her mother had died, by suicide, in her late 40s, a result of severe perimenopausal depression. And the impact of that on Tanya, and on Tanya’s children, had been, and was to that day, profound. As I listened, I was struck by the recognition that when we care for women experiencing menopause, we are not just caring for them, but for their partners and children and grandchildren and friends, and all the interconnected networks and communities that they are part of and contribute to, and to all the generations that will follow.

It is time to acknowledge and correct the serious gaps in menopause education, not only at the undergraduate level, but also across all postgraduate training programs. While comprehensive menopause education within general practice training is essential, our physicians, psychiatrists, surgeons and gynaecologists must also be equipped with holistic knowledge and skills. With better education and understanding, stigma is reduced, and a menopause consultation is recognised for what it truly is: not something to be ignored, avoided or feared, but the very essence of general practice – complex, dynamic, interconnected, holistic and deeply rewarding.

* Name has been changed.

** In this editorial and the accompanying articles, the term ‘women’ refers to cisgender women, but non-binary and transgender people might also experience menopausal symptoms and require appropriate menopause care.

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