MDForLives

MDFORLIVES IN-DEPTH INSIGHT REPORT

Menopause Care in Primary Care: Where FPs and GPs Feel the Pressure

A global peer report on rising menopause demand, MHT prescribing confidence, digital information, GSM detection, time pressure, long-term health assessment, and the future architecture of midlife care.

Family physicians and GPs · 6 countries · Global peer perspectives

431	611	6	70.5%
Complete responses	Survey records	Countries represented	Completion rate

THE CLINICAL QUESTION

As menopause demand rises, where is the greatest pressure appearing in primary care?

The strongest pressure is not a single prescribing decision. It is the combination of rising demand, conditional confidence, digital information, multi-system assessment, and limited appointment time. FPs and GPs in this survey are already managing menopause frequently, but many describe a need for more time and a reliable specialist pathway around complex cases.

The responses point toward a shared-care future: primary care remains the front door and often the coordinator, while gynecology or menopause expertise becomes a structured escalation layer rather than the default destination for every patient.

> **Coverage:** United States, United Kingdom, Canada, Italy, France, Germany. Survey findings are presented as the opinions and practice patterns reported by participating professionals.

EXECUTIVE SUMMARY

The pattern in one view

The findings show a primary care workforce that is already carrying menopause care at scale. The gap is less about willingness and more about capacity: consultation time, complexity, and the growing information burden around modern menopause treatment.

01 / SIGNAL

Demand is clearly increasing

Nearly three-quarters report higher menopause demand over five years, while two-thirds already manage related concerns at least several times a week.

02 / SIGNAL

Confidence is broad but conditional

Most respondents can initiate MHT in at least standard cases, yet complete independence is much less common.

03 / SIGNAL

The visit now includes information correction

Social media, clinical updates, DTC services, and media coverage are all influencing what patients bring to primary care.

04 / SIGNAL

Shared care fits the pattern

Respondents most often choose a primary-care-plus-gynecology model rather than moving menopause wholly into either setting.

> **Reading across the findings:** Demand, confidence, and capacity do not move in parallel. Menopause consultations are increasing, and most FPs and GPs are at least moderately confident with MHT, yet time remains the leading system barrier and long-term health domains compete for space inside the same visit. The preferred shared-care model makes sense when those findings are read together: primary care is not stepping away from menopause, but it is signaling a need for more room and a dependable escalation pathway.

SECTION 01

Menopause demand is rising across routine primary care

CONTEXT

Menopause care has become more visible across public culture and clinical medicine. For primary care, that visibility translates directly into appointment volume because FPs and GPs are often the first clinician a midlife patient sees.

DATA

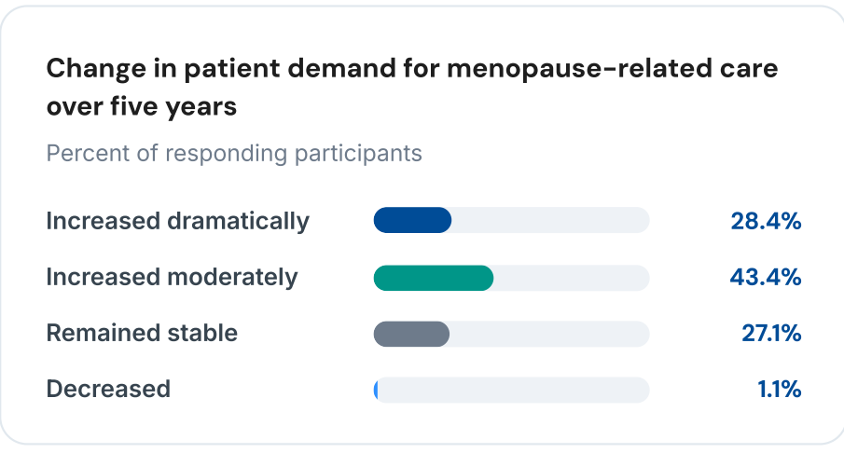
28.4% report a dramatic increase and 43.4% a moderate increase in menopause-related demand over five years. Separately, 66.6% manage menopause concerns daily or several times per week.

INSIGHT

This is not a niche workload for most respondents. Menopause has become a recurring primary care domain.

WHY IT MATTERS

More frequent demand increases the need for consistent assessment pathways, clear patient information, and access to specialist support when cases become complex.


Change in patient demand for menopause-related care over five years

Percent of responding participants

The survey also shows why raw consultation numbers can underestimate workload. A menopause visit often contains preventive and chronic-care tasks that extend beyond symptom relief, from blood pressure and lipids to bone risk, sexual health, sleep, mood, and medication review.

The result is a compounding effect: more patients are asking for care at the same time that the scope of what "good menopause care" includes has expanded.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The increase is broad rather than confined to a small subset of practices. Menopause is becoming a more visible and recurring primary care workload. Greater public discussion, digital information, evolving treatment conversations, and direct-to-consumer services can all increase awareness and prompt patients to seek care earlier or more actively. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 02

Digital influence is now part of the clinical encounter

CONTEXT

Patients now arrive with information from social media, media coverage, direct-to-consumer clinics, and updated medical guidance. Those sources can improve awareness, but they also change the starting point of the visit.

DATA

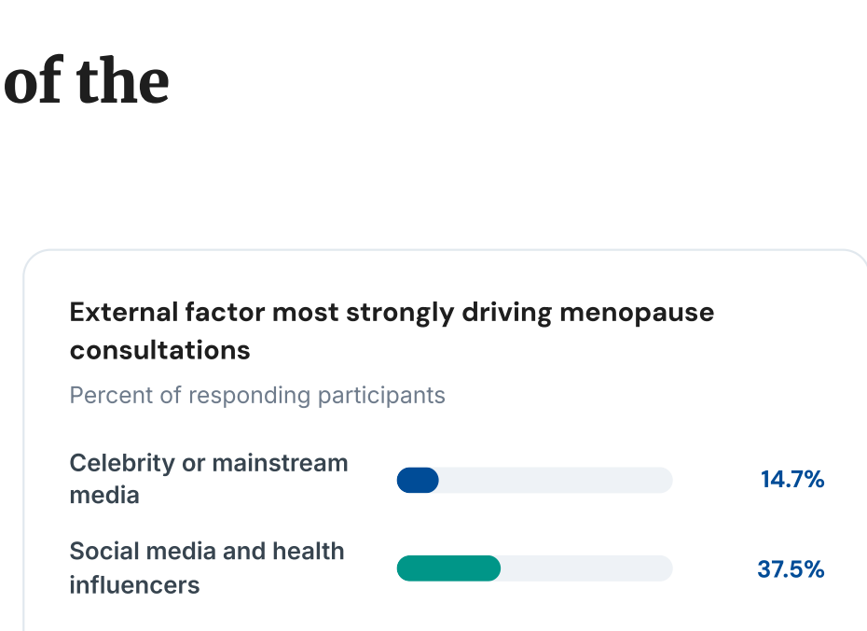
37.5% identify social media and online influencers as the strongest external driver of consultation growth, 31.3% point to evolving clinical safety updates, 16.6% to DTC telehealth, and 14.7% to celebrity or mainstream media.

INSIGHT

The information environment is mixed: professional evidence and consumer narratives are driving demand at the same time.

WHY IT MATTERS

Clinicians may spend part of the consultation validating accurate information while correcting claims that overstate safety, efficacy, or the range of problems hormone therapy can solve.


External factor most strongly driving menopause consultations

Percent of responding participants

The survey's separate digital-friction question reinforces this. Unrealistic expectations about reversing aging or cognitive decline lead at 34.4%, while 31.7% identify misinformation around compounded bioidentical products as the greatest friction.

That pattern helps explain why greater patient awareness does not automatically shorten the visit. A more informed patient can create a richer discussion, but a more fragmented information environment can create additional clinical work.

The significance of this finding becomes clearer when it is read against the rest of the dataset. Demand growth is being driven by both public culture and medical information. The patient arrives with a narrative that may contain accurate evidence, oversimplified claims, or both. Menopause has become a high-visibility health topic across news, social platforms, celebrity advocacy, and digital clinics, increasing the amount of pre-formed opinion entering the consultation. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 03

MHT confidence is broad, but complex cases still create a referral boundary

CONTEXT

MHT initiation in primary care sits on a spectrum from routine prescribing to high-risk decision-making. Confidence therefore depends on what kind of patient is in front of the clinician.

DATA

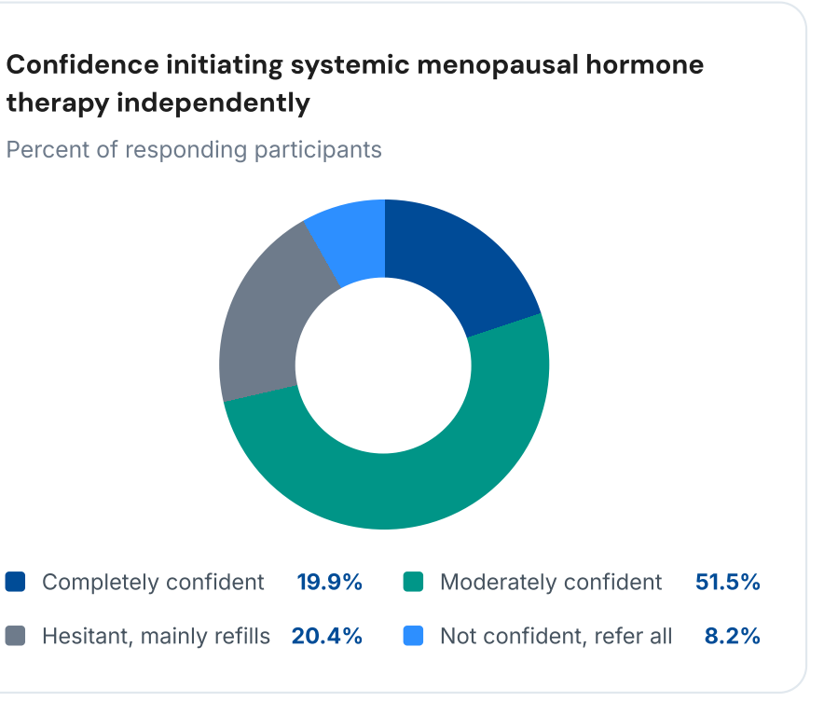
19.9% are completely confident initiating and titrating systemic MHT independently, 51.5% are moderately confident, 20.4% are hesitant and mainly comfortable refilling existing therapy, and 8.2% routinely refer hormonal management.

INSIGHT

The majority can manage standard cases, but the distribution shows a meaningful complexity boundary.

WHY IT MATTERS

A system that expects primary care to absorb rising menopause demand also needs a credible route for complex histories and uncertain risk-benefit decisions.


Confidence initiating systemic menopausal hormone therapy independently

Percent of responding participants

The uncertainty question shows why. Perimenopausal fluctuation leads at 29.9%, high-risk medical history at 28.1%, safety anxiety at 22.6%, and continuation beyond age 60 or 65 at 19.3%. The challenge is spread across several different types of complexity.

Current NICE guidance similarly emphasizes individualized risk discussion and referral to menopause expertise when contraindications or uncertainty make management less straightforward.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The dominant position is capable but conditional. Standard candidates may remain in primary care, while borderline histories and high-risk scenarios preserve a specialist boundary. MHT decisions require integration of symptoms, uterine status, thromboembolic risk, breast cancer history, age, time since menopause, patient preference, and route or formulation. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 04

GSM detection is split between proactive and reactive care

CONTEXT

GSM can be highly relevant to quality of life but may not be volunteered during a general consultation. Detection therefore depends partly on whether the clinician introduces the topic.

DATA

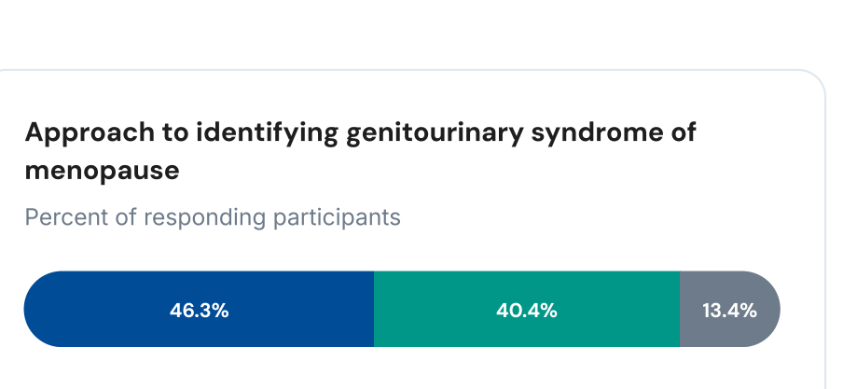
46.3% proactively screen for GSM symptoms, 40.4% respond when the patient raises localized symptoms, and 13.4% mainly treat secondary urinary or vulvovaginal issues in isolation.

INSIGHT

The cohort is divided between active case-finding and disclosure-dependent care.

WHY IT MATTERS

Where time is limited, intimate symptoms may remain outside the agenda unless screening is built into the consultation.


Approach to identifying genitourinary syndrome of menopause

Percent of responding participants

This matters because patients may normalize dryness, painful sex, or recurrent urinary symptoms as an unavoidable part of aging. A reactive model therefore depends on the patient recognizing the symptom as both relevant and discussable.

NICE guidance explicitly includes genitourinary symptoms among menopause-associated symptoms, reinforcing the clinical relevance of bringing them into routine assessment rather than treating them as a separate niche issue.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The near-even split suggests that GSM visibility depends substantially on whether the clinician opens the conversation first. Vaginal dryness, dyspareunia, urinary symptoms, and sexual health concerns may be underreported because they are personal, normalized, or not recognized as part of menopause. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 05

Consultation time is the strongest system pressure

CONTEXT

Primary care appointments have a fixed time budget, while menopause care increasingly involves multiple symptom domains and long-term risk questions. The survey asks which part of the system creates the greatest constraint.

DATA

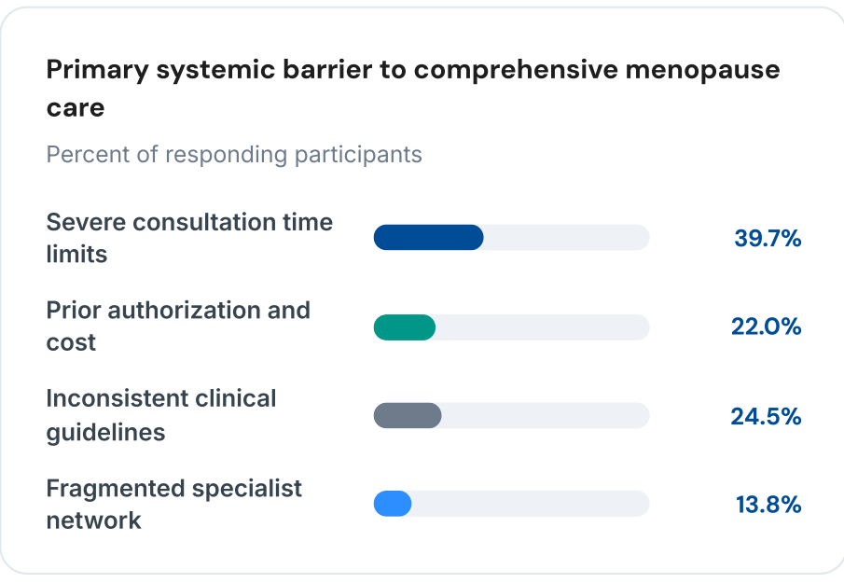
39.7% identify consultation time limits as the primary barrier, 24.5% inconsistent guidelines, 22.0% authorization or cost pressure, and 13.8% fragmented specialist networks.

INSIGHT

Time is the dominant structural ceiling, but it interacts with guidance and access rather than replacing those problems.

WHY IT MATTERS

When the visit is compressed, immediate symptom relief can crowd out preventive assessment or detailed risk communication.


Primary systemic barrier to comprehensive menopause care

Percent of responding participants

The survey's long-term-risk question shows exactly what can be displaced. Cardiovascular/endothelial risk is most often named as overlooked at 25.5%, bone density at 25.3%, cognitive vulnerability at 20.7%, sexual health at 14.7%, and sarcopenic obesity or metabolic syndrome at 13.8%.

This distribution is important: no single long-term domain dominates, suggesting that the time problem is broad. Different patients may leave with different pieces of the preventive agenda unfinished.

The significance of this finding becomes clearer when it is read against the rest of the dataset. The main constraint is not lack of patient demand or complete lack of clinical confidence. It is the amount of work that can be completed inside ordinary appointment architecture. A single menopause visit can involve symptom assessment, MHT risk discussion, mental health, sexual health, bone health, cardiometabolic risk, medication review, and correction of digital misinformation. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

SECTION 06

Shared care is the preferred future architecture

CONTEXT

A future care model has to reconcile two realities: menopause is common enough to sit naturally in primary care, but complex cases can require gynecologic or specialist expertise.

DATA

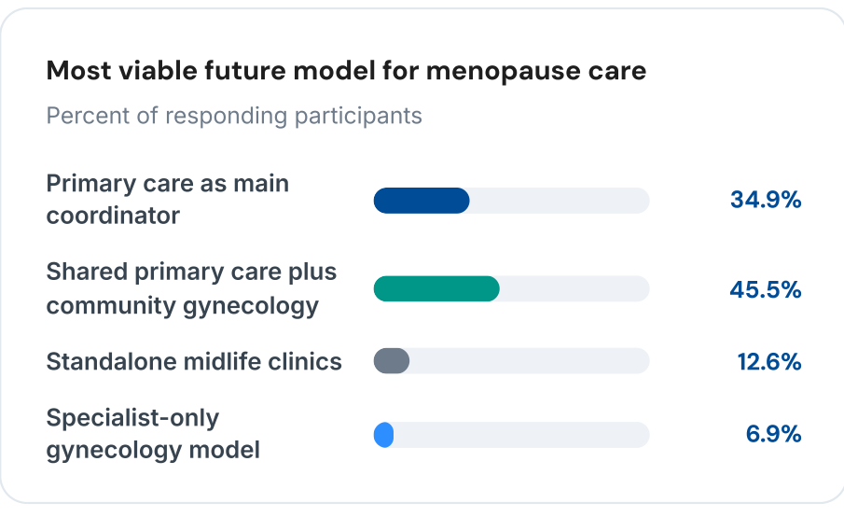
45.5% favor shared care between primary care and community gynecology, 34.9% prefer primary care as the main coordinator, 12.6% favor standalone midlife clinics, and 6.9% prefer a specialist-only model.

INSIGHT

Respondents favor keeping menopause care close to primary care while strengthening specialist connection.

WHY IT MATTERS

The preferred architecture is a network rather than a transfer of ownership.


Most viable future model for menopause care

Percent of responding participants

This preference also aligns with the confidence pattern. A large moderately confident group can manage many patients independently while benefiting from structured escalation for contraindications, unusual bleeding, refractory symptoms, or high-risk histories.

The model potentially addresses the 15-minute pressure as well: a shared pathway can distribute counseling, specialist review, and follow-up rather than forcing all complexity into one generalist encounter.

The significance of this finding becomes clearer when it is read against the rest of the dataset. Respondents are not moving menopause care out of primary care. They are looking for a stronger escalation pathway around it. Routine symptom management and preventive care fit naturally in primary care, while contraindications, complex bleeding, refractory symptoms, and high-risk histories can require specialist expertise. The percentage therefore sits inside a broader decision environment rather than operating as a stand-alone trigger.

PRACTICE PATTERN

What may be sitting underneath the responses

These are interpretive patterns, not clinical recommendations. They describe the tensions that appear across the survey when individual findings are read together.

Open-text comments broaden the same picture. Respondents mention longer appointments, clearer public and professional guidance, better access to HRT and non-hormonal treatment, insurance coverage, education for older women, workplace support, more women's-health services, and stronger coordination between oncology, gynecology, and primary care. These themes suggest that the care gap is partly clinical but also organizational and informational.

Demand is no longer optional workload

Volume pattern

Menopause concerns are frequent and rising, which means care pathways must function inside ordinary primary care rather than around it.

Digital influence changes the starting line

Information pattern

Patients increasingly arrive with treatment narratives already formed, adding interpretation and expectation work to the visit.

Confidence is layered by complexity

Prescribing pattern

Most respondents can initiate standard MHT, but high-risk and ambiguous cases still define a specialist boundary.

Shared care matches the reported tension

System pattern

The preferred future keeps primary care central while creating a stronger clinical route for complex menopause management.

CLOSING PERSPECTIVE

The menopause care boom is really a capacity question

The survey does not portray primary care as unwilling to manage menopause. Quite the opposite: most respondents encounter it frequently, most have at least moderate confidence with MHT, and nearly half proactively ask about genitourinary symptoms.

The strain appears because menopause care has expanded in both volume and scope. Patients are arriving with more information, more expectations, and more awareness of treatment options. Clinicians are simultaneously expected to assess vasomotor symptoms, sexual and genitourinary health, bone risk, cardiometabolic risk, mental health, medication interactions, and the appropriateness of hormone or non-hormone treatment.

The leading barrier, consultation time, therefore acts like a multiplier. It can turn correct clinical knowledge into incomplete execution because there is not enough room to cover every domain. The distribution of overlooked long-term risks reinforces that point: cardiovascular, bone, cognitive, metabolic, and sexual-health issues are all competing for the same limited minutes.

The preferred future model offers a clue to how respondents are reconciling this. Shared care preserves primary care as the accessible front door while adding a structured specialist layer for complex histories and uncertain decisions. The deeper pattern is not a debate over who owns menopause. It is a search for a care system proportionate to the complexity patients are already bringing through the door.

Questions professionals continue to ask

This topic remains dynamic. The questions below reflect common practical searches around the field rather than retrospective questions about this survey.

Can a family physician or GP manage menopause care?

Primary care clinicians commonly assess menopause symptoms, discuss treatment options, provide preventive care, and prescribe therapy when appropriate. Complex histories or contraindications can prompt specialist input.

How is perimenopause identified in primary care?

In otherwise healthy people aged 45 or older with typical symptoms and menstrual-cycle change, major guidelines generally rely on the clinical picture rather than routine hormone testing. Younger patients or atypical presentations may need different assessment.

What factors affect the choice of menopausal hormone therapy?

Age, symptoms, uterine status, personal and family history, thromboembolic and cardiovascular risk, breast cancer history, route of administration, formulation, and patient preference can all influence the treatment discussion.

What is genitourinary syndrome of menopause?

GSM describes menopausal changes affecting the vulva, vagina, bladder, and urethra. Symptoms can include dryness, discomfort, painful sex, urinary symptoms, and recurrent urinary infections.

What non-hormonal options are available for menopause symptoms?

Depending on the symptom and the person's health profile, options can include menopause-specific cognitive behavioral therapy and selected non-hormonal medicines. Fezolinetant is one newer option for moderate to severe vasomotor symptoms when HRT is unsuitable in settings where it is approved and recommended.

Why are longer menopause consultations often needed?

Menopause can involve multiple systems at once. A detailed visit may need to cover symptoms, treatment risks and benefits, sexual and genitourinary health, bone health, cardiovascular risk, mental health, and patient questions about online information.

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SELECTED EXTERNAL CONTEXT

1. NICE. Menopause: Identification and Management, updated April 2026
2. NICE. Menopause Recommendations

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