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Personal view

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Changing the change

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Four years ago, I was a Foundation Year 2 doctor on a four-month General Practice (GP) placement in a rural Hertfordshire practice. In the short time that I was there, it became increasingly clear that something was lacking: menopausal health care and, perhaps even more concerning, accurate knowledge of this field within primary care. I was first aware of this at the very local level, although it didn't take long to ascertain the problem was far more widespread.

In the first instance, all I knew was that I kept seeing women, largely in their mid-late 40s, who – for one reason or another – were no longer coping with life. The vast majority of these women were in work and, for the most part, had partners and families at home. For the past 20 or so years they had been successfully juggling their professional, personal and social lives and, yet, suddenly here they were: sitting bewildered in a junior doctor's consultation room, asking where it had all gone wrong.

Dry eyes, insomnia, palpitations, anxiety, irritability, irregular menstrual bleeding, headaches; no matter the presenting symptom(s), it was abundantly clear that the real issue often ran deeper than the surface presentation. And this did not escape the patients in question. On an almost daily basis, I was asked whether their symptoms and concerns were "related to hormones", "could it be menopause?" or told emphatically "I *know* this is peri-menopause, but what can I do to make things more bearable?"

Much of the time, I felt powerless to help. In most cases, if these women had sought advice previously, it wasn't that my colleagues had failed to recognize their symptoms as potentially (peri-)menopausal. Indeed, whilst an unfortunate few had been told they were likely depressed, suffering stress or "just getting older", most had received acknowledgement that hormonal changes were afoot and some had been offered treatment in the form of hormone replacement therapy (HRT). Nevertheless, those who had not been prescribed HRT (appropriately or otherwise) were left floundering, and those who had been given hormones and had not responded as expected continued to struggle.

I thought back to medical school, scanning my memory for useful nuggets concerning the "change of life" but couldn't remember the menopause being discussed other than in the "be aware" category. Rather embarrassingly, it transpired that the sum total of my knowledge was that vasomotor symptoms were an indication for HRT. Palpitations, vaginal atrophy, nausea and aching joints were simply not on my radar; I was not even aware that HRT could be prescribed transdermally. A recent four-month stint in Obstetrics & Gynaecology had been no help; gynaecology on-calls and labour ward duties had left me none the wiser. I felt out of my depth.

I asked one of the partners in my practice for advice, and wondered if there was a local menopause clinic to which we could refer those women we were unable to help further. I remember him shaking his head, saying there was no such service, despite it being badly needed. I was given the name of a private gynaecologist, with the suggestion that this could be passed onto those patients who wished (and were able) to go down that route. It felt as though we could do more.

Fast-forward two years. Now a GP specialty trainee, I was once again in primary care and found myself facing a familiar challenge. I approached a local practice lead in Women's Health, and asked if we could arrange a session to discuss HRT and how to prescribe it appropriately. I was told it was simple: "Open MIMS and turn to the section on Hormone Replacement Therapy. Start at the top and work your way down, depending on whether the woman needs continuous or sequential therapy. They don't need progesterone if they have had a hysterectomy". That was it.

I hoped that my GP Specialty Training Programme (GPSTP) release sessions would shed some light. However, the entirety of menopause was covered in 15 min by a fellow trainee who admitted he hadn't known the first thing until swotting up the previous evening. The session's facilitator cheerfully told us that the key thing, when prescribing HRT, was to look at the price tag. "Transdermals are to be used as a last resort", we were told.

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Throughout my six-month attachment, I encountered several cases that further demonstrated the pervasive need for increased competence in the management of menopause – both within primary and secondary care. A 53-year-old lady who suffered terribly with hot flushes and mood swings – denied HRT by an ill-informed GP as her maternal aunt had developed breast cancer in her late 50s. A 34-year-old nurse in surgical menopause deemed a ''hypochondriac'' when a 2 mg oestradiol tablet did not control her symptoms. A 58-year-old academic who had had her HRT withdrawn as she ''had been on it long enough'', enduring an unpleasant resurgence of insomnia and nausea. A 28-year-old breast cancer sufferer – in medical menopause – ''cured'' of her cancer, but with little quality of life. A discussion between colleagues describing the prescription of Testogel for low libido in one menopausal patient as a ''luxury'', with the suggestion it should be withdrawn. Misinformation and outdated ideas were widespread.

Just over two years into my GP training, and completing hospital rotations on a general medical ward, I continue to see the fallout of poor knowledge and misguided opinion. In the last six weeks alone I have seen two women in their early 40s, admitted for entirely unrelated reasons, who had both undergone bilateral salpingo-oophorectomy (BSO) in their late 20s. Neither had been offered HRT, either for symptomatic or prophylactic reasons. One of these patients had been informed that there was ''no point taking it now, only to suffer when it's withdrawn''; the other had been told by her GP that they didn't know how to prescribe HRT for someone ''that young'' and, therefore, would not prescribe anything at all! The fact that these young women had missed out on the potential cardio and neuro-protective effects of sufficient estrogen administration and had almost certainly suffered a significant decrease in bone mass seemed to have passed the majority by.

A few months ago, I attended an evening lecture on Women's Health by a gynae-oncologist from a tertiary treatment centre. He asked the audience what topic they would most like covered. The answer was menopause. Frustratingly, his opinion was that HRT was never indicated over the age of 52 (owing to the ''risks hugely outweighing the benefits'') and he was adamant that testosterone should never be prescribed. He stated that it was generally ''given out by private doctors in London, to women with too much money, for dubious psychological reasons...''

In more positive news, the GP trainees were recently given an up-to-date lecture by a local gynaecologist with an interest in the menopause. It was a comprehensive and informative session, with many of my peers commenting on how useful it was. I spoke with the consultant at the end and asked about the (lack of) local service provision in menopausal medicine. He told me that there had previously been a local menopause clinic but funding had been withdrawn a couple of years ago when the lead consultant had retired. Further opportunistic discussion with the occupational health department revealed that this had actually had a direct negative impact on the local hospital's workforce. One nurse confided that she sees a number of female staff dealing with menopausal symptoms that are having a detrimental effect on their professional, and personal, lives. She told me that in the past she had been able to refer to the community menopause clinic and the education, advice and treatment that resulted had ensured that most women had remained at work. Unfortunately, she said she had noted an increase in absence from work related to menopausal symptoms since the closure of the clinic. This unsurprisingly backs up the findings of Nuffield Health's recent survey on menopausal symptoms and women's ability to cope: One in five women say their symptoms have a detrimental effect on their work, with one in 10 considering quitting their job.

So, is it really as gloomy as it first appears? Are women to be forever marginalized for the way their reproductive systems (mal)function? I hope not, and I do believe there is light at the end of the tunnel. For one thing, NICE guidance is due out later this year and this can only serve to improve the current situation.

In the four years since my eyes were first opened to the poor state of menopausal health care, and my own inadequate knowledge, I feel that things are slowly changing. In addition to personal study, I have been fortunate enough to meet several influential people in the menopausal health care world, and have been welcomed with open arms. I have been encouraged to contribute and become actively involved; the enthusiasm for my own keenness in this area has been, and continues to be, highly motivating. Working as a junior doctor in Medicine can often feel isolating; it makes a change to be seen as an individual with a passion rather than an anonymous SHO filling a shift, keeping the cogs of the hospital wheels turning. It is good to be reminded that we can all make a difference. It ignites the flame for positive change.

When I first realised that I wished to develop a special interest in menopausal health, I took the step of joining the British Menopause Society (BMS). Attending their annual conference in June 2014 enabled me to network with like-minded individuals and I came away feeling animated. Connecting with fellow primary care colleagues with similar fervor has led to the development of a rudimentary online group, which we hope to establish further over the coming months. We are surveying local practices to determine exactly where

the knowledge gaps lie to ascertain how we can improve things for our colleagues and patients in the future. I have been in contact with my local clinical commissioning group (CCG) to discuss future plans to set up a community-based menopause clinic, together with local gynaecologists, and am helping coordinate a BMS study day aimed at GPs through the Primary Care Women's Health Forum (PCWHF). It's an exciting time to be involved in menopausal health care. Change is afoot.

I am also involved with Menopause UK – a policy network developed to improve the way menopause care is planned, funded and delivered. We are currently collaborating with organisations such as Endometriosis UK and The National Osteoporosis Society to raise awareness of intercurrent issues. In March 2015, we are planning to run several campaigns as part of NHS Change Day. With the ever-increasing use of social media in medical circles, we are hoping to reach a large number of people. It is a start, and hopefully a promising one.

In recent months, I have written an educational article on Menopause and HRT for GPs in training and have podcasts in the pipeline. I have had the opportunity to get involved in writing up an interesting case report and, of course, express myself here. Last month I attended the joint BMS/RCOG meeting on Post-Reproductive Health and have now fulfilled the theoretical component of the joint BMS/FSRH Certificate in Menopause. Trainers are few and far between in my local area, but I hope to develop the relevant competencies and complete the work-based assessments over the next couple of years. In time I would like to undertake the Advanced Certificate, which will enable me to accept external referrals. It is currently a way off, but I am optimistic that I will be able to develop a portfolio career within community post-reproductive health, incorporating the education of both professionals and patients and the delivery of a targeted, yet holistic, clinical service.

Women-specific health matters account for 25% of a GP's time. With one-third of the British female population currently peri- or post-menopausal, we owe it to our patients and to ourselves to secure a better future for menopausal health care. One in four women state that menopause adversely affects their quality of life and, of these, 10% still have problematic symptoms after 15 years. Good management of post-reproductive health has a substantial positive impact on women's current and future well-being. Additionally, whilst menopause isn't a disease state in itself, its physical effects do predispose women to an increased risk of conditions such as osteoporosis and cardiovascular disease. These risks are heightened in women who undergo an early or premature menopause, and it is vital that this is realised by health professionals in order that serious health consequences are avoided.

It's time to change the change.

Further information

- The British Menopause Society: www.thebms.org.uk
- Menopause Matters: www.menopausematters.co.uk
- Menopause UK: www.menopauseuk.org
- Nuffield Health: www.nuffieldhealth.com/hospitals/news/menopause-symptoms-support
- RCGP. Clinical example 3.06: Women's Health, www.rcgp.org.uk/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-3-06-Womens-Health.ashx (accessed 11 February 2015).
- Primary Care Women's Health Forum: http://www.pcwhf.co.uk/
- Change Day Campaign Twitter hashtag: #changethechange