

# Women's needs and wants when seeing the GP in relation to menopausal issues

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**Objective** – To explore women's needs and wants when seeing the GP in relation to menopausal issues.

**Design** – A qualitative interview study.

**Setting and subjects** – The study was part of a larger project, targeting menopause. It included in-depth interviews of 24 women aged 52–53 years who came from all over Denmark. The women showed a great variety of menopausal experience of symptoms and treatment.

**Main outcome measures** – An acquaintance with the women's agendas when seeing the GP about menopausal issues.

**Results and conclusion** – Women consulting their GPs either wanted to discuss treatment for menopausal symptoms, to have an examination for diseases or to get a risk assessment. Their needs for medication or examination were satisfied but several women wanted

more information, especially about the pros and cons of hormone therapy (HT). Risk assessment, if not requested, indicated problems, with some women feeling uncomfortable if the GPs started a discussion about HT and osteoporosis, if they only wanted an examination to be reassured that everything was normal. The authors' findings indicate that GPs encounter a subtle balance in considering the question of risk information to menopausal women who do not request it.

**Key words:** menopause, health services needs and demand, family practice, doctor–patient relationship, qualitative research.

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More than two thirds (71.8%) of menopausal women in Denmark have discussed menopause with their GP or another doctor (1) and similar high numbers are found elsewhere in the Western world (2).

But what do the women want from their GPs at menopause, what motivates them to make contact, and how should their needs be met? Being female GPs ourselves, and interested in how to take care of women's needs without contributing to medicalization, we found it relevant to examine these questions. Even if there is an increasing amount of knowledge on how women experience menopause (3,4) and why women choose hormone therapy (HT) or not (5–8), still little is known about their contact with the GP. One investigation (9), though, concludes that a clearer understanding of women's experiences concerning menopause may enhance communication in physician–patient interactions.

As part of a larger project on the menopause experiences of Danish women, the aim of this part of the study was to explore women's needs and wants when seeing the GP in relation to menopausal issues, and in particular to examine which issues were raised and whether the women's needs and wants appeared to be satisfactorily met during these encounters.

## MATERIAL AND METHODS

A strategically selected sample of 24 menopausal women, 52–53 years old, from all over

Denmark, was interviewed in depth by the first author (LH).

The sample was selected in order to cover a varied and broad spectrum of Danish women, their menopausal experiences and contact with the healthcare system. The women were selected primarily on the basis of their answers to a preceding survey about menopause, sent to 1261 Danish women, 51 years of age in 1998 (response rate 77%). Findings from the questionnaire have previously been presented elsewhere (1).

The women had different social backgrounds and marital status. Most of the women were married or had a boyfriend, but 6 were single. All except one had

Two-thirds of menopausal women have discussed menopause with their GP, but what are their wants and needs when seeing their GP?

- Women consulting their GPs either want to discuss treatment for menopausal symptoms, to have an examination for diseases, or to get a risk assessment.
- Several women wanted more information about the pros and cons of hormone therapy and about menopause itself.
- Risk assessment, if not requested, made some women uncomfortable if they visited the GP only to be examined.

children of their own. Almost all women were employed, most of whom had a short or mid-length education, but there were also unemployed women as well as highly educated women with academic jobs. Only Danish-born women who were Danish citizens were selected.

The menopausal experiences differed across the sample. Some had almost no symptoms; others were much bothered. Half of the women had taken hormone replacement therapy at some time. From an initial sample of 24 interviewed women, we concentrated our analysis on the data from 18 women who had discussed menopause with a doctor. The interviews lasted 1–2 hours and took place during 1999–2000, mostly in the women's homes. The interviews were semi-structured and included various aspects of menopause (e.g. course, symptoms and treatment), a short social status (education, family relations, work), and finally questions about attitudes to ageing and femininity. The women were asked thoroughly about their contact with their GPs and other doctors.

### Analysis

All the interviews were audiotaped, transcribed verbatim, read and listened to repeatedly. The interviews were analysed by using a phenomenological approach (10) and an ethnographic method (11), to find themes and new categories covering typical experiences across the material. All texts were systematically browsed and coded according to 10 general themes, e.g. "contact with doctors", "thoughts about medication", or "menopausal symptoms". All strings of text relating to the general theme "contact with doctors" were printed, read and discussed by LH and SR, and the text strings were analysed for emerging new themes and categories, following the editing analysis style (12). In accordance with our preconceptions, perspectives on medicalization (13,14) and patient-centredness (15,16) focused the reading and contributed to the choice of categories presented below.

## RESULTS

The initiative to discuss menopause with the GP was in almost all cases taken by the women, and they clearly remembered what first made them consult a doctor. Women seeing their GP about menopause basically wanted one out of three things: (1) to discuss treatment for menopausal symptoms, (2) to have an examination to ascertain if anything serious was going on or, finally, (3) to get a risk assessment concerning future diseases, especially osteoporosis. These findings are elaborated in more detail below.

After the menopause or menopausal symptoms had first been introduced, several other aspects could be handled, often on the initiative of the doctor, e.g. recommendations for possible tests which the woman had not considered at first, such as bone mineral scans, smears, mammographs or blood tests. Some of the women had seen their doctor to discuss menopause more than once and would then raise new issues.

### 1. Discussing treatment for menopausal symptoms

Women with notable menopausal symptoms contacted their GPs to discuss the need for treatment with HT; for example a farmer's wife suffering a lot of symptoms said: *I had read that medication might be helpful for hot flushes, bad night sleeps, irritation and things like that.*

These women had typically already made up their minds and just wanted a prescription, but some said that they also wanted to discuss potential side effects or the possibility of managing without medication.

All women contacting their GPs for HT got the prescription they wanted, but some who also had expected a thorough discussion of advantages and disadvantages were unsatisfied: A school teacher who contacted her GP to get treatment for hot flushes complained: *He didn't tell me much. It would have been good to know about the side effects, and that cancer was a possibility.*

In general, the women said that they wanted more information; not only about HT, but also about how other women had managed their menopause; and they wanted more information about both the positive and the negative dimensions of menopause.

Several women spontaneously commented on the doctor's gender in relation to menopausal counselling. A clerk, telling of her experiences, smilingly said that consulting a male GP was a problem because: *He hasn't the foggiest idea about this*, and another woman shook her head as she said: *He doesn't really know about this, unless he has a wife to talk to about it.*

On the other hand, one woman, speaking of her experiences with two different doctors, stated that she would rather see a male doctor because: *I think a man would take me more seriously because he has not experienced the problem himself. He would have to read about it. Maybe he is a better listener because he doesn't really know what it is like.*

### 2. Examination to ensure it was not something serious

Women also reported that they would consult a doctor due to fear of cancer, or just to be reassured everything was all right: *When menstruation stops, well, either it is the menopause or something else. My mother got cancer when she was about my age, so I consulted a doctor to exclude that possibility, you see.*

The wish for treatment was not high in this group as long as it was proved that nothing was seriously the matter. *I mean, what happens within the body is not easy to understand. Isn't that why we have doctors who can examine, inform and calm us down?*

Women wanting an examination on the whole seemed to get what they wanted. They said that they felt very secure and safe after the examination. They spoke highly about their GPs as "very thorough", "good" or "clever", and the technical examinations were reassuring: *I felt safe when the blood samples were taken in order to see if I needed anything.*

The biggest problem in this group arose when the GPs began promoting HT or telling women about the risk of future diseases. This was very confusing to some of the women, especially if they already had made up their mind not to start HT. Some said that they got rather irritated, wondering if the GP had been "bought by the pharmaceutical industries" and one woman claimed that she did not want to hear about all the troubles to come since: *The more I know about it, the sicker I feel.*

### 3. Wanting a risk assessment

Some women wanted an assessment of the risk of future diseases, and the potential ability of HT to reduce this risk. In particular osteoporosis was mentioned, as well as the possible risk of getting breast cancer due to hormones. One woman with both breast cancer and osteoporosis in her family was concerned: *I told the doctor that my mother had osteoporosis ... but I was worried about taking hormones ... I had read that the risk of getting breast cancer would be higher ...*

Some women claimed that they were very satisfied with the counselling and thorough explanations they received, and that the GPs helped them make their choices. But others became frustrated because there was no exact answer: *He refused to tell me what the best thing to do was; it was my own decision.*

However, other women became frustrated if the GPs actually offered their own opinions and left no room for discussion. One woman, fearing side effects and wanting a clear statement from her GP, commented: *It is so hard to know what to do. What is right and what is wrong. I told him I was worried about taking hormones, but he just told me not to worry. And so I had to be satisfied with that answer – it was rather irritating.*

## DISCUSSION

Women consulting their GPs either wanted to discuss treatment for menopausal symptoms, to have an examination for diseases or to get a risk assessment. Their needs for medication or examination were satisfied but their wants concerning risk assessment

and information about menopause, especially the pros and cons of hormone therapy, indicated problems, and some women wanted more information about alternatives to HT.

The results deal only with the experiences of women who *have* seen a doctor. Differences between women who discuss menopause with a doctor and those who do not are dealt with thoroughly in another paper (1).

The semi-structured interviews turned out to be very useful in getting the sort of information we were looking for. In particular, the women seemed to remember in detail their thoughts when first talking to their GP about menopause. However, after the first question had been launched and further topics were discussed, it was more uncertain as to who took the initiative, the patient or the GP.

We have described the three reasons for encounter separately for clarity and because the women so clearly described what *first* made them contact the doctor. In a normal GP setting, however, it is very likely that many women will have a mixed agenda when consulting their GP.

The study was conducted with healthy women from all parts of Denmark, who had a wide variety of menopause experiences according to symptoms and treatment, and could be seen as covering parallel patterns of other Danish women's menopausal experience. However, women from other cultures might hold other views on menopause, and subsequently have different expectations of their GP.

The interviewer's position, with LH as a researcher, GP and woman in her mid-forties as well, might have influenced the interviews. The women might have imagined that LH would be interested in only the medical aspect of menopause. We sought to avoid this factor by asking broad questions about life in general. Interference from the GP setting was reduced by conducting the visits in the women's own homes with plenty of time to listen. It may be that the women felt it easy to talk about menopause and their experience in this respect because LH was a middle-aged woman herself. Some women perhaps did not want to speak of negative experiences for fear of slandering one of LH's colleagues. Such bias might have been avoided if the interviews had been performed by someone from another profession. On the other hand, women could have felt it easy to reflect on different dimensions of their interaction with GPs, since they were confronted with someone from this profession.

Our study intended to explore the agendas of menopausal women consulting their GP. But are the women's agendas really represented by our findings? We do not know to what extent their remarks reflect culturally mediated attitudes, disseminated by health-care and media sources. However, such attitudes are

also embedded in the mind of patients consulting their doctor.

New evidence has recently turned medical counselling on HT upside down. Only a few years ago, when this study was conducted, it was advocated, especially by experts in gynaecology that medical treatment with HT seemed to be useful for almost all women (17). However, results from the WHI (18) and the Million Women Study (19) have changed the recommendations. The European Agency for the Evaluation of Medicinal Products made a statement in December 2003 (20), recommending that the minimum effective dose and shortest duration should be used, and that hormones are not favourable as first-line treatment for osteoporosis. Even if this latest evidence is new, most of the women in our study were aware of the possibility of side effects. But the new evidence could have affected the results concerning women wanting treatment, since their doctors surely would not have prescribed HT so easily.

Overall, the women's needs for medication and examination appeared to be satisfactorily met. Yet, there was a wish for more information, especially about the pros and cons of HT and the menopause itself. Our findings concerning the problems related to risk assessment and information are supported by similar findings in other studies concerning information on risk (8,21,22). Some women felt uncomfortable if the GPs started a discussion about HT and osteoporosis, if they only wanted an examination to be reassured that everything was normal. The GP needs to become acquainted with the individual women's experiences and thoughts in order to accommodate her wants and needs. The question is, should GPs start giving information on risk if the women do not want to discuss such issues? Should they instead handle menopausal questions within the framework of consultation without contributing to the total medicalization surrounding these issues? All the new evidence that puts HT in an unfavourable light gives us the opportunity to think otherwise.

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