Clinical Perspective

Closing the Gap in Menopause Education

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Menopause is a universal experience among women and all those seeking gynecologic care, yet most physicians—including obstetrician–gynecologists—report inadequate training on menopause-related care. As a result, people experiencing menopause often navigate the physical, social, and emotional challenges that accompany menopause on their own. The vacuum left by health care professionals in menopause care is increasingly filled by unregulated and potentially harmful recommendations from social media and the wellness industry. Medical educators in medical schools and residency programs must accelerate and amplify efforts in menopause education to ensure that health care professionals are able to meet the needs of patients seeking care for menopause-related concerns.

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Nearly half of the human population will go through menopause during their lifetime, making menopause one of the most common lived human experiences.[1] Menopause has historically been perceived as a part of normal aging and something to be borne silently and stoically. Funding for menopause-related research has been paltry, particularly when compared with funding allotted to other gender-specific and less universal conditions.[2] Clinical care has traditionally diminished individual experiences of menopause, with one-size-fits-all approaches to management that have swung dramatically from liberal use of hormones to prohibition of hormones and back again.[3] Medical education has neglected to teach menopause-related care beyond the most superficial aspects necessary for board licensing examinations.[4–8] This wholescale devaluing of menopause in research, clinical care, and health care education has culminated in a health care system unprepared to support patients through this inevitable and consequential life transition.

In the absence of comprehensive approaches to manage menopause and a health care workforce capable of providing them, people commonly seek guidance from nontraditional sources, including social media. Social media sources may recommend expensive, ineffective, or even harmful treatments for menopause-related care, often with undisclosed financial support from the companies behind the tests or treatments being recommended.[9,10] Social media–sourced information has seeped into medical offices, with clinicians reporting increasing patient requests for hormone testing or untested treatments for menopause symptoms. This effectively puts reproductive health care professionals in the role of correcting misinformation or denying requested care. This may further the narrative that physicians are insensitive or unresponsive regarding menopause care and further corrode patients' trust in reproductive health care professionals. By failing to integrate comprehensive menopause education into educational curricula, educators cede the management of a major life transition to the unregulated wellness marketplace.

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Educational support has sprung up in the void where medical schools should have been, including health care–adjacent programs and continuing medical education (CME) programs to retroactively educate health care professionals on menopause-related care.[11,12] In addition, certification programs through The Menopause Society have become increasingly popular and represent another vehicle to retroactively educate the workforce on menopause-related care.[13]

This article aims to summarize the current state of health care education in menopause and menopause-related care, to explore barriers to more comprehensive menopause education in undergraduate and graduate medical education curricula, and to provide evidence-based and expert-recommended approaches to improve the state of education in menopause-related care in undergraduate and graduate medical education.

CURRENT LANDSCAPE OF MENOPAUSE-RELATED EDUCATION IN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

Learning objectives specific to menopause have been available to the medical education community for the past 5 decades. The Association of Professors of Obstetrics and Gynecology (APGO) has included an educational objective on menopause in their Medical Student Educational Objectives since 1966 (internal communication with APGO). The menopause educational objective has been revised and expanded approximately every 5–6 years, most recently in 2024; the current APGO educational objective on menopause includes seven learning outcomes mapped to competencies, entrustable professional activities, and educational resources, including a teaching case and accompanying video.[14] In 2018, APGO also published a basic science teaching script that explores the physiology of menopause, association with symptoms, and underpinnings of treatment for various menopause symptoms.[15] The European Menopause and Andropause Society published learning objectives for undergraduate medical education in 2014 that were expanded in scope and depth in 2022, with current objectives delivered through a comprehensive guide on menopause, well-being, and prevention.[16,17]

Despite the long-standing availability of learning objectives and educational resources from both the APGO and European Menopause and Andropause Society to guide medical schools in their adaptation for their curricula, medical students report poor training and low confidence when caring for patients experiencing menopause. Medical students on obstetrics and gynecology and family medicine clerkships report inadequate exposure to patients with menopausal concerns during their rotations, with 40–93% of students reporting not seeing a patient for menopause-related care despite it being a clerkship learning objective.[5,18] Nearly 60% of medical students could not identify one treatment for menopausal symptoms and used potentially harmful terminology such as "geriatric" when discussing patients experiencing menopause.[7]

This training deficiency extends to graduate medical education. Among residents in primary care disciplines–internal medicine, family medicine, and obstetrics and gynecology–the vast majority (93%) agree that it is either important or very important to be able to manage menopause, yet only 7% feel prepared to manage menopause.[8] Fewer than one-third of obstetrics and gynecology residency programs reported having a dedicated curriculum or clinical experience for menopause care.[6] More than 50% of graduating obstetrics and gynecology residents reported needing to learn more about all aspects of menopause care to practice effectively.[19]

Similar to the information vacuum that patients commonly fill through social media, the educational vacuum left by medical schools and residency programs is increasingly filled by legislated CME requirements. In March 2026, the Illinois state senate passed a bill to require health care professionals to complete CME on menopause and perimenopause.[20] Similar bills are under consideration in more than a dozen other states. At the federal level, in January 2025, Congress introduced a bill requiring improved quality of menopause care at all Department of Veterans Affairs facilities,[21] and in April 2026, a bipartisan group of senators reintroduced the Advancing Menopause Care and Mid Life Women's Health Act, which would mandate menopause-related CME.[22] Although these legislative efforts aim to improve the ability of the health care workforce to serve patients experiencing menopause, the medical education community should strive to render these initiatives unnecessary by adequately educating their trainees.

BARRIERS TO MENOPAUSE-RELATED EDUCATION

The foundational preclerkship curricula in undergraduate medical education is increasingly time constrained. There are now nearly 40 U.S. accelerated medical school programs, and more are on the horizon, which requires further compression of the undergraduate medical education curriculum.[23] The

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United States Medical Licensing Examinations often drive curricular decisions including whether and to what degree a topic is covered. Current United States Medical Licensing Examinations content related to menopause lists "ovarian failure, premature menopause, perimenopause, premenopausal menorrhagia, postmenopausal atrophic vaginitis (vaginal atrophy), postmenopausal bleeding, and vasomotor symptoms" as the necessary components of menopause education for preclerkship medical school curricula.[24] The osteopathic licensing examination, COMLEX, lists only "menopause, perimenopause" as necessary components of menopause education.[25] Not surprisingly, aspects of the menopause transition that patients cite as being unaddressed by the health care system–fatigue, insomnia, metabolic changes, cognitive changes, mood changes, and joint pain–are not represented in many undergraduate medical education curricula on menopause.[26]

Clerkship faculty typically teach topics in which they consider themselves expert. Thus, the sense of inadequacy that many physicians cite regarding menopause necessarily translates into less teaching on menopause in the clinical setting. This effect likely carries over to graduate medical education as well. Residency training traditionally emphasizes the care of hospitalized patients over those in ambulatory settings.[27,28] This likely further contributes to the finding that the majority of obstetrics and gynecology graduates do not feel ready to provide menopause care.[19]

Although menopause and perimenopause belong solely within the "female reproductive system" according to the United States Medical Licensing Examinations content outline, menopause symptoms span disciplines. Patients with menopausal symptoms present to clinicians in family medicine, internal medicine, orthopedics, neurology, psychiatry, endocrinology, and emergency medicine. Failing to accurately diagnose symptoms of "brain fog," insomnia, or joint pain, for example, as menopause-related symptoms is a lost opportunity for treatment and learning.[29] As organizations develop multidisciplinary menopause clinics to improve care for patients, these can also provide opportunity for learners to identify and manage the diverse symptoms of menopause, regardless of their future discipline. Ensuring that both undergraduate and graduate medical education learners are welcomed into these clinical spaces is critical to ensure that the health care workforce ultimately does not depend on academic hubs of excellence and is prepared to care for patients experiencing menopause regardless of geographic location or discipline.[30]

STRATEGIES TO ENHANCE MENOPAUSE EDUCATION IN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION CURRICULA

Learning objectives for menopause and menopause-related care have been available for decades, and the strategies to teach these concepts have also been honed over time. Survey data of undergraduate and graduate medical education learners support that the most preferred method of learning is through actual clinical experiences, followed by case-based discussions or patient presentations.[19] In addition to being preferred, clinically focused active learning strategies are associated with greater mastery and long-term retention of concepts.[19,31,32] An intentional approach to menopause education will ensure that learners are exposed to menopause-related content and are able to retain and apply that learning to patient care in years to come.

Technology has been increasingly used to ensure standardization of learning and to adapt to the current generation of medical learners. Several peer-reviewed menopause curricula are currently indexed and include an objective structured clinical examination for a telemedicine encounter with a patient experiencing symptoms of menopause,[33] a web-based curriculum for teaching menopause designed for internal medicine clerkship students,[34] and a series of podcasts on menopause with associated case-based discussion scripts for obstetrics and gynecology residents,[35] among others (Table 1). Educators can consider exploring materials available through professional organizations (eg, APGO, European Menopause and Andropause Society) and through peer-reviewed publications (eg, PubMed, MedEd Portal) and adapting them for their organizations' and their learners' needs. Educators developing menopause-related curricula or assessment tools are encouraged to disseminate their materials to further increase the availability of menopause-related educational resources.[6]

Undergraduate Medical Education

In the preclerkship phase of undergraduate medical education, pairing foundational physiology–such as the basic science teaching scripts provided by APGO–with a patient presentation to reinforce clinical aspects of menopause is likely to enhance holistic learning and to augment long-term retention of content. Instead of being considered the sole purview of reproductive medicine courses and obstetrics and gynecology clerkships, menopause could instead be considered as a thread running throughout the

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Table 1. Menopause-Related Educational Resources for Undergraduate and Graduate Medical Education Educators

Resources for Menopause-Related Education	Includes	How to Access
Association of Professors of Obstetrics and Gynecology resources	Educational program objective Learning objectives mapped to competencies, EPAs, and resources Teaching case Educational video Basic science teaching script	apgo.org,[14,15]
European Menopause and Andropause Society resources	Learning objectives Comprehensive Guide on Menopause	Rees et al[17]
Objective structured clinical examination	Pre-encounter learning instructions Standardized patient case Pre-encounter information (door card) Postencounter scoring criteria Postencounter learner note example Postencounter standardized patient checklist	Reid et al[33]; MedEdPortal
Web-based women's health curriculum, including menopausal hormone therapy	Description of generation and delivery of web-based content	Zebrack et al[34]
Podcast series and discussion script	6 podcast episodes Associated case-based discussion scripts	Vesco et al[35]

EPA, entrustable professional activity.

curriculum. As menopause centers of excellence become more commonplace, the multidisciplinary approach to care will serve as a blueprint for multidisciplinary educational opportunities. Examples may include a case-based discussion of arthralgia within a musculoskeletal course in which menopause is on the differential and the role of collagen or physical therapy may be considered or an insomnia case within a neurology course in which menopause-related sleep disturbances are on the differential and menopause hormone therapy is discussed as a potential treatment.

Standardized patient encounters should be considered as assessment tools to ensure that students demonstrate competence in interpersonal skills, medical knowledge, and clinical reasoning related to menopause care. Because students commonly graduate from medical school without directly caring for patients experiencing menopause symptoms,[5,18] it is incumbent on medical schools to ensure a standardized encounter that all students complete, regardless of clinical sites or faculty expertise, to ensure competency in this incredibly common and debilitating condition.[33]

Graduate Medical Education

Residents across disciplines should participate in multidisciplinary and potentially interprofessional clinical educational programming regarding menopause. Opportunity exists for collaboration between residency programs spanning obstetrics and gynecology, family medicine, internal medicine, orthopedic surgery, and psychiatry and among other health care professions that care for patients in menopause such as pharmacy, physical therapy, and social work. Multidisciplinary educational symposia on menopause—with case-based discussions, patient presentations, or standardized patient encounters to ensure relevance and retention—can optimize efficiency across programs. Peer-reviewed curricula are available that can support this type of multidisciplinary programming, and newly developed curricula should be similarly disseminated to amplify their influence.[36]

CONCLUSION

Menopause has lately been receiving long-overdue attention in both the lay literature and medical spheres. As medical educators, it is our duty to adequately educate future health care professionals to serve the populations' health care needs, menopause among them. Our dereliction of this responsibility has led to people seeking care elsewhere and to a loss of patient trust in their doctors and systems that serve them. We believe that trust in evidenced-based recommendations by health care professionals is salvageable, but only if we hold up our end of the bargain by listening, learning, serving, and teaching. Our hope is that the message and the tools provided in this article bring us closer to that restoration of trust and improved care for people experiencing menopause. We must ensure that the physicians we train are well informed, clinically experienced, and confident to

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care for patients experiencing menopause and to help close the gap between patients' needs and patients' experiences in menopause-related health care.

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