



A model of care for healthy menopause and ageing: EMAS position statement



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ABSTRACT

Worldwide, the number of menopausal women is increasing. They present with complex medical issues that lie beyond the traditional scope of gynaecologists and general practitioners (GPs). The European Menopause and Andropause Society (EMAS) therefore provides a holistic model of care for healthy menopause (HM). The HM healthcare model's core consists of a lead clinician, specialist nurse(s) and the woman herself, supported by an interdisciplinary network of medical experts and providers of alternative/complementary medicine. As HM specialist teams are scarce in Europe, they are also responsible for structuring and optimizing processes in primary care (general gynaecologists and GPs) and secondary care (HM specialists). Activities for accreditation of the subspecialty Women's Health are encouraged.

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1. Introduction

The menopause can now be considered to be a mid-life event as the lifespan of women continues to increase in developed countries [1]. By the year 2025, the number of postmenopausal women is expected to rise to 1.1 billion worldwide. Although not all women will experience short- or long-term problems of menopause, the high prevalence of hot flushes [2,3] and vaginal atrophy [2,4], which can last for many years, as well as osteoporosis (1 in 3 women are at risk of an osteoporotic fracture) [5], makes caring for ageing women a key issue for health professionals.

The European Menopause and Andropause Society (EMAS) aims to provide holistic consensus advice on the management of menopausal women through its position statements and clinical guides [6]. This position statement intends to provide a model of care for (healthy) ageing menopausal women.

2. Concept of healthy ageing and healthy menopause

Health and disease can be conceptualized as a continuum, reflected by a dynamic balance between faced demands and an individual's capacity to adapt physiologically, psychologically and socially. That concept incorporates physical, mental and social functioning, which differs between individuals and changes due to ageing [7]. Healthy ageing includes survival to old age, delay in the onset of non-communicable diseases (NCDs) and optimal functioning for a maximal period at individual levels of body systems and cells. The conceptual framework of Active and Healthy Ageing (AHA) [8] incorporates items such as functioning (individ-

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ual capability and underlying body systems), wellbeing, activities and participation, and diseases, including NCDs. Signs of impaired function may act as markers of failure to reach developmental potential (“health resources”), accelerated ageing or underlying disease processes, and offer opportunities for early intervention [9]. Furthermore, markers of function and wellbeing above average (“health strengths”) may act as guidance for successful and sustainable interventions to reach best age- and lifestyle-related health status in an individual or epidemiological approach.

The conceptual framework of the Healthy Menopause (HM) [7] breaks the AHA concept down to menopause regardless of when and why menopause occurs. Herein, HM is defined as a dynamic state, following the permanent loss of ovarian function, characterized by self-perceived satisfactory physical, psychological and social functioning, incorporating disease and disability as well as a woman’s desired ability to adapt and capacity to self-manage. Thus, HM incorporates both obtained and developed resources aiming to maintain, revisit, adjust, recover and improve that dynamic balance. Most importantly, the conceptual HM framework encompasses women as a whole, beyond their hormonal, reproductive and physiological health.

3. Evidence of what women want

Women’s conceptions of the menopausal transition are individual and incorporate both physical and psychological symptoms. However, the menopausal transition has also been described, in a more holistic view, as a natural process affected by endocrine and lifestyle factors, the psychological situation and ageing per se [10]. Ethnic and sociodemographic differences in menopausal symptom management have been observed. A US study [11] found that white women tended to focus on specific symptoms by seeking help through formal healthcare systems, but ethnic minorities approached their symptoms more holistically, by seeking help through their family members and friends. Thus, medication for menopausal symptom relief was a first step for white women and a final step for ethnic minorities. Moreover, attitudes towards the menopausal transition may differ between women and their physicians [12]. Thus, awareness and identification of women’s different perspectives are crucial for healthcare professionals, as consultations regarding menopause-related matters constitute a significant part of the workload [13].

Despite the omnipresence of all kinds of media, there is a lack of knowledge among women regarding menopause, treatment options and possible risks associated with menopausal hormone therapy (MHT) [14–16], making informed decisions difficult for individual women. Furthermore, some women may feel completely ignored by their healthcare providers [17]. Thus, first of all, women want their healthcare providers to start listening to what they report [17]. Secondly, women want clear, evidence-based information about the various hormonal and non-hormonal treatment options [16,18–21]. In addition, they want to discuss and seek help for non-vasomotor menopause-related symptoms, such as weight gain, sleep disturbance, tiredness, moodiness, low sexual desire and dyspareunia [22].

4. Current healthcare provision for menopausal women

Although in women aged 45–64 years, the prevalence and incidence of at least once menopause-related consultation has been reported to have fallen from 18.1% in 1996 to 10.4% in 2005 [13], menopause remains an important part of general practice work, especially when facing the increasing number of women (“baby-boomers”) currently reaching menopause. This is in stark contrast to the poor specialized training most GPs and gynaecologists

receive in post-reproductive healthcare. For them (and others), international scientific societies have provided numerous clinical standards and guidelines on treatment of menopausal symptoms, including the International Menopause Society (IMS) [23], EMAS [24–27], Endocrine Society [19,28], North American Menopause Society (NAMS) [29–32] and NICE [33]. EMAS has also provided recommendations on the management of menopausal women with comorbidities such as cardiovascular disease [34,35], osteoporosis [36–39], obesity [40,41], endometriosis [42], lichen sclerosus [43] and epilepsy [44]. Despite the many recommendations available, an electronic survey of UK GPs found that the majority lacked confidence in effectively managing peri- and postmenopausal women [45]. Similarly, trainees in obstetrics and gynaecology have been shown to be insufficiently qualified for post-reproductive bone healthcare (Switzerland) [46], sexual healthcare (UK) [47] and core menopause topics (USA) [48]. These findings are not surprising given the rapid changes in opinion on the benefits and risks of MHT during the past decade, which has caused confusion among healthcare providers and women. To counter this deficit in knowledge, a 2-year formal menopause medicine curriculum introduced to trainees in obstetrics and gynaecology in the USA has been shown to significantly improve their knowledge and self-assessed competence in core menopause topics [48].

5. Healthcare model for a healthy menopause

The conceptual HM framework [7] is a holistic model of care covering physical, psychological and social functioning. It also reflects the need of midlife women to at least maintain if not improve their (health-related) quality of life (QoL), which is now an integral component of contemporary healthcare [49].

The HM concept incorporates disease and disability, thereby targeting a healthy menopause for every woman regardless of her comorbidities. The latter is of tremendous significance, as the prevalence of (multiple) chronic medical conditions has been shown to increase dramatically in midlife women within a short period of time. Thus, the more conditions a woman develops, the greater reduction in health-related QoL will she experience [50].

Obviously, this holistic approach in the management of menopausal women, also recommended by the FIGO Committee for the Ethical Aspects of Human Reproduction and Women’s Health [51], requires a less traditional model of healthcare provision.

Here we provide an integrated healthcare model for HM. The main goals are healthcare and health promotion for midlife women and empowerment of women to make positive choices for their post-reproductive health and wellbeing. The HM healthcare model’s core is the triangle consisting of: 1) a lead clinician (gynaecologist, sexual and reproductive health specialist or GP with special interest) who holds appropriate national qualifications or other recognized certificates, with support from other appropriately qualified clinicians to cover for training, leave and other absences; 2) (a) specialist nurse(s) who can run independent clinics supported by the clinicians; and 3) the woman herself. The triangle’s objective is to set up a personalized care plan for a woman’s short-, mid- and long-term goals in the context of physical, psychological and social functioning, incorporating the woman’s perception of her life status within her culture and value system, expectations, concerns and opinions about endocrine and age-related physical and psychological changes related to midlife. Lead clinicians should provide specialist expertise that is both comprehensive and integrated for the care of the midlife female, as detailed in Table 1 [52,53].

The specialist nurse(s) should provide and/or support strategies for empowerment in relation to educational interventions, phys-

Table 1
Overview of healthcare provider skills., adapted from the HM healthcare model [52].

Clinical skills	Procedural skills
<ul style="list-style-type: none"> • Expertise in provision of medical management to peri- and postmenopausal women regardless of age at menopause • Knowledge of comorbidities (autoimmune conditions, thyroid disorders, rheumatological conditions, chronic pain syndromes, cardiovascular disease) and high-risk peripartum conditions which have long-term health implications at menopause and beyond • Knowledge of menopausal symptoms and differential diagnoses • Ability to assess and interpret bone mineral density scans • Knowledge of the current literature, guidelines and recommendations from scientific societies on menopausal hormone therapy, and an understanding of the risks and benefits • Knowledge of current literature and guidelines from scientific societies on non-hormonal therapies for menopausal symptoms, and an understanding of the risks and benefits • Knowledge of current literature and guidelines from scientific societies on treatment options for osteoporosis, and an understanding of the risks and benefits • Knowledge of national screening programmes and guidelines for non-communicable diseases (NCDs) • Expertise in dealing with results of cervical cancer screening in accordance with national guidelines • Expertise in fertility and contraception • Expertise in medical management of abnormal uterine bleeding • Expertise in managing female sexual dysfunction • Expertise in medical management of urinary incontinence and assessment of genital prolapse • Expertise in the management of women with a personal or family history of breast disease • Expertise in providing personalized gender-based care 	<ul style="list-style-type: none"> • Transvaginal ultrasound • Colposcopy • Cervical and endometrial polyp removal • Intrauterine device insertion/removal • Pessary fitting and placement for pelvic organ prolapse

Table 2
Network of medical disciplines supporting the HM healthcare model.

Most frequent non-communicable diseases/conditions in midlife women (modified according to [55])	Network of medical disciplines
Ischaemic heart disease	Cardiology
Chronic low back pain, neck pain	Orthopaedics, anaesthesiology
Stroke	Neurology
Musculoskeletal diseases	Rheumatology, orthopaedics, physiotherapy
Cancer	Oncology, surgery
Depression	Psychiatry, psychology
Diabetes mellitus	Endocrinology, nutrition medicine
Chronic respiratory disease	Respiratory medicine
Dementia	Radiology
	Laboratory medicine
	Pathology, microbiology

ical activity/exercise, healthy diet, stress management, healthy lifestyle, and prevention of (non-)communicable diseases [54].

Beyond the HM healthcare model's core, the triangle, there is an interdisciplinary network providing backup medical expertise for the most frequent medical conditions and disabling diseases in developed countries [55] (Table 2). Referral pathways should be short, transparent and well structured.

This interdisciplinary network of medical specialists may be complemented by additional healthcare providers from the alternative/complementary medicine field, such as physiotherapy, osteopathy, chiropractic, naturopathic treatment, homeopathy and traditional Chinese medicine. A medical specialist team dedicated to the HM healthcare model should follow standard quality criteria and receive internationally acknowledged quality management certification from bodies such as the International Organization for Standardization (www.iso.org) or the European Foundation for Quality Management (www.efqm.org).

6. Translating the HM healthcare model into practice

In most European countries, post-reproductive gynaecological care is delivered either by GPs or by general gynaecologists. Only women with complex issues or who fail to respond to treatment are referred to specialist services (secondary care). However, across Europe dedicated specialist health service provision is scant. Until women's healthcare (including menopause healthcare) is accredited as a medical subspecialty it will not receive sufficient support from healthcare authorities and governments. Thus the proposed multifaceted HM healthcare model will remain split into primary and secondary care (Fig. 1).

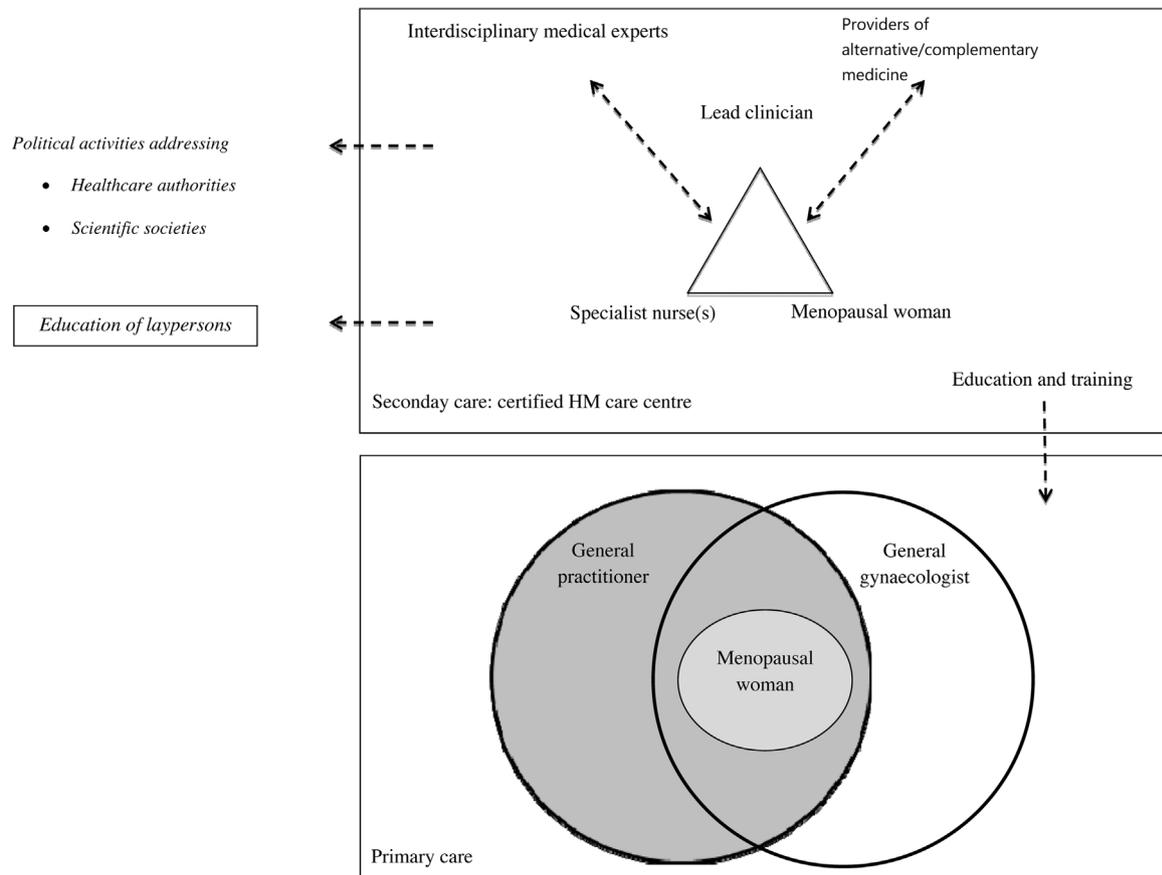


Fig. 1. Healthcare model for Healthy Menopause (HM).

The HM healthcare model's core consists of a lead clinician, specialist nurse(s) and the woman herself, supported by an interdisciplinary network of medical experts and providers of alternative/complementary medicine (secondary care). The HM specialist team is responsible for structuring and optimizing processes in primary HM care (GPs and general gynaecologists) and for education (including web-based interventions such as the Webinars provided by EMAS) of primary care physicians and laypersons, and should play an active role in scientific societies and during negotiations with healthcare authorities.

The HM specialist team is also responsible for structuring and optimizing processes in primary and secondary HM care. Each health authority/region should have a dedicated HM medical specialist team. Therefore the major resource implication is in funding and supporting a specific clinical team outside routine gynaecological services. Patient flow needs to be regularly mapped so that bottlenecks can be identified and dealt with within established referral timescales. Time needs to be made available in job plans so that members of the HM medical specialist team can regularly undertake teaching in primary care. In that way, rather than services being provided by unregulated non-medical professional groups, evidence-based care can be provided by trained health and allied health professionals [56]. Thus, accreditation of the subspecialty Women's Health should be a political goal, as it will create national academic leaders qualified to run interdisciplinary Women's Health Centres, improving holistic clinical care [51,52].

7. Conclusions and recommendations

- The conceptual framework of the Healthy Menopause (HM) is a holistic model of care covering physical, psychological and social

functioning and incorporating disease and disability. It encompasses women as a whole, beyond their hormonal, reproductive and physiological health.

- The HM healthcare model aims to translate the HM framework into practice.
- The HM healthcare model's core consists of a lead clinician, specialist nurse(s) and the woman herself, supported by an interdisciplinary network of medical experts and providers of alternative/complementary medicine.
- Provision of HM specialist teams in Europe is scant and needs to be expanded, as the number of postmenopausal women is increasing.
- HM medical specialist teams should follow standard quality criteria and receive internationally acknowledged quality management certification.
- Accreditation of the subspecialty Women's Health should be actively promoted.

Conflict of interest

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