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REVIEW

Navigating Uncharted Waters: A Meta-Ethnography Exploring General Practitioners and Women's Experience of Perimenopause Consultations in General Practice

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Background: Perimenopause precedes menopause and can cause a wide range of symptoms for women. General Practitioners (GPs) are often the first point of contact for symptom management. Shifting societal attitudes to perimenopause have prompted more women to seek care within general practice, yet many report suboptimal support. Despite the increasing body of research on menopause care, the experiences of perimenopause consultations in general practice have yet to be conceptually synthesised. This qualitative evidence synthesis, therefore, aimed to explore the experiences and perceptions of women and General Practitioners regarding perimenopause consultations in general practice.

Methods: We followed the methods of meta-ethnography as developed by Noblit and Hare and our reporting follows the eMERGE reporting guidance. Seven databases were systematically searched to identify studies detailing the experiences of women and GPs during perimenopause consultations. To evaluate confidence in the review findings, we employed the GRADE-CERQual approach.

Results: Ten studies were included in the synthesis. *Navigating uncharted waters* was established as an overarching metaphor in a line of argument encompassing four main themes: (1) Adrift in the sea of perimenopause uncertainty, (2) Taking the helm: women's advocacy, agency, and negotiated power in perimenopause care, (3) Gendered dynamics: women's experiences and GP perspectives, (4) Navigating structural obstacles and fragmented care. Findings illustrate how pervasive both uncertainty and the ways in which power is negotiated within clinical encounters shape the quality, depth, and direction of perimenopause consultations. Findings highlight how imbalances in perceptions of knowledge and authority shape perimenopause consultations.

Conclusion: This qualitative evidence synthesis highlights the tensions and challenges encountered by women and GPs as they navigate the uncertainties inherent in perimenopause care. The results underscore the importance of sensitive and empathetic communication, where normalisation is delivered with compassion, and uncertainty is acknowledged and conveyed transparently. Openly recognising these uncertainties helps manage expectations.

Keywords: perimenopause, general practice, qualitative evidence synthesis, meta-ethnography

Introduction

Perimenopause precedes menopause and includes the years leading up to a woman's final menstrual period.[1] While perimenopause is a universal experience, the way it manifests can vary significantly and for some women it can be a challenging time. Symptoms of perimenopause include but are not limited to vasomotor symptoms, genitourinary symptoms, cognitive symptoms and changes in mood and mental health. The duration of perimenopause varies widely, with some estimating that perimenopause may last between five and ten years.[2] While many women experience perimenopause with manageable or minimal symptoms, others contend with symptoms that significantly affect their quality of life.[1,3] Over 60% of symptomatic women seek healthcare for perimenopause[4] with General Practitioners (GPs)

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frequently the first point of contact.[5] There has been a notable increase in the number of women seeking care in general practice for perimenopausal concerns[5,6] including those at younger ages than previously anticipated.[2] GPs are ideally positioned to deliver person-centred care that considers both the medical histories of women and their individual needs, which is particularly crucial when considering treatment options for perimenopausal symptoms.[7] Menopausal Hormone Therapy (MHT) is recommended for its efficacy in managing some perimenopausal symptoms such as vasomotor symptoms in healthy women undergoing natural perimenopause.[8,9] While the role of MHT is well-established in treating menopausal women, there is still less certainty concerning its role during perimenopause.[9] Following the Women's Health Initiative (2002)[10] and the Million Women Study[11] (2003), prescribing of MHT declined significantly[12] as both women and GPs became hesitant due to fears of breast cancer and cardiovascular risks associated with its use. Subsequent research has clarified the role of MHT for the management and treatment of perimenopausal symptoms. This evidence has informed the National Institute for Health and Care Excellence (NICE) guidelines (2015, 2024)[13] and The International Menopause Society recommendations for MHT (2016)[14] for managing perimenopause and menopause.

Over the past decade, prescriptions for Menopausal Hormone Therapy have increased significantly,[15,16] especially in women aged 45–54 years[17] reflecting shifts in both clinical and societal attitudes. The way perimenopause is discussed and understood is greatly influenced by a shift in public discourse. Social media is a popular source of information regarding menopause related health, especially among perimenopausal women[18,19] While growing awareness is beneficial, it has arguably outpaced the medical community's capacity to respond.[20] As more women seek care in general practice, understanding the consultation experience becomes increasingly important. Exploring how these interactions occur, including expectations and decision-making processes, will provide valuable insights to inform best practice recommendations.

Existing evidence syntheses[21–23] frequently encapsulate perimenopause within the broader menopause narrative, obscuring the distinct diagnostic ambiguity and symptom variability that shape perimenopause. Examining perimenopause as a discrete experience is therefore essential for understanding the specific challenges of perimenopause consultations within general practice. Although grounded in contemporary empirical research and policy trends, this study adopts an interpretive approach informed by women's and GPs' experiences of perimenopause consultations. This qualitative evidence synthesis aims to gain insight into the experiences and perceptions of perimenopause consultations in general practice from the perspectives of women and GPs, and to explore how treatment decisions are made within these encounters.

Methods

This qualitative evidence synthesis follows the seven steps of meta-ethnography described by Noblit and Hare[24] (Table 1) and is informed by worked examples.[25–29] The protocol for this qualitative evidence synthesis has been previously

Table 1 Seven Steps of Noblit and Hare's Meta-ethnography[24]

Phases	Strategies
1. Getting started	Identify the topic of interest and define the aim.
2. Deciding what is relevant	Describing search strategy, inclusion and exclusion criteria, including relevant studies.
3. Reading the studies	In-depth repeated reading.
4. Determining how the studies are related	Determining relationships between the studies, listing key concepts, themes, metaphors. Determining if relationships are reciprocal, refutational or present a line of argument.
5. Translating the studies into one another	Identify the presence/absence of similarities, comparing concepts, themes and metaphors across studies while staying true to the findings of each study.
6. Synthesising translations	Creating a new whole from the sum of the parts. Studies are no longer viewed as individual studies but as a whole.
7. Expressing the synthesis	Determining the appropriate format for effectively communicating the synthesis to the audience.

published.[30] Minor deviations from the protocol are described in Supplementary File 1. The study was registered in the International Prospective Register of Systematic Reviews database (PROSPERO) (CRD42024520537).[30] This evidence synthesis is reported following the eMERGE reporting guidance[31] in Supplementary File 2.

Phase 1: Getting Started

Once the topic of interest was identified, a protocol was developed and published.[32]

Phase 2: Deciding What is Relevant

Seven databases were systematically searched: Academic Search Complete, CINAHL, Embase, Medline, PsycINFO, Scopus, and Web of Science from 2014 to June 2025 to identify studies published after the publication of NICE Guidelines: Diagnosis and Management of the Menopause (NG23) in 2015.[13] A university librarian at University College Cork provided guidance on the search strategy and database selection. The search strategy was developed using the Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) tool.[33]

The initial search was conducted on March 16th, 2024, and was re-run on June 3rd, 2025. The search strategy for each database is presented in Supplementary File 3 Studies were included if they provided qualitative data on the experiences of women and/or GPs within perimenopause consultations. While perimenopause is experienced by people of other gender identities, this review focuses on the experiences of women only.

While meta-ethnography was originally intended to synthesise qualitative studies, it is now frequently employed to synthesise studies conducted using mixed-methods.[34,35] Mixed methods studies with a qualitative component were eligible for inclusion in this review. Studies that investigated other clinical conditions or other women's health issues, with findings specific to experiences of perimenopause consultations, were included. Inclusion and exclusion criteria (Table 2) were informed by the SPIDER framework.[33] Identified citations were imported into Endnote™ 21 and duplicates removed. The remaining citations were transferred to Raayan a systematic review management tool and authors LJM, AOM, and SMH carried out title/abstract and full-text screening.

Table 2 Inclusion and Exclusion Criteria

	Inclusion Criteria	**Exclusion Criteria**
Sample	General practitioners (or equivalents, must be physicians). Perimenopausal women who have sought care in general practice (or its equivalent).	Healthcare providers who are not physicians. Physicians in secondary care. Post-menopausal women, premature ovarian insufficiency, iatrogenic menopause.
Phenomenon of Interest	Experiences of perimenopause consultations in general practice. Studies that report on wider women's health issues that report experiences of perimenopause consultations.	Experiences of perimenopause consultations in settings other than general practice. Experiences of menopause only (not perimenopause experience).
Design	Qualitative or mixed methods studies reporting the lived experience of perimenopause or of providing care to women with perimenopausal symptoms. Primary studies must report on qualitative methods of data collection and analysis.	Studies that report quantitative methods only. Mixed methods where it is not possible to extract qualitative data.
Evaluation	Qualitative analysis of lived experience of perimenopause consultations.	Studies that evaluate experiences of perimenopause quantitatively only. Studies that do not report a qualitative method of analysis.

(*Continued*)

Table 2 (Continued).

	Inclusion Criteria	Exclusion Criteria
Research type	English full text available. Peer-reviewed literature.	Non-English language. Grey literature, non-peer-reviewed literature, opinion pieces, editorials, protocols, reviews, and theses.

Quality Appraisal

Quality appraisal was conducted by LJM using the Critical Appraisal Skills Programme (CASP) checklist for qualitative research and is presented in Supplementary File 4. No studies were excluded based on quality appraisal, as studies with lower quality appraisal ratings can still contribute valuable insights to qualitative evidence synthesis.[36] The overall quality of the studies was high, meeting most of the criteria outlined by the CASP. A few minor concerns, primarily related to authors not clarifying the relationship between researchers and participants, were noted in eight of the studies.[37–44]

Phase 3: Reading the Studies

The included studies were examined through repeated reading (by LJM) to achieve a comprehensive understanding of the key themes, and a list of the principal findings from each study was compiled. LJM extracted data for all included studies, and AJ independently checked a sample of 20% for accuracy and consistency. Contextual data were extracted, including the author, year of publication, country of origin, study aims and objectives, study design, study setting, sample, participant characteristics, data collection methodology, coding approaches, analysis, themes, and subthemes.

Phase 4: Determining How the Studies are Related

This phase focused on identifying and exploring the interconnections among the concepts derived from the included studies. First-order constructs (participants' quotations) and second-order constructs (authors' interpretations, including themes, concepts, and metaphors) often located in the discussion and results sections of articles[45] were treated as the raw data for synthesis. The research team met regularly to discuss these constructs and collaboratively organised them into conceptual categories, based on similarities and differences across studies. To facilitate comparison, we constructed a matrix similar to the approaches of Hjelm[27] and Allum[26] that mapped first- and second-order constructs across studies. Studies were arranged chronologically, with the earliest positioned in the leftmost column, allowing us to explore whether the experiences of women and GPs evolved over time, particularly in relation to the publication of the NICE guidelines.[13] While some meta-ethnographies use an index study to anchor the translation process, we opted for a chronological approach to better capture temporal shifts in experience and interpretation.[45] Separate matrices were initially developed for studies focusing on women and those focusing on GPs, enabling us to examine patterns within and across these groups. These matrices supported the identification of reciprocal and refutational relationships between concepts.

Phase 5: Translating the Studies into One Another

During the extraction process, we examined the interrelationships among the study concepts by identifying commonalities, overarching themes, and metaphors, while also making preliminary interpretations. Translations of the data were initially conducted separately from the studies with women and from the studies with GPs and then translated into one another. The matrix created in phase 4 aided translations by incorporating the main concepts and our interpretations of both first and second-order constructs. The translation process allowed concepts to be identified and subsequently abstracted into thematic categories.[29] The translation process is provided in Supplementary File 5. The process was inductive and iterative, requiring a continual back-and-forth movement through the data.[28] While the translation process enabled the identification of overarching themes and metaphors, not all data aligned neatly with these categories and did not contribute directly to the synthesis. These instances were noted and considered in relation to their contextual significance.

Phase 6: Synthesising Translations

Translations from phase 5 were analysed to identify common or overarching concepts and to develop new interpretations (third-order constructs).[28] Through regular team discussions during this phase, we synthesised arguments and gradually developed an analytical perspective that evolved into a line of argument synthesis. A line of argument integrates simultaneous use of reciprocal and refutational translation, rather than opting for one over the other.[29] "A line of argument is a new 'storyline' or overarching explanation of a phenomenon".[28]

Phase 7: Expressing the Synthesis

This meta-ethnography is presented as a scientific article with a metaphorical line of argument synthesis, which is based on four themes and sub-themes. The GRADE-CERQual[46] approach (Confidence in the Evidence from Reviews of Qualitative Research) was applied to determine our confidence in the review findings using the Interactive Summary of Qualitative Findings (iSoQ)[47] a free online tool.

Results

The electronic database search returned 2158 articles, and 693 duplicates were removed. Title/abstract screening of 1465 articles was conducted, leading to the identification of 98 studies for full-text review. The search and screening process is outlined in a PRISMA flow diagram (Figure 1). Ten studies, published between 2018 and 2025, were included in the final synthesis. Six studies were conducted in the United Kingdom, two in Australia, and two in the United States. The methodological approaches included six qualitative studies[37,39,42,43,48,49] and four studies employing mixed methods.[38,40,41,44] Eight studies focused on experiences of women,[37–43,48] and two on the experiences of GPs, both from the UK.[44,49] The studies involving women have significant heterogeneity in their focus, ranging from understanding self-directed learning about menopause,[38] perimenopausal women's knowledge and attitudes towards menopause,[40] experiences of seeking health care for perimenopausal symptoms,[42] contraception choices in women age 40 years plus,[48] perimenopausal women's feelings towards their menstrual periods,[43] menopause-related health literacy and experiences with menopause-related health care among immigrant women[39] and the impact of perimenopause serving in the defence forces.[41] However, all studies describe some aspect of perimenopause, the experiences of women interacting with GPs or equivalent, or the experiences of GPs. Although the setting was not always explicitly stated, we only deemed studies eligible if they discussed healthcare interactions within a general practice setting, or if participants shared experiences involving a general practitioner or equivalent. For example, in two studies conducted in the USA[38,42] we only included data that were specific to women seeking care from primary care physicians and not other healthcare professionals.

Although only two studies[44,49] investigated the perspectives of GPs, both reveal similar and overlapping challenges faced by GPs in treating women with perimenopausal symptoms, despite the studies being conducted in markedly different clinical settings and for very different patient populations. One study evaluated the confidence of GPs working in general practice for the defence forces in managing perimenopause.[44] This study is part of a broader research project that includes another study by the same study authors[41] which is also included in this qualitative evidence synthesis but focuses on the perspective of women. This dual perspective was important for understanding the distinctive features of the clinical environment. The other study from the GP perspective examined the experiences of GPs regarding help-seeking behaviours related to perimenopause among women from ethnic minority groups.[49] In this study[49] findings were presented to a group of ethnic minority women with lived experience (Public and Patient Involvement group) to aid in data interpretation. Characteristics of the included studies are summarised in Table 3 and Table 4.

Findings

The synthesis identified four key concepts encompassing four subthemes, reflecting the experiences of women and GPs during perimenopause consultations and their perceptions of these interactions. The concepts represent third-order constructs, that is, our interpretations of the data.

As supporting data, first-order constructs (participants' understandings) are presented with quotations and participant details in brackets. Second-order interpretations (study authors' interpretations of participant interpretations) are marked

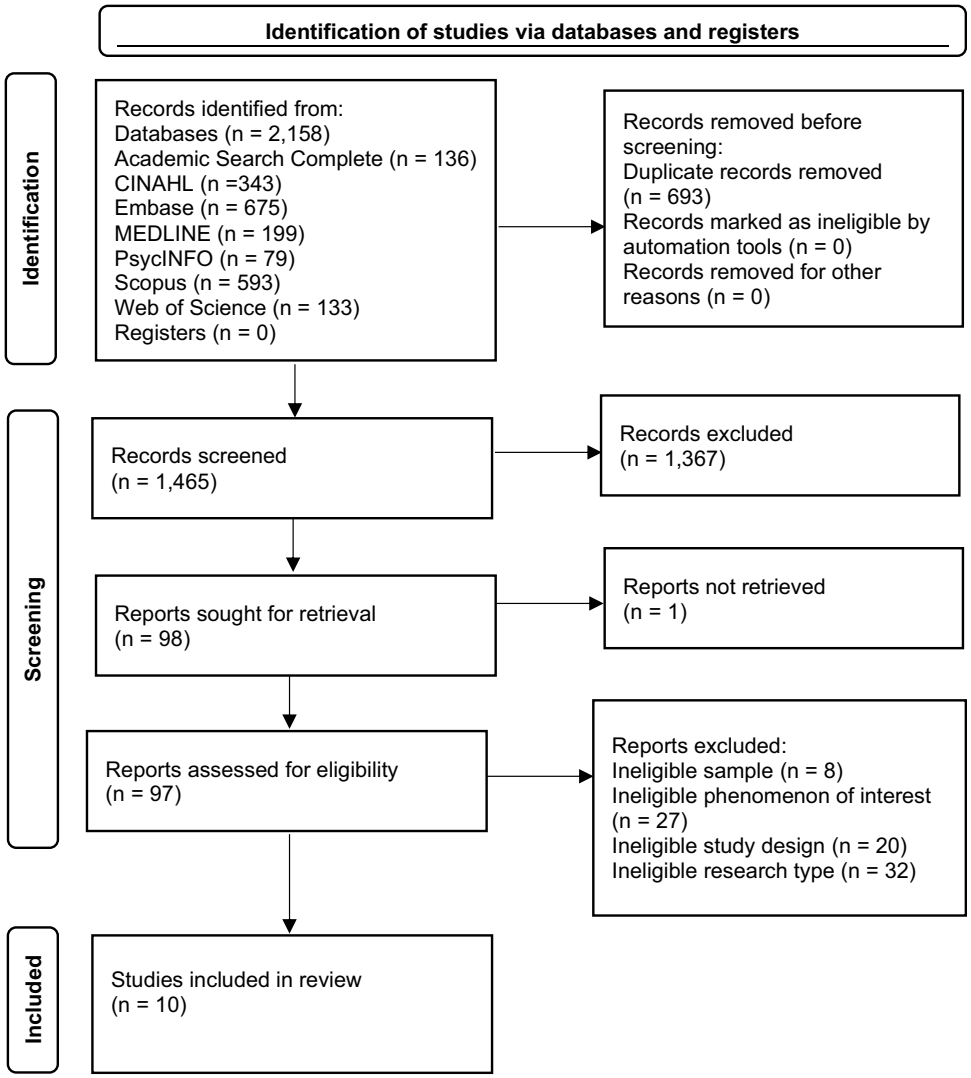

Figure 1 PRISMA flow diagram.

by quotations and labelled as second-order constructs in brackets. Both GPs and women encounter challenges in managing the complexities and uncertainties of these consultations. It is important to note that women's experiences are documented more widely in the literature, hence the number of studies from the perspective of women.[37–43,48] Two studies[41,49] explored the perspectives of GPs both conducted in the UK. One assessed the confidence of GPs working in Defence Primary Health Care in the management of the perimenopause.[44] The other explored GP experiences of perimenopause help-seeking among women from ethnic minorities in areas of deprivation.[49] These studies suggest that GPs have similar experiences and face similar challenges, regardless of the clinical setting they work in or the patient population they treat. However, the limited evidence concerning GP perspectives makes it difficult to draw firm conclusions about the extent and consistency of these challenges.

Navigating uncharted waters was constructed as an overarching metaphor in a line of argument synthesis. Development of the line of argument is presented in Supplementary File 6.

Adrift in the Sea of Perimenopause Uncertainty

This theme describes the experiences and challenges experienced by both women and GPs in identifying and interpreting perimenopausal symptoms, which was a central focus across the included studies.[38,40–43,48,49] It describes the ambiguity surrounding symptom presentation, the desire for diagnostic clarity, and the communication challenges that arise during consultations.

Table 3 Characteristics of Studies with Women

Author Ref	Year	Location	Population	Aim	Design	Data Collection	Analysis
Cooper[38]	2018	USA	227 women, 35–55 years 118 not reached menopause	To investigate the degree to which women use self-directed learning to investigate their own perimenopause	Mixed methods	Online survey with free text response	Content analysis
Herbert[37]	2020	Australia	32 women, 40–64 years 10 PRE, 3PERI, 11 E-POST 8 L-Post	To explore women's understanding of menopause and its consequences, and their menopause-related health-care experiences	Qualitative	Semi-structured interviews (telephone)	Reflexive thematic analysis
Stanzel[39]	2022	Australia	12 migrant women, 45–60 years, 3 perimenopausal	Explore how Vietnamese-born women who migrated to Australia in adulthood manage the menopausal transition and their postmenopausal health	Qualitative	Semi-structured interview (face to face)	Thematic analysis
Harper[40]	2022	UK	3150 women aged 40 years and older, 947 perimenopausal 545 women (qualitative analysis)	Attitudes and knowledge of the menopause in women older than 40 years.	Mixed methods	Online survey with free text response	Thematic analysis
Burgin[48]	2022	England	14 cisgender women 40–52 years 8 of which were perimenopausal	Factors affecting contraceptive choice in women over 40	Qualitative	Semi-structured interviews (online)	Thematic analysis
Willman[41]	2023	UK	465 women, aged 40 years and over (80.9% of respondents identified as perimenopausal)	Understand how perimenopause affects women in Defence	Mixed methods	Online survey with free text response	Thematic analysis
Richardson[42]	2023	USA	946 women aged 35–55 years	Factors that contribute to making perimenopausal healthcare interactions satisfying or unsatisfying	Qualitative	Online questionnaire with free text response	Content analysis
Ray[43]	2023	UK	31 women, 40–55 years	Perimenopausal women's attitudes towards their periods	Qualitative	Focus groups (online)	Content analysis

Table 4 Characteristics of Studies with GPs

Author Ref	Year	Location	Population/ Setting	Aim	Design	Data Collection	Analysis
MacLellan[49]	2023	UK	31 GPs Years of experience 1–30, mean 11 Special interest in women's health n = 10	Primary care practitioners' experiences of women from ethnic minorities seeking help for perimenopause and/or menopause symptoms	Qualitative	Interviews (online and telephone)	Thematic analysis
Willman[44]	2025	UK	11 uniformed and civilian GPs working in defence primary health care	To assess the confidence of GPs working in defence primary health care in the management of the perimenopause	Mixed methods	Semi-structured interviews	Thematic analysis

Recognising Symptoms and the Quest for Diagnostic Certainty

Women across the studies described experiencing symptoms they associated with perimenopause, particularly vasomotor symptoms.[37,38,40,42,43,49] However, when symptoms were less commonly recognised as perimenopausal, women reported feeling confused and uncertain. While women acknowledged their limited awareness of the full spectrum of potential perimenopausal symptoms,[38,40,41,43,48] they nonetheless expected GPs to demonstrate proficiency not only in recognising

these symptoms but also in diagnosing perimenopause.[38,40,42,43] This expectation was often unmet, leading to disappointment and frustration when GPs failed to "spot signs" of perimenopause or attribute symptoms to perimenopause.[43,48]

> 'I had very little idea of the range of symptoms of the perimenopause. I knew about flushes and I didn't have those so couldn't work out what was happening to me. I honestly thought I was going mad. I also really struggled to get any help from my GP.' (perimenopausal woman)[40]

Many women perceived that their perimenopausal symptoms and associated concerns were not taken seriously by their GP.[37,38,40,43,48,49] Some women who experienced symptoms at younger ages reported being dismissed by GPs, who considered them too young to be perimenopausal[40,43] contributing to a sense of invalidation.

> 'I was obviously having symptoms. And... my GP said, 'you're too young.' Right? So, I'm still like, late 30s. I think there's this idea that your symptoms are going to hit you between your mid-40s and your mid-50s. And anything outside of that window, anything before mid-40s, it's not perimenopausal, it's something else.' (perimenopausal woman)[43]

Like the women, GPs described challenges in interpreting or recognising symptoms that fall outside more easily recognised hallmark perimenopausal symptoms. GPs reported challenges in identifying perimenopausal symptoms, particularly when women presented with atypical or multiple symptoms[41,49] complicating the recognition of perimenopause.

> 'And I think the other point is that potentially perimenopausal patients can present with a cluster of symptoms. And as a GP, that can feel a bit overwhelming when they say, well, my mood is low, but I've also got, you know, dryness, I've also got skin issues.' (GP)[41]

While GPs observed an increase in women presenting with perimenopausal symptoms in general practice, it was noted that this rise was not evident among women from ethnic minority groups, which GPs attributed to a potential lack of awareness of perimenopause.[49]

> 'I say "Oh, do you get sweats and things?" and they'll say "Oh yes, I do get them", and I'll say, "Oh, do you think you might be going through the menopause?" But they're like, "Oh, but I'm still having periods". The idea that there might be a perimenopause and actually that this is a transition, I don't think is something that [all] people really particularly [understand].' (GP)[49]

Mixed Signals

This theme describes convergence and divergence in how normalisation was perceived by women and enacted by GPs in consultations. It captures the interpretive tension between reassurance and dismissal. The same message of perimenopause as a normal life stage can be experienced as either validating or invalidating. While many women described perimenopause as a natural life stage[37–39,42,49] a tension emerged between accepting perimenopause as a normal process and the way this normalisation was communicated by GPs during consultations. This tension was reflected in women's varied responses to how GPs framed their symptoms. Women described feeling 'reassured that symptoms were typical of their age and perimenopause' (second-order construct)[42] which gave a sense of satisfaction with the care they received. Normalisation could be comforting when accompanied by validation and support. GPs echoed this perspective, describing how some women found relief in learning that their symptoms were part of a natural transition.

> 'Some of the women that I've spoken to about […] the menopause, I think they found it a real revelation, it's not that there's something wrong with them. That it's a natural part of life and of ageing.' (GP)[49]

However, this framing was not universally experienced positively by women. Some women interpreted the normalisation of perimenopause as dismissive.[40,42,49] For example, women described being told it was normal[38,40,42,49] or 'a phase every woman goes through' *(perimenopausal women)*[40] resulted in feeling invalidated and reluctant to seek further help. This perceived dismissal contributed to feelings of frustration and confusion, especially when consultations lacked clarity[40–42,49] or failed to acknowledge perimenopause altogether.[38,40,42,49]

Taking the Helm: Women's Advocacy, Agency, and Negotiated Power in Perimenopause Care

This theme reflects how women navigate consultations by advocating for themselves, often in response to perceived gaps in GP knowledge or support. It captures the emotional and practical labour involved in preparing for consultations, seeking alternative care, and asserting treatment preferences. It also reflects on the interpersonal dynamics of shared decision-making and the impact of feeling heard and validated within consultations.

Self-Educating and Advocacy as a Response to Perceived Gaps

Some women perceived the interactions they had with GPs as being marked by a lack of clarity and completeness.[38,40,48] There were instances where women expressed confusion regarding the information communicated by GPs, contributing to a sense of uncertainty and dissatisfaction.[40,43,48] Many women expressed feelings of frustration when they did not receive clear communication during consultations.[37,38,40,43,48] Women across the studies consistently expressed a need to educate themselves about perimenopause and to advocate for their own healthcare, often in response to perceived deficiencies in GPs' knowledge or support. Many women perceived GPs as lacking the necessary expertise to effectively guide them through perimenopause.[38,40,41,43,49] Specifically, some women perceived that GPs lacked a general awareness of perimenopause[38,40] and the ability to identify symptoms of perimenopause,[40–42,48,49] as well as knowledge regarding the interconnection between perimenopausal symptoms and other conditions[40,42,49] Some women described independently seeking information,[38,40,43] preparing for appointments, and in some instances, instructing their GP on perceived appropriate prescriptions.[40] In some cases, women recounted bringing resources such as guidelines to their GP appointments to ensure their concerns were addressed:

> 'I have the NICE guidelines to inform GP practice of this perimenopausal gaslighting and mis-prescribing (perimenopausal women).'[40]

In contrast, other women perceived GPs to be a reliable source of information:

> 'I will follow the recommendation and guidelines in Australia, the medical um Western approach. I hope that I can, when the symptoms are more severe I will go to the family doctor and ask her advice on how to improve it.' (perimenopausal woman)[39]

Women reported leaving appointments 'without even a mention of perimenopause' (second-order construct).[40] Few women expressed a desire for GPs to initiate conversations about perimenopause opportunistically[39,41] and inquire about perimenopausal symptoms during consultations for other conditions.[39–41] However, when this did not occur, some women blamed themselves for not asking or seeking information.

> 'The problems are probably that I didn't ask for much information. So I didn't get a lot (perimenopausal woman).'[38]

Seeking Partnership in Perimenopausal Care: Negotiating Treatment Options and Women's Agency in Consultations

While many women described disempowering experiences with GPs, others recounted moments of shared decision-making, even if not explicitly labelled as such. Women valued being involved in decisions about their treatment and appreciated when GPs engaged in open discussion of options. For example, one woman described how:

> 'My Primary Care Provider recommended anti-depressants. I recommended St. John's Wort. She agreed with the St. John's Wort, but said if that did not work, we should revisit the antidepressants.' (perimenopausal woman)[42]

This was interpreted as evidence of shared treatment planning and negotiation (second-order construct). Similarly, women described actively seeking advice and discussing options with their GPs:

> 'I guess you can look at going the homeopathic way with herbal medicine and things like that or going to your doctor and saying 'What are my options? Is there pills?' and then maybe looking to hormone replacement therapy and things.' (perimenopausal woman)[37]

GPs themselves referred to the value of women advocating for themselves during consultations, noting 'if the woman is unable to advocate for herself' (second-order construct), it potentially impacts the outcomes of what is achievable during the consultation. This, in turn, may influence how women perceive the quality of the care they receive.[49]

Across multiple studies, women expressed frustration when consultations did not align with their expectations for perimenopausal care. Many women perceived a distinction between right and wrong approaches, with MHT often the preferred option and antidepressants viewed as less favourable.[40–43]

> 'Not great. I saw three different GP [and] was prescribed antidepressants even though I said I thought it might be perimenopause.' (perimenopausal woman)[43]

While others expressed that

> 'better [GP] baseline knowledge could improve opportunistic questioning, reduce inappropriate prescribing of antidepressants.' (second-order construct)[41]

Women showed a clear preference for MHT and often interpreted the offer of other pharmacological treatments as dismissive or as reflecting a lack of recognition of their perimenopausal symptoms. This perceived mismatch led women in some studies to seek private healthcare, believing it offered a more knowledgeable and empathetic response to their needs:

> 'I have had to pay for help, which concerns me because I have asked my own GP several times.' (perimenopausal woman)[40]

Others noted that women

> 'should not have to seek private consultations to manage the perimenopause (second-order construct).'[41]

Gendered Dynamics: Women's Experiences and GP Perspectives

This theme explores how the gender of a GP shapes women's experiences and perceptions of perimenopause care and highlightings how assumptions around expertise, trust, and empathy are influenced by gender. It also reflects how GPs perceive gender differences in confidence and competence in delivering perimenopause care.

Women's perceptions of perimenopause consultations were often influenced by the gender of their GP, though perceptions varied depending on the context. In several studies, women expressed feeling more at ease discussing perimenopause with female GPs, attributing this comfort to empathy and shared experiences.[37,39] Some women from ethnic minority groups described a sense of mistrust in male GPs[37,39] and that they were not listened to by male GPs.[43,49] Women from ethnic minority groups also reported challenges accessing female GPs, particularly in rural areas, which led to delays in seeking care.[49]

In both GP studies, GPs acknowledged gender differences in confidence and competence. Male GPs were often perceived by themselves[41] and others[49] as less confident and more likely to refer patients to female colleagues, seen as more skilled in perimenopause care.[41,49]

> 'My male colleagues say, We don't feel we have the vocabulary or confidence to ask some of the questions when thinking about menopause whereas female doctors naturally do.' (GP)[49]

Similarly, female GPs described being seen as the default providers of women's healthcare within their practices, as patients 'perceive them to offer a more holistic approach'(second-order construct).[49] In contrast, other GPs expressed the belief that female GPs might sometimes be less sympathetic, expecting women to 'power through'.[41]

Navigating Structural Obstacles and Fragmented Care

Structural barriers and fragmented care shaped the experiences of both women and GPs during perimenopause consultations. These systemic constraints contributed to women's dissatisfaction with care, which in some cases led them to seek private healthcare. For GPs, short appointment times were identified as a barrier to meaningful engagement.[41,49] GPs described the challenge of addressing complex symptom presentations and exploring treatment options within the constraints of standard consultation lengths.

> 'A good menopause consult cannot be done in 10 minutes. I mean you struggle to do it properly in 20 minutes, but you're lucky if you get 20 minutes.' (GP)[49]

Furthermore, GPs expressed that holistic assessment often requires multiple appointments and a nuanced understanding of symptoms, especially 'in light of her symptoms and age profile'(second-order construct).[49] GPs acknowledged a knowledge and confidence gap in perimenopause care despite rising demand.[41,49] Limited GP training and lack of exposure to perimenopause-related consultations were highlighted as barriers for GPs delivering care to women.

> 'Despite a rise in perimenopause and/or menopause consultations among primary care clinicians, there is still a knowledge and confidence gap in practice.' (second-order construct)[49]

Some women's experiences were further shaped by fragmented care pathways and limited continuity. Some described frustration at having to consult multiple GPs or other healthcare professionals outside of general practice[38,42], which they felt delayed recognition of perimenopause and subsequent treatment, and eroded trust in the healthcare system. This was particularly challenging for women from ethnic minority backgrounds[39,49] and those in rural areas[37] who faced additional barriers in accessing female GPs. While some women appreciated care involving multiple providers or care with a GP as part of a multidisciplinary team, it was more often viewed negatively. Repeated consultations and having to restate concerns[38,42] were described as burdensome. For some, these experiences led to seeking private healthcare,[40–42] driven by the perception that their GP could not provide adequate support.

> 'Not all GPs are equipped to give support, information and appropriate medication. Few of us can afford private obgyn.' (perimenopausal woman)[40]

Line of Argument: Navigating Uncharted Waters

Women's experiences of perimenopause consultations were shaped not only by clinical outcomes or GP characteristics but by how the consultation process aligned with their expectations for recognition, clarity, and partnership. Across the synthesis, women evaluated care based on the quality of their interactions with their GP, distinguishing between consultations that felt validating and collaborative, and those that felt dismissive, unclear, or unsupported. Rather than seeking symptom relief alone, they sought care that affirmed their experiences and recognised them as credible agents in their own health. Consultations were perceived positively when GPs listened, acknowledged symptoms, and engaged in shared decision-making. In contrast, negative experiences were marked by vague communication, perceived misinformation, and a lack of engagement. While such evaluative framings are not unique to perimenopause, in this context they reflected a deeper emotional need for legitimacy and partnership. A continuum of authority emerged within consultations. At one end, women described feeling dismissed and compelled to take control, educating themselves, preparing for appointments, and attempting to direct treatment decisions. At the other end, some experienced moments of joint ownership, where treatment options were discussed and negotiated collaboratively. This dynamic underscored how authority was not fixed but actively negotiated. GPs navigated a complex clinical terrain shaped by systemic constraints, diagnostic ambiguity, and evolving societal narratives around peimenopause. Time pressures, limited training, and fragmented care structures influenced their ability to engage meaningfully with women's concerns. As a result, consultations were often characterised by shared uncertainty and negotiated authority.

GRADE CERQual

Confidence in the findings of this qualitative evidence synthesis was assessed using the GRADE-CERQual approach via Interactive Summary of Qualitative Findings (iSoQ). The GRADE-CERQual approach allows evaluation of each review finding across four domains: methodological limitations, relevance, coherence, and adequacy of data. We assessed our confidence in review findings as moderate (3 findings) to high (1 finding) and are presented in Table 5.

Table 5 GRADE-CERQual Summary of Findings

	Review Findings	Studies Supporting	Overall Confidence
1	Adrift in the sea of perimenopause uncertainty	[37,38,40,41,43,44,48,49]	High confidence
2	Taking the helm: women's advocacy, agency, and negotiated power in perimenopause care	[36,39–43,49]	Moderate confidence
3	Gendered dynamics: women's experiences and GP perspectives	[37,39–41,49]	Moderate confidence
4	Navigating structural obstacles and fragmented care	[37–42,44,49]	Moderate confidence

Discussion

This qualitative evidence synthesis explored the experiences and perceptions of women and GPs during perimenopause consultations in general practice. Four themes were developed: (1) Adrift in the sea of perimenopause uncertainty (2) Taking the helm: women's advocacy, agency, and negotiated power in perimenopause care (3) Gendered dynamics: women's experiences and GP perspectives (4) Navigating structural obstacles and fragmented care.

Our findings demonstrate that both women and GPs experience challenges in recognising perimenopausal symptoms. Women often entered consultations expecting diagnostic clarity, reassurance, and support. However, when symptoms were atypical or presented in clusters, these expectations were frequently unmet, leading to confusion, frustration, and a sense of being dismissed. Conversely, GPs described difficulty in attributing diverse and sometimes ambiguous symptom profiles to perimenopause, particularly when symptoms overlapped with other conditions. GPs expressed uncertainty in recognising perimenopausal presentations, especially in younger women or those from ethnic minority backgrounds.

A recent qualitative study[50] explored how women and GPs experience mental health consultations within the perimenopause age range and found they shared this uncertainty. Women in this study expressed confusion about whether their symptoms were due to perimenopause or mental health issues. Similarly, GPs found it challenging to determine whether symptoms could be attributable to perimenopause in this group of women, with uncertainty complicating the effort to achieve a balance for themselves and the women. Furthermore, the uncertainty experienced by women and GPs in ascertaining if symptoms were secondary to mental health or perimenopause complicated shared decision-making processes.

NICE guidelines for managing perimenopause[13] emphasise the importance of shared decision-making in menopause care, recommending that care should be guided by shared decision-making, involving collaborative discussion to reach a joint decision about care, by providing clear, evidence-based information and taking into account women's individual symptoms, preferences, and circumstances. 'Decision-making around menopause care is a complex, iterative process'[51] and communicating this complexity to women may help manage expectations and foster more realistic, collaborative care plans. This also extends to the nature of and communication of uncertainty within consultations in general practice.[52]

Hickey et al[53] advocate for normalising menopause and providing realistic, balanced information about the likely nature, severity, and duration of symptoms, suggesting this can empower women and support informed decision-making. While this aligns with our findings that women value clarity and recognition, our synthesis highlights a delicate tension: when normalisation is communicated without sufficient empathy or validation, it can be experienced as dismissive. Women described being told their symptoms were 'normal' or 'a phase every woman goes through', which sometimes led to frustration, confusion, and reluctance to seek further help. This suggests that normalisation must be relationally sensitive, meaning it should be delivered in a way that acknowledges the emotional and social context of the woman's experience, validates her concerns, and offers meaningful support. In this way, our findings extend Hickey et al's recommendations[53] by emphasising that how perimenopause is normalised matters as much as the message itself.

Gendered dynamics influenced how women interpreted their interactions with GPs. Many expressed a preference for female GPs, citing empathy and perceived understanding. This preference is not unique to perimenopause care. Women often prefer female GPs for a range of health concerns, particularly those related to reproductive and intimate health.[54,55] However, seeing a female GP alone did not guarantee a positive experience; some women felt unsupported regardless of

their GP's gender. This suggests that while gendered perceptions shape trust and expectations, the quality of communication and clinical engagement ultimately determines how care is experienced. Gender dynamics influence not only women's comfort with disclosure in perimenopause consultations but also GP confidence. Similar to our findings, a qualitative study[6] found that GPs, particularly male GPs, often lacked confidence in recognising perimenopausal symptoms, especially when they presented as mental health concerns. This lack of confidence led some male GPs to refer women to female colleagues, a pattern also noted by female GPs in the study.

Women frequently described their interactions with GPs as emotionally charged and complex, frequently feeling the need to strongly advocate for MHT. Many reported being 'denied' MHT or being offered antidepressants instead, an approach which they perceived as suboptimal. A study conducted in 2023 reinforces this perception, noting that being offered an antidepressant is commonly viewed negatively by women, despite being a valid treatment option for certain symptoms.[56] The authors suggest that women's preference for MHT may partly reflect limited awareness of treatment options beyond MHT, such as antidepressants and highlight the importance of GPs explaining to women the rationale behind suggesting antidepressants for some perimenopause-related symptoms. These frustrations, compounded by structural barriers such as short appointment times and fragmented care, contribute to a shift toward private providers.

An observational study conducted by McCartney and colleagues [57] found that over two-thirds of online content from the most popular platforms about MHT was inconsistent with NICE guidelines. The authors further noted that much of this content appears to be commercially driven, often linked to private clinics, and rarely transparent about conflicts of interest. Misinformation may distort public understanding of perimenopause care and contribute to the conflation of private care or specialist menopause care with superior care. A retrospective audit[58] of GP referrals to a specialist menopause clinic within the NHS revealed that some referrals were initiated at the patient's request rather than due to GP concerns. This may indicate that patients perceived a lack of confidence in GPs' ability to effectively address their symptoms. While consulting multiple physicians may sometimes be appropriate, involving more than one physician can lead to fragmented care if accurate and complete information about the patient and their treatment plan is not shared among all involved.[59]

While our findings identified challenges faced by GPs in recognising and discussing perimenopause, particularly with women from ethnic minority backgrounds and highlighted the role of patient advocacy, Eccles et al[60] argue that the absence of advocacy or initiation of conversation by women should not be interpreted as a lack of interest or agency. Rather, they argue that GPs should take a proactive role in initiating discussions about menopause, ensuring that both hormonal and non-hormonal treatment options are presented. This approach may help reduce disparities and improve the quality of menopause care across diverse populations.

Collectively, these findings underscore the importance sensitive and culturally competent approach to perimenopause care, one that effectively communicates the uncertainties inherent in perimenopause consultations.

Strengths and Limitations

A key strength of this qualitative evidence synthesis is its specific focus on perimenopause, an area that remains underexplored compared to menopause in the literature. Furthermore, the findings extend beyond those of the individual studies by generating new interpretive insights through the translation of concepts across accounts, thereby offering an added layer of conceptual understanding rather than a purely descriptive aggregation of accounts.

The interdisciplinary nature of the research team, expertise in general practice, public health, and qualitative methods enhanced the interpretive process. This diversity in expertise enabled critical reflection, challenged assumptions, and enriched the development of third-order constructs through collaboration throughout all stages. This synthesis followed Noblit and Hare's meta-ethnography[24] informed by worked examples,[25–29] a registered protocol[32] and is reported according to eMERGE guidelines[31], ensuring methodological rigour. Only two studies[44,49] included GP perspectives, which restricts the depth and balance of insight into consultations. We also acknowledge that our review only included the perspective and experiences of women and not gender diverse experiences of perimenopause. Our review did not encompass a search of the grey literature; however, given the comprehensiveness of our electronic database search, we believed that including grey literature would not yield any further insights. Evidence synthesised in this review is

predominantly drawn from studies conducted in high-income countries particularly the United Kingdom, therefore findings may not reflect experiences in lower middle-income settings.

Implications for Future Research

We endeavoured to include both women's and GP perspectives to provide insights into the dynamics of perimenopausal consultations, but only two of the included studies represented the views of GPs. Future research should prioritise qualitative studies that capture the GP voice. One of our original aims was to explore how decisions are made during perimenopause consultations; however, we found that many of the included studies did not discuss these aspects in significant detail, thus highlighting a gap in the current evidence base. Future studies should focus on the process of shared decision-making during perimenopause consultations, including how options are presented, how risks are communicated, and how women's preferences are incorporated. Findings can be used to inform future educational interventions and communication guidelines to support the management of perimenopause in general practice.

Conclusion

This qualitative evidence synthesis provides a new insight into how perimenopause consultations are perceived and experienced by women and GPs in general practice, thereby addressing a critical gap in the literature. This study highlights the multifaceted challenges faced by both women and GPs during perimenopause consultations in general practice. Our findings underscore the importance of sensitive communication, where normalisation is delivered with empathy and uncertainty is acknowledged and communicated transparently. Women's self-advocacy emerged as a response to perceived gaps in care, but this should not be a prerequisite for receiving appropriate support. GPs, meanwhile, navigate diagnostic ambiguity, time constraints, and evolving societal expectations. These new conceptual and interpretative findings point to opportunities to strengthen GP training and guide the development of communication guidelines that promote more coherent and effective consultations, while also offering valuable insights for policymakers aiming to enhance women's health services and improve the responsiveness of care pathways.

Disclosure

The authors report no conflicts of interest in this work.

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