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Family Medicine Physicians’ Advice about Use of Nonconventional Modalities for Menopausal Symptom Management

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ABSTRACT

Aims: This study explores the beliefs and practices of family medicine physicians regarding the use of nonconventional modalities for menopausal symptom management.

Methods: Anonymous self-administered questionnaires were distributed to faculty and residents from eight participating family medicine residency programs around Florida, with an overall response rate of 66% (212 respondents). The survey explored what physicians report about patterns of patient inquiries and their responses to patients’ inquiries about nonconventional modalities for specific menopausal symptoms and what physicians’ report on their advice to patients about using specific herbs and supplements for menopausal symptom relief.

Results: Behavioral approaches were encouraged more than herbal therapies, acupuncture, and body therapies for the treatment of most of the menopausal symptoms. However, the most frequent response category was No advice. Resident physicians were significantly more likely than faculty to encourage acupuncture. Faculty physicians were more likely than residents to recommend particular herbal remedies. The majority of the respondents believed there was not sufficient evidence for recommending any of the herbs and supplements listed.

Conclusions: These data reveal some important trends about how family medicine physicians respond to nontraditional approaches for menopausal symptom management. Because family medicine physicians typically receive some training in behavioral and psychotherapeutic approaches and there is some evidence for the effectiveness of behavioral strategies in menopausal symptom management, it is not surprising that they are more likely to endorse these approaches. Most family medicine physicians, however, have little or no training in the other nonconventional modalities, and our data show that these modalities received lower levels of endorsement, suggesting that physicians are not clear on their advantages or disadvantages.
INTRODUCTION

The popularity of complementary and alternative medicine (CAM) has been steadily increasing in many Western countries over the past decade and a half.1–4 Surveys conducted in the 1990s indicated that >40% of the adults in the United States were using at least one CAM modality or product and that a higher percentage of women than men used CAM,5,6 with one study indicating as many as 80% of women aged 45–60 reporting CAM use for menopausal symptom relief.7 There is abundant evidence that midlife women are using CAM either alone or in combination with hormone therapy for treatment of menopausal symptoms.2,3,8–16

Symptoms related to menopause are found worldwide,17 and although some women experience very few, if any, emotional or physical complaints, others become debilitated by menopausal symptoms.18 Reports suggest that up to 80% of women will experience some degree of physical or emotional symptoms during perimenopause and menopause, including vasomotor symptoms, vaginal dryness, sleep disturbances, changes in libido, mood changes, and fatigue.19,20 Some women seek treatment from their healthcare providers for these complaints, whereas others never seek any treatment or seek alternatives to conventional therapies.10,11,21

The early termination in 2002 of the main arm of the Women's Health Initiative (WHI) trial, an observational trial designed to assess the major health benefits of the commonly used combined hormone preparation, estrogen and progestin, sparked heightened interest in CAM approaches to menopausal symptom management.22 The WHI data revealed an increased risk of breast cancer, heart attacks, strokes, and blood clots in women taking estrogen and progestin, and study investigators concluded that the risks of the hormone combination outweighed the benefits (fewer hip fractures and colon cancer) for prevention of disease.23 Primary care physicians faced increasing demands to respond to inquiries about use of CAM therapies in treating menopausal symptoms.23 There is little evidence of how physicians address these inquiries, but there is evidence that patients believe they are not receiving adequate advice from their providers regarding CAM therapies.24 Several studies suggest that patients frequently do not inform their providers about their use of CAM1,10,13 and that physicians generally underestimatate patients’ use of CAM.25 There is disagreement across physician-based and patient-based studies about the percentage of physicians who inquire about their patients’ CAM use, with some studies reporting over three quarters of physicians surveyed routinely asked their patients about CAM use26,27 and others noting that few physicians routinely or consistently ask patients about CAM use.11,24,25,28

This study explores beliefs and practices of family medicine physicians in regard to CAM modalities for menopausal symptom management. The purpose of this study is to contribute to existing literature in several ways. First, we examine what advice physicians give their patients on use of nonconventional modalities for menopausal symptoms. Second we examine physicians’ self-reports of their advice to patients about using specific herbs and supplements for menopausal symptom relief. We also examine how physician advice on nonconventional therapies differs by physician gender, resident status, and volume of women patients aged 45–65.

MATERIALS AND METHODS

Study design and population

The University of Florida Institutional Review Board approved this study protocol in 2004. The data presented are from a cross-sectional survey of interns, residents, and faculty of the eight participating family medicine residency programs in Florida. The behavioral medicine/science faculty or staff from these eight programs formed a research consortium that enables the collection of data at all eight sites. All the participating programs have family medicine centers where faculty and residents see patients in a community-based outpatient setting.

Family medicine residency program faculty and residents were surveyed at their program sites between the months of June 2004 and August 2004. Several methods were used for survey distribution, including handing surveys out at residency program meetings, putting them in resident and faculty mailboxes, and giving them directly to eligible respondents. A full description of the sample and study protocol is published elsewhere.29

The survey instrument was a two-page, self-administered questionnaire that took approxi-
mately 5 minutes to complete. The survey elicited demographic information, including gender, specialty, and year residency training was/would be completed. In order to evaluate the volume of menopausal patients practice respondents had, we also asked respondents to estimate the approximate number of women patients aged 45–65 they saw in their practice in an average week.

Eligible respondents were all family medicine interns, residents, and faculty in eight programs. We excluded surveys completed by nonphysician clinicians (e.g., physician assistants and nurse practitioners) and physicians who were in specialties other than family medicine because they were such a small proportion of the total sample \(n = 5\) and \(n = 8\), respectively). Overall, there were 229 eligible residents and 90 eligible program faculty in family medicine.

For this study, we analyzed responses to two sets of survey items. First, we asked respondents to indicate their practices regarding encouraging or discouraging the use of four nonconventional modalities for treatment of menopausal symptoms. Three of these nonconventional modalities included in the survey were CAM modalities, specifically herbal medication, acupuncture, and body therapies (e.g., massage). We also asked physicians about their practices regarding encouraging or discouraging behavioral therapies for menopausal symptoms. The current definition of CAM from the National Institutes of Health (NIH) National Center for Complementary and Alternative Medicine (NCCAM) is “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” (nccam.nih.gov). Behavioral therapies debatably fall into the CAM category of mind-body interventions, or “a variety of techniques designed to enhance the mind’s capacity to affect bodily function and symptoms.” According to NCCAM, some techniques that were considered CAM in the past have become mainstream (e.g., patient support groups and cognitive-behavioral therapy) (ncam.nih.gov). Other mind-body techniques are still considered CAM, including meditation, prayer, mental healing, and therapies that use creative outlets, such as art, music, or dance. Nonetheless, we included behavioral therapies in this study along with the three CAM modalities because they are a nonconventional approach to menopausal symptom management.

Respondents were asked if they encouraged use of any of the four nonconventional modalities for any of nine common menopausal symptoms (vaginal dryness, vasomotor symptoms, sleep disturbance, decreased libido, emotional lability, anxiety, depression, irregular menses, and fatigue). Response categories were Strongly discourage use, Discourage use, No advice either way, Encourage use, and Strongly encourage use.

Next, we asked respondents to focus specifically on herbs and supplements. They were asked if their patients had ever asked about phytoestrogens or any of eight specific herbs (phytoestrogens, black cohosh, St. John’s wort, red clover, evening primrose oil, dong quai, ginseng, wild yam, valerian root). (Phytoestrogens comprise a class of herbs; black cohosh, red clover, and dong quai all contain or are thought to contain some phytoestrogen component.) They were also asked if their patients had ever asked about any of four specific vitamins or supplements (B vitamins, vitamin D, vitamin E, and calcium supplements) for treatment of menopausal symptoms. They were then asked if they had recommended the specific herb or supplement to their patients (Yes or No) and if they believed there was sufficient evidence for recommending the specific herb or supplement (Yes, No, or Unsure). The basis for the inclusion of these nine specific herb and supplement products was that there was some evidence in the literature for their use with menopausal symptoms.

Analysis

We recoded the year residency was or would be completed by creating a new variable indicating whether the respondent was a resident or a faculty member at the time of the survey (i.e., those who completed residency in 2003 or earlier were coded as faculty; those who were completing residency in 2004 or later were coded residents). Responses to the item that asked respondents to estimate the approximate number of women patients aged 45–65 they saw in their practice in an average week were recoded into a dichotomous variable (i.e., 1–10, 11 or more) for the bivariate comparisons in the analysis. Likert scale responses to the item asking respondents about their practices regarding advising CAM therapies for the nine listed menopausal symptoms were recoded into a new variable where Strongly encourage use and Encourage use were combined, and Strongly discourage use and Discourage use were combined and compared with
No advice. Descriptive statistics were used to examine the distribution of responses to all the survey items. Chi-square significance tests were used to examine bivariate associations in the data. 

Tests for differences in means were used to compare residents and faculty on average number of women patients aged 45–65 seen per week.

RESULTS

Respondent characteristics

Of the 319 eligible respondents, 212 returned completed surveys, for an overall response rate of 66%. Almost one quarter of the survey respondents were family medicine residency program faculty, and the rest were family medicine program residents (Table 1). Specific response rates for faculty and residents were 69% (62 of 90) and 65% (148 of 229), respectively. Residency/faculty status was unknown for 2 of the respondents. The mean number of women patients aged 45–65 seen by all respondents in an average week in the total sample was 14.9 (SD 13.6). Residents reported a mean of 13.7 (SD 11.2) women patients aged 45–65 per week, and faculty reported a mean of 16.8 (SD 14.7) each week. The difference between the mean numbers of women seen by residents vs. faculty respondents was not significant (t 1.538, p = 0.128).

Advice to women on nonconventional modalities for menopausal symptoms

Respondents were asked to indicate if they encouraged, discouraged, or offered no advice regarding the use of four general modalities (herbal therapies, acupuncture, body therapies, and behavioral therapies) for treatment of nine menopausal symptoms. Responses are presented in Table 2. A higher percentage of respondents encouraged behavioral approaches than herbal therapies, acupuncture, or body therapies for treatment of most of the menopausal symptoms. The majority of the physicians encouraged behavioral approaches for depression (88%), anxiety (88%), emotional lability (86%), decreased libido (76%), sleep disturbances (76%), and fatigue (71%). Over half of the respondents encouraged use of herbal therapies for vasomotor symptoms (58%); fewer than half encouraged herbs for vaginal dryness (37%), irregular menses (21%), sleep disturbance (46%), emotional lability (41%), and fatigue (36%). The majority of respondents encouraged body therapies for sleep disturbances (53%), fatigue (55%), anxiety (51%), and emotional lability (50%). The most frequent response category in regard to advising use of any of the four therapies for vaginal dryness and irregular menses was No advice. Acupuncture was the therapeutic modality that was least frequently encouraged for treatment of any of the listed menopausal symptoms.

Bivariate comparisons showed that resident physicians were more likely than faculty to encourage acupuncture for decreased libido ($\chi^2 = 8.282, p = 0.016$), emotional lability ($\chi^2 = 7.682, p = 0.021$), anxiety ($\chi^2 = 10.614, p = 0.005$) depression ($\chi^2 = 9.341, p = 0.009$), and fatigue ($\chi^2 = 11.640, p = 0.003$), and body therapies for vasomotor symptoms ($\chi^2 = 5.987, p = 0.05$), depression ($\chi^2 = 10.101, p = 0.006$), and fatigue ($\chi^2 = 5.996, p = 0.05$). There were no significant associations between physician gender and encouragement of any of the modalities.

Recommendations for use of herbs and supplements

Physicians were asked about patient inquiries and their advice to patients about specific herbs or supplements to treat menopausal symptoms (Table 3). The top five products physicians said they recommended were calcium supplements,

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**Table 1. Characteristics of Physician Respondents to Survey**

<table>
<thead>
<tr>
<th></th>
<th>n = 212</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>122</td>
<td>57.5</td>
</tr>
<tr>
<td>Male</td>
<td>90</td>
<td>42.5</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residents</td>
<td>148</td>
<td>69.8</td>
</tr>
<tr>
<td>Female</td>
<td>80</td>
<td>(54.1)</td>
</tr>
<tr>
<td>Male</td>
<td>68</td>
<td>(45.9)</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>(0)</td>
</tr>
<tr>
<td>Faculty</td>
<td>62</td>
<td>29.2</td>
</tr>
<tr>
<td>Female</td>
<td>35</td>
<td>(56.5)</td>
</tr>
<tr>
<td>Male</td>
<td>21</td>
<td>(33.9)</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td>(9.6)</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>Average number of women patients aged 45–65 seen each week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–10</td>
<td>108</td>
<td>50.9</td>
</tr>
<tr>
<td>11 or more</td>
<td>93</td>
<td>43.9</td>
</tr>
<tr>
<td>Missing</td>
<td>11</td>
<td>5.2</td>
</tr>
</tbody>
</table>
black cohosh, B vitamins, phytoestrogens, and vitamin D. The top five products their patients asked about were black cohosh, calcium supplements, phytoestrogens, St. Johns wort, and vitamin E.

The percentage of physicians saying they recommended these herbal products to patients were closely paralleled by the percentage who said they believed there was sufficient evidence for recommending these products. However, across the board, levels of belief in evidence for the effectiveness of these products in the treatment of menopausal symptoms were not as high as recommendation frequency. Almost half of the respondents believed there was sufficient evidence for recommending calcium supplements and black cohosh, and 33% thought there was sufficient evidence for recommending phytoestrogens.

Faculty physicians were more likely than residents to recommend phytoestrogens \( (p < 0.001) \), St. Johns wort \( (p < 0.001) \), evening primrose \( (p < 0.05) \), ginseng \( (p < 0.05) \), and wild yam \( (p < 0.05) \) (Table 4). There were no statistical differences between male and female physicians in their likelihood of recommending any of the herbs and supplements. Physicians who had a higher volume of female patients (>11 per week) were significantly more likely to recommend black cohosh \( (p < 0.001) \), B vitamins \( (p < 0.05) \), and phytoestrogens \( (p < 0.05) \).
DISCUSSION

Until very recently, the conventional treatment for common menopausal symptoms was hormone replacement therapy (HRT) because of its efficacy in treating the most prevalent symptoms plus the belief that it was a useful approach for preventing coronary heart disease (CHD).\textsuperscript{31,32} Even before the release of the WHI results in 2002 and 2004, many women discontinued HRT use early in their treatment because of fear of increased cancer risk, vaginal bleeding, and other health concerns or the inconvenience of taking a daily pill.\textsuperscript{10,33,34} Consequently, interest in non-conventional modalities for treatment of menopausal symptoms continues to increase among

### Table 3. Physicians Who Say They Have Recommended Specific Supplements and Herbs, Whose Patients Have Inquired About Specific Herbs and Supplements, and Who Believe There Is Sufficient Evidence for Recommending Products to Patients (n = 212)

<table>
<thead>
<tr>
<th>Supplement/herb</th>
<th>% Who have recommended products to patients</th>
<th>% Whose patients have asked about products</th>
<th>% Who believe there is sufficient evidence for recommending products to patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supplements</strong></td>
<td><strong>Calcium</strong></td>
<td>56</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td><strong>B vitamins</strong></td>
<td>44</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td><strong>Vitamin D</strong></td>
<td>39</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td><strong>Vitamin E</strong></td>
<td>31</td>
<td>42</td>
</tr>
<tr>
<td><strong>Herbs</strong></td>
<td><strong>Black cohosh</strong></td>
<td>51</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td><strong>Phytoestrogens</strong></td>
<td>42</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td><strong>Evening primrose oil</strong></td>
<td>23</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td><strong>St. John’s wort</strong></td>
<td>23</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td><strong>Ginseng</strong></td>
<td>13</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td><strong>Valerian root</strong></td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td><strong>Wild yam</strong></td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td><strong>Red clover</strong></td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td><strong>Dong quai</strong></td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

### Table 4. Physicians Who Say They Have Recommended Specific Herbs and Supplements, by Training Status, Gender, and Average Number of Women Patients per Month (n = 212)

<table>
<thead>
<tr>
<th>Respondent status</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supplements</strong></td>
<td><strong>Calcium</strong></td>
<td>67</td>
<td>52</td>
<td>53</td>
<td>58</td>
<td>51</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td><strong>B vitamins</strong></td>
<td>55</td>
<td>39</td>
<td>49</td>
<td>40</td>
<td>34</td>
<td>52*</td>
</tr>
<tr>
<td></td>
<td><strong>Vitamin D</strong></td>
<td>31</td>
<td>39</td>
<td>34</td>
<td>39</td>
<td>35</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td><strong>Vitamin E</strong></td>
<td>31</td>
<td>30</td>
<td>31</td>
<td>29</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td><strong>Herbs</strong></td>
<td><strong>Black cohosh</strong></td>
<td>56</td>
<td>51</td>
<td>54</td>
<td>50</td>
<td>40</td>
<td>63**</td>
</tr>
<tr>
<td></td>
<td><strong>Phytoestrogens</strong></td>
<td>58</td>
<td>35**</td>
<td>43</td>
<td>40</td>
<td>31</td>
<td>53*</td>
</tr>
<tr>
<td></td>
<td><strong>Evening primrose oil</strong></td>
<td>33</td>
<td>18*</td>
<td>22</td>
<td>23</td>
<td>16</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td><strong>St. John’s wort</strong></td>
<td>40</td>
<td>16**</td>
<td>17</td>
<td>28</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td><strong>Ginseng</strong></td>
<td>21</td>
<td>9*</td>
<td>12</td>
<td>15</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td><strong>Valerian root</strong></td>
<td>15</td>
<td>9</td>
<td>11</td>
<td>11</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td><strong>Wild yam</strong></td>
<td>19</td>
<td>4*</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td><strong>Red clover</strong></td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td><strong>Dong quai</strong></td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>3</td>
</tr>
</tbody>
</table>

*\(p < 0.05\); **\(p < 0.001\).
Physicians and other healthcare providers have also expressed interest in these modalities and in learning more about the scientific evidence of their efficacy and safety.24,26,27 Our data increase our understanding of how family medicine physicians respond to nontraditional approaches to menopausal symptom management in primary care settings and raise some interesting questions about why they respond in certain ways. Family medicine physicians are more likely to endorse behavioral medicine approaches than herbal or body therapies or acupuncture for treating menopausal symptoms. Family medicine physicians are typically trained to some degree in behavioral and psychotherapeutic approaches, and there is limited evidence for the effectiveness of behavioral strategies in menopausal symptom management. For example, relaxation training has been shown to cause a reduction in hot flashes and a general improvement in quality of life.35–37 Exercise, relaxation, and meditation have been recommended not only to lower the frequency of hot flashes but also to improve cardiovascular health, bone health, and general well-being.38,39 There is also evidence for the effectiveness of psychotropics: specifically selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs), in treating vasomotor symptoms.38,40,41

On the other hand, most family medicine physicians have little or no training in the other nonconventional modalities included in this study.42 and our data show that these nonconventional modalities received lower levels of endorsement for use in treating menopausal symptoms. The high percentage of physicians responding, No advice either way, in reference to use of these therapies for menopausal symptoms suggests that they are not clear on the advantages or disadvantages of these approaches; this is supported by previous studies.24,26,27

There may be significant cohort differences in physicians’ beliefs about nonconventional therapeutics as potentially benign, active, or interactive with other therapeutics. Previous studies have found that physicians who had been in practice longer were more opposed to CAM therapies than those who had been practice for fewer years.27,42 We found some differences between faculty and resident physicians in endorsement of herbals and supplements and acupuncture. For almost every herb and supplement, proportionately more faculty than residents reported recommending their use in treating menopausal symptoms. Residents were less likely than faculty physicians to believe there was sufficient evidence for endorsing herbals and supplements. Furthermore, although acupuncture was one of the least endorsed nonconventional therapies in this physician sample, residents were more likely to endorse its use than faculty. Given that acupuncture is a relatively benign modality and there is some evidence of its effectiveness in relieving hot flashes, sleep disturbance, and mood changes in menopause,43,44 it is unclear why faculty physicians in particular are not recommending its use in treatment of menopausal symptoms. Within the category of herbals and supplements, there was a strong trend of endorsement of black cohosh and phytoestrogens for vasomotor symptoms. Black cohosh, which has significant documentation of its efficacy in treating hot flashes for ≤6 months, was the herbal remedy patients were most likely to ask about, and it received the highest level of physician endorsement among the herbs included in this study.8,18,45 Both black cohosh and phytoestrogens have received considerable attention as to their efficacy and safety in recent years, and several organizations have recommended their use, with a few cautions. For example, the American College of Obstetricians and Gynecologists (ACOG), based on reviews of clinical trial results, advises the use of soy and isoflavones for short-term treatment (≤2 years) of vasomotor symptoms but cautions that they may interact with estrogen and may be of potential harm for women with estrogen-dependent cancers.46 They also note that these products may be helpful in improving lipoprotein profiles and may protect against osteoporosis. ACOG advises that use of black cohosh for short-term (≤6 months) treatment of vasomotor symptoms may be helpful and that St. Johns wort may be helpful for short term (≤2 years) treatment of mild to moderate depression. The North American Menopause Society (NAMS) also recommends the use of dietary isoflavones and vitamin E along with lifestyle changes, such as regular exercise, paced respiration, and using relaxation techniques to improve symptoms.47 NAMS also encourages adequate calcium and vitamin D intake for prevention of osteoporosis in all postmenopausal women, through the use of dietary supplements if their diet does not provide enough of these nu-
trients. The American Association of Clinical Endocrinologists (AACE) suggests physicians evaluate their patients’ risk of osteoporosis and encourage sufficient calcium and vitamin D intake as well as exercise to maintain muscle tone and help reduce the risk of falling.

It is important to note some of the limitations of our study. First, the data are based on self-reports of physician behavior and not actual behavioral data; thus, the results must be interpreted with caution. Second, as some of our analysis was based on questions referring to general classes of therapeutic modalities, for example, behavioral therapies and body therapies, it is important for future studies to gather more specific information on how family medicine physicians define these classes of therapies and what types of modalities within these classes they endorse or believe there is evidence for endorsement in treatment of menopausal symptoms.

The research into nonconventional modalities for menopausal symptom management has been advancing since the release of the WHI findings. Although we are waiting for clearer evidence for the use of nonconventional therapeutics, it is important to conduct more research aimed at further explicating the decision-making processes of physicians in response to these nonconventional modalities. The ways physicians respond to patients’ complaints of menopausal symptoms present a useful context for exploring physician decision making in general. Further research can be conducted to elucidate specific processes physicians engage in when endorsing various types of behavioral therapies for menopausal symptom management.

REFERENCES


