

Building capacity for menopause care: a national needs assessment of menopause education in US family medicine residency programs

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Abstract

Objectives: Family physicians care for women across the life-span, yet little is known about the menopause education they receive during training. We conducted a national survey of US family medicine program directors to characterize the current state of menopause education, including curriculum structure, didactic content, clinical training, and program directors' perspectives on improvement and standardization.

Methods: A cross-sectional survey on menopause education was embedded within the Council of Academic Family Medicine Educational Research Alliance (CERA) omnibus survey, which is administered biannually to family medicine residency program directors and collects standardized program demographic data.

Results: Of 313 family medicine program directors who responded to the omnibus survey (44.7% response rate), 279 completed the menopause-specific questions. The majority (94%) reported either a dedicated menopause curriculum or menopause education integrated within a broader women's health curriculum. Overall 56% of program directors agreed there was a need to improve menopause education; those with an established formal curriculum were less likely to agree (46%

vs. 61%, $P = 0.02$), although interest in a standardized national curriculum was similarly high across groups.

Conclusions: Menopause education is broadly incorporated across US family medicine residency training, reflecting a meaningful foundation for evidence-based menopause care. However, didactic volume remains limited, content coverage is variable, and training relies heavily on continuity clinic exposure, with little formal assessment. Scalable, on-demand learning modules with competency assessment represent a promising avenue for strengthening menopause training.

Key Words: Curriculum, Education, Menopause, Needs assessment.

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Women spend approximately one-third of their lives in the postmenopausal state, yet evidence suggests that many physicians graduate from residency training with significant gaps in menopause-related knowledge and clinical skills.^{1,2} Gaps in US Obstetric and gynecology (ObGyn) menopause education have recently been characterized,³ including a 2023 national needs assessment reporting only 31% of programs had a formal menopause curriculum.⁴ In contrast, the current state of menopause education across US family medicine residency programs has not been characterized at a national level. This is particularly relevant given family medicine's role in providing care in settings where gynecology access is limited or absent. Although the American Academy of Family Physicians' women's health curricular guidelines identify menopause management as a core knowledge area,⁵ the absence of formal competency assessment means the actual depth and consistency of menopause education across programs remains unknown. This is a notable contrast to training frameworks in the United Kingdom, where menopause competency is formally evaluated.⁶ As a result, the quality and depth of menopause education in family medicine programs may vary

substantially, leaving future graduates underprepared to meet growing patient demand for evidence-based menopause care.

The majority of women over 50 in the United States receive their cervical cancer screening from internal medicine and family medicine clinicians in primary care,⁷ suggesting these clinicians represent the most consistent point of contact with the population most affected by the menopause transition. When primary care clinicians are underprepared, patients who lack access to specialist care are left without adequate options. Specialist access is particularly challenging in rural and underserved communities, highlighting the importance of expanded menopause education for all health care professionals.^{8,9} Menopause evaluation and management fall well within the scope of comprehensive primary care practice. As such, ensuring competency in menopause care is not simply a matter of compensating for limited specialist availability but preparing family medicine physicians to deliver high-quality evidence-based care for a common and expected life transition. Emerging models of menopause care, including direct-pay concierge clinics and subscription telehealth services, while expanding access for some, remain largely inaccessible to patients without financial means. Ensuring that family medicine graduates are equipped to deliver evidence-based and guideline-concordant menopause care is therefore not solely a clinical care concern, it is a matter of promoting health equity.

To characterize the current state of menopause education in US family medicine training, we conducted a national survey of family medicine residency program directors (PDs). Our aims were to (1) describe the breadth and structure of existing menopause curricula, (2) identify gaps in didactic content and clinical training opportunities, and (3) understand PDs' perspectives on the need for improvement and gauge interest in a national standardized menopause curriculum.

METHODS

The menopause survey questions were embedded within a larger omnibus survey administered by the Council of Academic Family Medicine Educational Research Alliance (CERA), which surveys family medicine residency program directors biannually and collects standardized program demographic data.¹⁰ Ten survey questions were developed for this study, across three thematic sections: four questions addressing didactic curricular components, four addressing clinical training experiences, and two assessing perceived need for improvement and interest in standardized curriculum adoption (Supplementary Digital Content, <https://links.lww.com/GME/A17>). Questions were adapted from a survey instrument used in a needs assessment of menopause education among Obstetric and Gynecology residency programs³ and modified to meet CERA submission requirements. The CERA steering committee reviewed all questions for consistency with the study aims, readability,

and existing evidence of reliability and validity. Pretesting was conducted with family medicine educators who were not members of the target population, and questions were subsequently refined for flow, timing, and clarity.

The sampling frame comprised all Accreditation Council for Graduate Medical Education-accredited US family medicine residency PDs, as identified by the Association of Family Medicine Residency Directors. Newly accredited programs and those that had not yet graduated at least three resident classes were excluded to ensure respondents had sufficient program experience to meaningfully assess curriculum structure, yielding a final sample of 701 eligible programs. Survey invitations were distributed electronically through SurveyMonkey. Four weekly follow-up reminders were sent to nonrespondents after the initial invitation, with a final reminder distributed 2 days before survey closure. The overall response rate was 44.7% (313/701). Of the 313 respondents, 279 (89%) completed the menopause curriculum survey as an embedded subset of the omnibus survey, and analyses of menopause curriculum items are therefore reported with a denominator of 279 unless otherwise specified.

PD participation was voluntary. No identifying data were retained, and no individual programs or respondents were identified in the reported data. Informed consent was obtained electronically before survey completion. The project was approved by the American Academy of Family Physicians Institutional Review Board in October 2025. Data were collected from November 12 to December 19, 2025.

Statistical analysis

Descriptive statistics were used to summarize demographic characteristics and survey responses. Categorical variables were reported as frequencies and percentages, whereas continuous variables were summarized using mean (SD) and medians (Q1, Q3) due to non-normal distributions. Demographic variables between curriculum types were compared using Wilcoxon rank-sum tests, or χ^2 tests, as appropriate. Survey responses were further stratified and examined by residency program type and by inclusion of menopause care education in the didactic curriculum. χ^2 tests were used to compare perceived need to improve menopause education (Q9) and interest in adopting a standardized curriculum (Q10) between program with and without a dedicated menopause curriculum. Kruskal-Wallis tests were used to compare didactic hours (Q2) and topic breadth (Q3) across program types. Multivariable logistic regression was performed to identify predictors of having a dedicated menopause curriculum, with program type, size and geographic region specified a priori as candidate predictor variables, based on our hypothesis that larger, urban and academic programs would have the institutional resources to support a formal curriculum; all three were entered simultaneously without interaction terms and results were reported as odds ratios (ORs) with 95% CIs. All statistical analyses

were conducted using SAS version 9.4 (SAS Institute, Cary, North Carolina).

RESULTS

Of 313 family medicine PDs who responded to the CERA omnibus survey, 279 completed the menopause curriculum questions. Table 1 summarizes respondent and program characteristics, including years in role, program type, geographic region, program size, and number of core faculty.

Of the 279 PDs completing the menopause curriculum questions, 104 (37%) reported having a dedicated menopause curriculum and 158 (57%) reported incorporating menopause education within a broader women's health curriculum without a formal dedicated structure; 17 programs (6%) reported no menopause education was routinely taught. Regarding didactic volume, 167 programs (60%) provided 1-3 hours of menopause-specific didactic content across the 3-year or 4-year residency, whereas 102 (37%) provided 4 or more hours. In terms of topic breadth, 246 programs (88%) taught three or more menopause topic areas, with 143 (51%) teaching six or more topics. Interest in standardized curricular resources was strong: 176 (63%) reported they would adopt a free, evidence-based, nationally standardized online curriculum if available, an additional 88 (32%) indicating they might. In contrast, only 38 programs (14%) reported that resident trainees had access to self-paced, online menopause education modules (Table 2).

Regarding clinical exposure, most programs required 3-4 clinical weeks in women's health or gynecology settings that include postmenopausal patient care, with 175 programs (63%) falling within this range; however, 11 programs (4%) reported no required clinical weeks in such settings. Despite this clinical contact, 222 PDs (79%) agreed or strongly agreed that resident trainees derive most of their clinical menopause training from continuity clinic experiences rather than dedicated specialty settings. Most programs (88%) offered no dedicated menopause clinic rotation; 19 programs (7%) provided an optional rotation, and 12 (4%) had a required menopause clinic rotation. Formal competency assessment was rare: 2 of 279 programs (<1%) reported a formal menopause knowledge or competency assessment. Of the remaining programs, half of PDs reported informal evaluation through precepting or feedback, whereas the other half reported no menopause competency evaluation of any kind. Fifty-six percent of PDs agreed or strongly agreed that there is a need to improve menopause education in their programs.

In the multivariable logistic regression analyses, there were no differences in the odds of having a formal menopause curriculum based on program size, geographic location, or residency program type (Fig. 1). The hours spent in menopause didactics and topic breadth covered also did not vary across program types. PDs in programs with established formal menopause curricula were less likely to agree/strongly agree with the need to improve their menopause curricula when compared with PDs of

TABLE 1. Demographics of program directors and programs stratified by dedicated menopause curriculum

	No dedicated menopause curriculum, N = 175	Dedicated menopause curriculum, N = 104
Program director characteristics		
Gender, n (%) ^a		
Female/woman	101 (58.7)	55 (55.0)
Male/man	71 (41.3)	45 (45.0)
Missing	3	4
Race or ethnicity, n (%) ^a		
White	127 (75.6)	80 (79.2)
All other racial/ ethnic groups	41 (24.4)	21 (20.8)
Missing	7	3
Age, n (%)		
30-39 y	23 (13.1)	20 (19.2)
40-49 y	88 (50.3)	34 (32.7)
50-59 y	48 (27.4)	33 (31.7)
60+ y	16 (9.1)	17 (16.3)
Highest degree, n (%)		
DO	38 (21.7)	25 (24.3)
MD	134 (76.6)	78 (75.7)
PhD	3 (1.7)	0 (0)
Missing	—	1
Years as program director		
Mean (SD)	4.54 (4.13)	5.30 (5.11)
Median (Q1, Q3)	3 (1.5, 6)	4.25 (1.5, 7)
Missing	3	—
Program characteristics		
Program type, n (%)		
University-based	29 (16.6)	21 (20.2)
Community-based, university-affiliated	100 (57.1)	58 (55.8)
Community-based, non-affiliated /military/others	46 (26.3)	25 (24.0)
Geographic region, n (%)		
Northeast	35 (20.6)	20 (20.0)
South	52 (30.6)	29 (29.0)
Midwest	49 (28.8)	25 (25.0)
West	34 (20.0)	26 (26.0)
Missing	5	4
Community size, n (%)		
< 30,000	22 (12.6)	17 (16.3)
30,000-74,999	33 (18.9)	18 (17.3)
75,000-149,999	31 (17.7)	20 (19.2)
150,000-499,999	45 (25.7)	23 (22.1)
500,000-1 million	18 (10.3)	12 (11.5)
More than 1 million	26 (14.9)	14 (13.5)
Program size (total residents), n (%)		
< 19	69 (39.4)	43 (41.3)
19-31	80 (45.7)	43 (41.3)
> 31	26 (14.9)	18 (17.3)
No. core faculty		
Mean (SD)	8.09 (4.75)	8.54 (5.25)
Median (Q1, Q3)	7 (5, 9.5)	7 (5, 11)
Missing	3	1

^aGender was a select-all-that-apply item; one respondent who selected multiple gender categories was excluded from gender analyses. Percentages reflect female/woman versus male/man only. Race/ethnicity was also select-all-that-apply; respondents selecting more than one racial/ethnic category were regrouped as Multiracial and included in the "all other racial/ethnic groups" category, such that White versus all other racial/ethnic groups are mutually exclusive and percentages sum to 100%. The 20-29 years age category had zero respondents and was excluded; the 60-69 and 70+ categories were collapsed into 60+ due to small cell sizes.

TABLE 2. Menopause curriculum characteristics stratified by curriculum type

	No menopause education N = 17, n (%)	Menopause integrated within women's health curriculum N = 158, n (%)	Dedicated menopause curriculum N = 104, n (%)
Total menopause didactic hours			
0 h	6 (35.3)	2 (1.23)	0
1-3 h	11 (64.7)	93 (59.6)	63 (60.6)
4-6 h	0	49 (31.4)	31 (29.8)
7-9 h	0	7 (4.5)	9 (8.7)
10 or more hours	0	5 (3.2)	1 (1.0)
Total menopause didactic topics			
0 topics	2 (11.8)	0	0
1-2 topics	7 (41.2)	18 (11.5)	5 (4.8)
3-5 topics	6 (35.3)	64 (40.8)	33 (31.7)
6-7 topics	2 (11.8)	42 (26.8)	32 (30.8)
8 or more topics	0	33 (21.0)	34 (32.7)
Do residents have access to self-paced online menopause modules			
No	10 (58.8)	110 (69.6)	77 (74.0)
Yes	2 (11.8)	24 (15.2)	12 (11.5)
Unsure	5 (29.4)	24 (15.2)	15 (14.4)
Our residents derive MOST of their clinical menopause training from experiences in their own continuity clinic.			
Strongly disagree/	3 (17.7)	31 (19.6)	25 (24.0)
disagree			
Strongly agree/	14 (82.4)	127 (80.4)	79 (76.0)
agree			
Do residents rotate in a dedicated menopause clinic?			
No	16 (94.1)	143 (91.1)	87 (84.5)
Yes—optional	1 (5.9)	7 (4.5)	11 (10.7)
rotation			
Yes—required	0	7 (4.5)	5 (4.9)
rotation			
No. required clinical weeks in women's health/ gynecology clinics			
0	0	8 (5.1)	3 (2.9)
1-2	3 (17.7)	25 (15.9)	14 (13.6)
3-4	12 (70.6)	95 (60.5)	67 (65.1)
5-6	2 (11.8)	13 (8.3)	9 (8.7)
7 or more weeks	0	16 (10.2)	10 (9.7)
Presence of menopause competency evaluation			
No	13 (76.5)	79 (50.6)	42 (40.4)
Yes—informal	4 (23.5)	75 (48.1)	57 (54.8)
assessment (eg, precepting, feedback)			
Yes—formal	0	1 (0.6)	1 (1.0)
assessment (eg, examination, OSCE)			
Unsure	0	1 (0.6)	4 (3.9)

OSCE, objective structured clinical examination.

programs without a formal menopause curriculum (46% vs. 61%, $P = 0.02$). However, there was similarly high interest in access to standardized national menopause education resources that did not differ among PDs with and without formal curricula (Table 3).

DISCUSSION

This national needs assessment suggests menopause education has been broadly incorporated into US family

medicine residency training. Thirty-seven percent of programs reported a dedicated menopause curriculum, comparable to the 31% of ObGyn residency programs reported in a 2023 national survey,⁴ although direct comparison across specialties is limited by differences in training structure and curricular expectations. An additional 57% of family medicine programs reported teaching menopause care within a broader women's health curriculum. How this compares with other specialties and other health care clinicians providing menopause care both nationally and internationally is uncertain. A recent scoping review mapping menopause education found only 14 dedicated studies of this topic, with only 1 study from outside the US and limited data studying primary care and nonphysician health care professionals' education.¹¹

Most family medicine programs dedicate three hours or fewer to didactic menopause educational content across the entire training. PDs report that residents derive most of their practical menopause experience from continuity clinic encounters rather than structured clinical rotations. This pattern reflects a fundamental design constraint of family medicine training rather than programmatic indifference to the topic. Family medicine residencies are required by the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Family Medicine (ABFM) to prepare graduates for full-scope care across the lifespan and across settings. Requirements span competency in inpatient medicine, obstetrics, pediatrics, mental health, procedural training, and continuity clinic volume with point-of-care ultrasound competency requirements being added in 2027 (https://www.theabfm.org/app/uploads/2025/12/2025-12_Core-Competencies-for-2026-and-Procedures-for-2027.pdf). In this context, any expansion of menopause-specific didactic time must be weighed against competing curricular demands. This reality does not diminish the need for improved menopause training, but it does define the format that any solution must take.

Continuity clinic is a cornerstone of family medicine training, and in many respects represents an ideal setting for menopause education—longitudinal patient relationships, full primary care context, and direct relevance to future practice. That 79% of PDs report continuity clinic as the primary venue for clinical menopause training is therefore expected. However, clinical exposure alone, without an accompanying didactic framework, may not build consistent or reliable competency. Unstructured experiential learning is inherently variable.^{12,13} The menopause cases a resident encounters, and the depth of preceptor engagement with those encounters, will differ substantially across programs and over time. A structured didactic curriculum serves not to replace this clinical experience but to ensure residents have the conceptual framework to learn from it effectively.

Programs incorporating menopause education within a broader women's health curriculum reported similar didactic hours and topic breadth to those with a dedicated menopause curriculum, suggesting that the organizational structure of menopause teaching may matter less than its

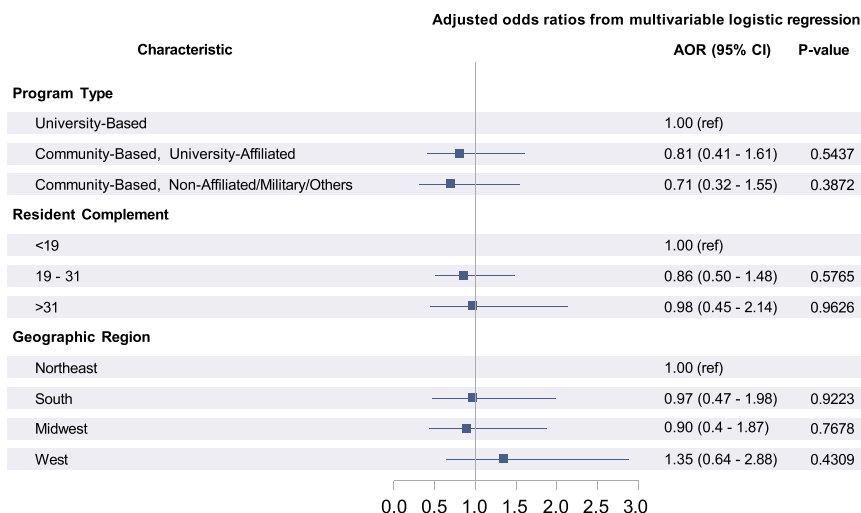


FIG. 1. Forest plot displays odds of having a menopause curriculum by candidate predictor variables: residency program type, size, and geographic location. Squares represent adjusted odds ratios (AOR), mutually adjusted for the other two predictors, with no additional covariates in the model; horizontal lines represent 95% CI. The reference category for each characteristic is denoted 1.00 (ref). The vertical line marks an AOR of 1.0 (no association).

content. This finding reframes the 57% of programs without a formal dedicated curriculum and underscores the importance of content standards over curriculum labels: what programs call their menopause teaching may matter less than whether it meets a defined content standard. This finding further supports the case for a nationally standardized framework against which programs, regardless of how they structure their menopause teaching, can benchmark and improve their training.

This is particularly important in menopause medicine, a domain characterized by a complex and evolving evidence base that is uniquely vulnerable to misinterpretation. The lasting influence of the Women's Health Initiative on clinical practice and public perception of hormone therapy, and the current proliferation of menopause-related content on social media and direct-to-consumer platforms have created an environment in which both patients and clinicians may hold outdated or inaccurate beliefs about menopause management.^{14–16}

Evidence-based care in this area requires not only factual knowledge but the ability to critically appraise evidence and counsel patients through genuine clinical uncertainty—competencies that are central to family medicine training, yet difficult to develop through unstructured clinical exposure alone, and harder still to evaluate through informal preceptor assessment. That only 2 of 279 (<1%) programs report any formal menopause competency assessment is therefore an important finding, and suggests that even programs with robust clinical exposure may lack the tools to verify that residents are developing the skills patients will depend upon.

In rural and underserved settings where access to gynecology or specialty menopause clinics is limited or absent, the family physician may be the only available clinician for women navigating the menopause transition. Ensuring that family medicine residency training produces graduates competent in evidence-based menopause care is a matter of health equity as much as curricular design.

TABLE 3. Perceived need for improvement and interest in standardized curricular resources by formal curriculum status

	No menopause education routinely included/ menopause taught within broader women's health curriculum N = 175, n (%)	Dedicated menopause curriculum N = 104, n (%)	P ^a
"There is a need to improve my program's education on menopause care."			0.0148
Strongly disagree/disagree/neither disagree nor agree	68 (38.86)	56 (53.85)	
Strongly agree/agree	107 (61.14)	48 (46.15)	
Would you be likely to adopt a national, evidence- based, no-cost standardized menopause curriculum?			0.1519
Yes	114 (69.94)	62 (61.39)	
Maybe	49 (30.06)	39 (38.61)	

^aχ² tests.

Strengths and limitations

The use of the CERA omnibus survey infrastructure provided access to a comprehensive, nationally representative sampling frame of all ACGME-accredited family medicine residency programs. This yielded a geographically and programmatically diverse sample, including representation across US census regions and across university-based, community-affiliated, and independent community programs. The survey assessed multiple dimensions of menopause education: didactic volume, topic breadth, clinical exposure, competency assessment, and program director attitudes, providing a more comprehensive characterization of the curricular landscape than has previously been available for family medicine.

However, there are several limitations to consider. The cross-sectional survey design captures a single point in time and cannot establish whether observed patterns reflect stable programmatic features or transient curricular states. As this survey represents the first national baseline characterization of menopause education in US family medicine residency training, no historical data exist for trend comparison. However, CERA's omnibus survey infrastructure permits resubmission of survey items at ~5-year intervals, offering a mechanism for future assessment of curricular change in subsequent survey cycles. As with all voluntary surveys, selection bias may have influenced results: PDs with greater interest in, or concern about, menopause education may have been more likely to respond, potentially overestimating the prevalence and depth of menopause curricula nationally. Finally, the survey relied on program director self-reports rather than direct curriculum review, and responses reflect perceived rather than verified curricular content.

CONCLUSIONS

Family medicine physicians care for women across their reproductive lifespan in every practice setting, including communities where specialty menopause care is unavailable, making the quality of this training a matter of both clinical preparedness and health equity. Menopause education is broadly integrated across US family medicine residency training; however, the predominant model of limited didactic hours, reliance on continuity clinic exposure, and near-absent formal competency assessment reveals meaningful gaps. Future work developing and disseminating evidence-based, standardized curricular resources, designed within the structural constraints of residency training and incorporating formal competency assessment will be an important step toward ensuring that all patients, regardless of where they receive their care, have access to a physician well prepared to guide them through the menopause transition.

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