Measuring and managing complexity

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Hormones. In certain consultations, female patients aged 15–55 years often use the word 'hormones' to frame their presenting complaints. Could it be, they ask, that hormones are implicated in fatigue, fragile moods, fights with partners, weight gain, unreasonable work colleagues, periods that come a few days late or early, or sleepless nights? They always mean female reproductive hormones. Often there is a request to measure these hormones. The frequency of these requests puzzles me and, although I know a lot about hormones, I never quite know what's going on.

Are these requests, I've wondered, a way to invite my medical gaze by directing me towards a plausible physical request? After all, what could be more physical than tubes of blood being analysed by a machine? Why do these women seem apologetic at first, but then openly admit to the multifactorial nature of their presentations?

Hormone-related requests escalate from around 45 years of age: 'Could it be menopausal, doctor?' Menopause, we know, is established in retrospect – 12 months since the last menstruation – and while serology might hint at what is evolving, it does not provide a diagnosis. However, ordering a blood test is also a way to create time for exploration of other possibilities.

In the past, medicine has run ahead of the evidence when locating diseases and diagnoses in women's reproductive organs and brains.[1] However, perimenopausal hot flushes, itchy skin, vulvovaginal dryness, emotional lability, bone health, cardiovascular risk[2] and contraceptive needs[3] are all important to enquire after and can often be successfully managed. Occasionally, a younger woman presents with amenorrhea and the consultation takes a different turn.[4] But menopause usually comes at a time when both men and women may also have older children, ageing parents, marriages in the crucible of change, careers in peak or sudden decline, and bodies that are not quite robust but not yet frail.

There are several tools we can use to support women during menopause while avoiding spurious correlations. First, we need to actively engage our patients so that diagnoses are arrived at together. Arthur Kleinman, a psychiatrist and anthropologist, suggests a practical method of taking a history of relevant aspects of the patient's perspectives.[5] Instead of only asking 'where?' and 'what?', we enter the patient's world by asking 'why?', 'how?' and 'what next?'.

Another component is overcoming unconscious bias by healthcare providers who might have prematurely tailored treatment options. Many general practitioners, keenly aware of time constraints, will have a repertoire of books and websites they recommend to patients. For instance, the evidence around the risks of hormone replacement therapy, a complex and fraught topic, is summarised by the Australian Menopause Society in an accessible information sheet.[6]

Two ideas, both in their infancy, have also been put forward. These are question-prompt lists (a formal list of three questions patients are encouraged to ask)[7] and the more resource-intense method of teaching patients to apply the evidence to their situation.[8]

Decision aids, many of which are available locally and internationally,[9,10] are also used to help people make specific treatment choices, in addition to the patient–doctor conversation. One Cochrane review suggests that patients who use them feel better informed and clearer about their values.[11] However, such aids need frequent updates as evidence and treatment options alter.

By working in partnership, we can honestly acknowledge uncertainties and improve quality of life for women in midlife.

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