Patient Satisfaction Regarding Shared Decision-Making During the Menopausal Transition

Scoping Review

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Abstract

Introduction: Shared decision-making (SDM) is central to patient-centered care but remains underexplored in menopause management. Many women report dissatisfaction with menopause care, including feeling dismissed, inadequately informed, or excluded from treatment decisions. This scoping review examined existing evidence on the relationship between SDM and patient satisfaction during the menopausal transition.

Methods: Following PRISMA-ScR guidelines, literature searches were conducted in CINAHL, MEDLINE, and APA PsycINFO for peer-reviewed English-language studies published between 2002 and 2025. Studies examining SDM in menopause-related healthcare encounters with outcomes related to satisfaction, communication, or decision processes were included.

Results: Eight studies met inclusion criteria (sample sizes ranged from 24 to 964 participants). Interventions included decision aids, discussion guides, web-based tools, and pre-consultation preparation resources. Seven of eight studies reported improvements in satisfaction or satisfaction-related outcomes, including reduced decisional conflict, increased knowledge, and greater confidence in decision-making. Women reported higher satisfaction when clinical encounters included clear information, opportunities for participation, and relational elements such as empathy and validation.

Conclusions: Patient satisfaction with menopause care appears influenced by both informational support and relational dynamics within SDM encounters. Integrating decision-support tools with communication strategies that emphasize validation and collaboration may improve engagement and satisfaction during the menopausal transition.

Key Words: Patient satisfaction; Patient–provider communication; Women's health

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Introduction

Menopause and the menopausal transition are universal life stages that affect nearly half the population, yet research and clinical practice often fall short in addressing the full spectrum of women's needs during this period. The transition is associated with wide-ranging physiological, psychological, and social changes, including vasomotor symptoms, sleep disturbance, mood fluctuations, and increased risk for cardiovascular disease[1]. While biomedical aspects of menopause have been studied, the quality of care women receive remains variable, and many report shortcomings in the support provided during this stage of life[2].

Many women describe feeling dismissed or not taken seriously when seeking care for menopause-related concerns[3]. These experiences reflect broader gaps in clinical practice, including not only the prioritization of biomedical approaches over relational care but also a persistent lack of provider education about menopause itself. Although menopause is a normal life transition, this framing can lead some providers to minimize symptoms or assume women should simply cope, undermining compassionate, individualized care. Together, these dynamics contribute to an environment in which women's concerns may not be fully heard or validated. In this context, shared decision-making requires that providers first recognize women's symptoms and experiences as real and worthy of attention. This recognition is an essential foundation before collaborative decision-making can occur. Ensuring that clinical encounters are respectful, inclusive, and patient-centered is therefore critical to advancing equitable menopause care.

These challenges are further reflected in the historical response to the Women's Health Initiative (WHI) findings. Early reports from the trial suggested increased risks associated with combined estrogen–progestin therapy, prompting abrupt changes in clinical practice and contributing to ongoing uncertainty in menopause care[4]. Many women discontinued hormone therapy without individualized discussions about age, symptom severity, time since menopause, or personal risk profiles[4,5]. Although updated evidence and regulatory decisions have revised several earlier warnings, including the FDA's recent removal of broad "black box" warnings for hormone replacement therapy used in menopausal care, the lingering effects of WHI-era risk messaging continue to influence clinical decision-making and patient perceptions[6]. Incorporating shared decision-making (SDM) and decision aids into menopause care can help translate complex population-level evidence into personalized recommendations that align with each woman's values and circumstances, rebuild trust, and reduce decisional regret.

Emerging evidence suggests SDM improves menopause care outcomes. Decision aids and digital resources reduce decisional conflict, enhance understanding, and improve satisfaction with treatment decisions. For example, a 2025 interventional study found that SDM significantly lowered regret and uncertainty among women managing menopausal symptoms[7]. The North American Menopause Society (NAMS) endorses SDM as a mechanism to personalize care and rebuild trust in treatment decision-making[5].

Patient-centered approaches that emphasize communication, SDM, and holistic attention to women's concerns have improved satisfaction, trust, and engagement in other areas of women's health, particularly maternity care[3]. However, little is known about how these relational principles are applied in midlife care for women experiencing perimenopause or menopause. Understanding how SDM functions in this context is needed to guide provider education and promote equitable care. Therefore, the purpose of this scoping review was to map existing evidence on the role of SDM in care for women experiencing perimenopause or menopause, with particular attention to its influence on patient satisfaction. Specifically, this review sought to characterize how SDM has been applied in menopause care, examine its relationship with patient satisfaction during the menopausal transition, and identify gaps in the evidence base to inform future research, provider education, and clinical practice.

Methods

The protocol and reporting for this scoping review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR)[8]. The guiding question was: In women experiencing perimenopause or menopause, how does shared decision-making influence patient satisfaction during the menopausal transition? Although scoping reviews do not require a formal theoretical framework, an emancipatory feminist lens informed the interpretive synthesis of findings, particularly in relation to power dynamics, validation, and women's experiential knowledge.

After consultation with the University College of Nursing librarian, a comprehensive search strategy was developed and implemented across CINAHL, MEDLINE, and APA PsycINFO. The databases were searched on September 25, 2025 and focused on terms related to menopause or perimenopause, patient-provider communication, patient satisfaction, and shared decision-making. Limiters included peer-reviewed articles published in English between 2002 and 2025. A combination of controlled vocabulary and keywords was used, and search strategies were adapted as appropriate for each database. The full search strategy is provided below:

(MH "Perimenopause" OR MH "Perimenopausal Symptoms" OR MH "Menopause" OR menopause* OR perimenopause*)
AND

(MH "Professional-Patient Relations" OR MH "Nurse-Patient Relations" OR "nurse-patient relations*" OR "nurse patient relations*" OR nurse-patient interaction* OR provider* N3 relation* OR physician* N3 relation* OR clinician* N3 relation* OR provider* N3 interaction* OR physician* N3 interaction* OR clinician* N3 interaction* OR perspective* OR voice* OR attitude* OR experience* OR MH "Patient Satisfaction" OR MH "Personal Satisfaction")
AND
(MH "Decision Making, shared" OR MH "Decision Making, Patient" OR MH "Decision Making" OR MH "Decision Making, Ethical" OR decision N2 making)
AND
(patient OR nurse*) The initial search yielded 392 records, as shown in Figure 1. After removing 121 duplicates, 271 articles remained for title and abstract screening. Articles were included if they examined shared decision-making in healthcare encounters involving perimenopausal or menopausal women and reported outcomes related to satisfaction, communication, or decision processes. Because "patient satisfaction" is inconsistently defined across menopause research, this review included both direct measures of satisfaction (e.g., satisfaction scales, reported satisfaction with decision-making) and proxy indicators such as decisional conflict, knowledge, confidence, and perceived empowerment. These constructs were treated as related but distinct dimensions of satisfaction and were interpreted accordingly in the synthesis. Studies were excluded if they involved participants with significant comorbidities or focused solely on treatment efficacy without addressing SDM. Title/abstract screening and full-text review were conducted in Covidence[9]. Following full-text assessment, eight studies met final inclusion criteria.

Screening and data extraction were conducted by a single reviewer, which may introduce selection bias. This approach was selected due to feasibility constraints and is acknowledged as a limitation. Extracted variables included: author(s), year, country, study design, population and sample size, type of SDM intervention or tool, outcome measures, and key findings related to satisfaction. Study flow is summarized in the PRISMA diagram (Figure 1), and the characteristics of included studies are presented in Table 1.

Results

Eight studies met inclusion criteria, representing a range of designs such as randomized controlled trials[10-12], a mixed-methods evaluation[13], a quasi-experimental study[14], and cross-sectional studies[15-17]. These studies were published between 2002 and 2025 and reflect evolving approaches to supporting shared decision-making in menopause care. Across this time period, interventions increasingly emphasized patient engagement and individualized decision support. Collectively, the studies explored ways to enhance SDM for women navigating menopausal symptoms and treatment decisions.

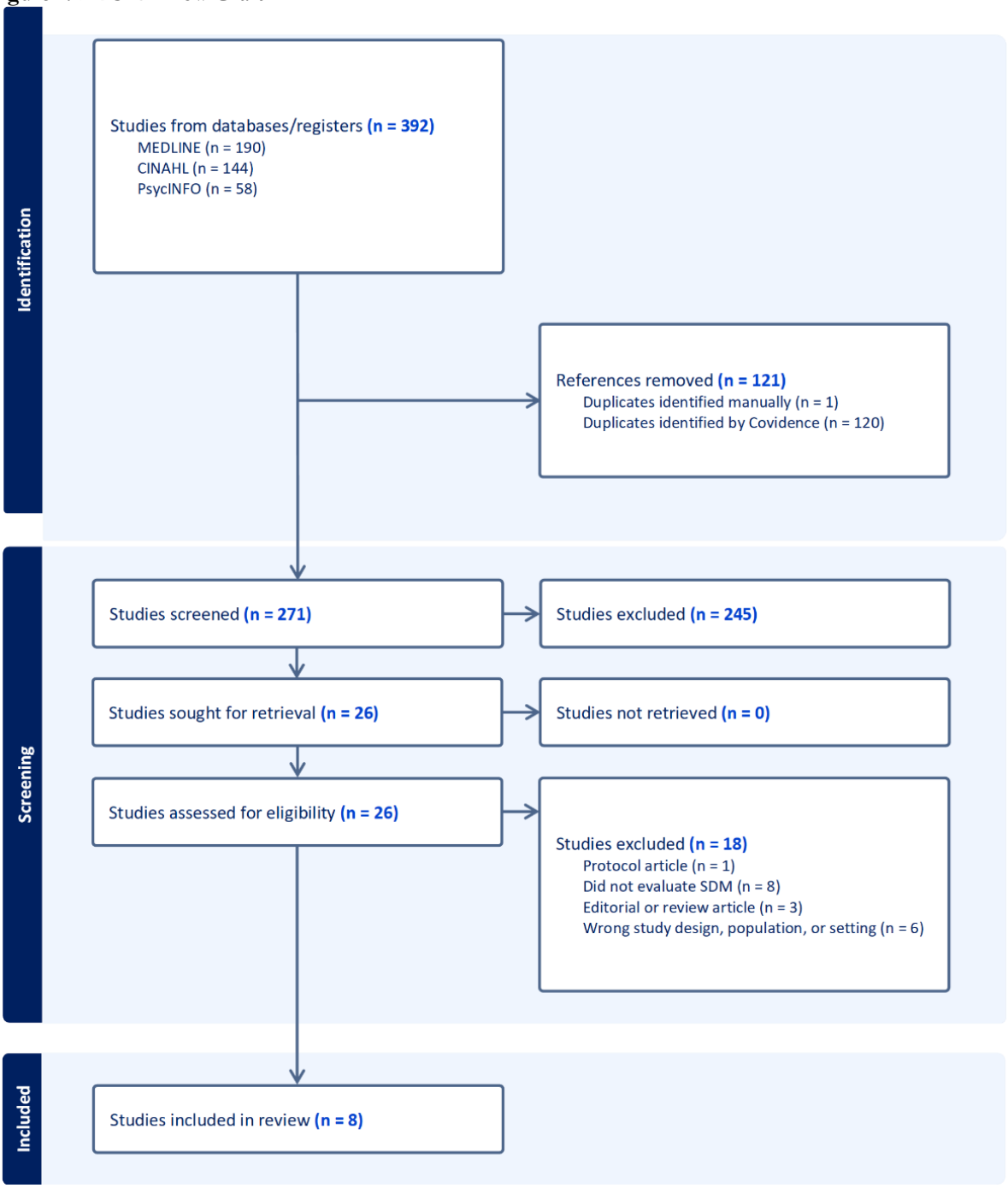
Most included studies evaluated decision-support interventions designed to help women make informed, value-aligned treatment decisions. Interventions included decision aids delivered through booklets or computerized tools, discussion guides, nurse-led pre-consultation preparation resources, and comprehensive SDM tools for clinicians and patients. These approaches consistently improved knowledge, clarified treatment preferences, and supported more collaborative clinical discussions. These findings suggest that structured decision-support tools play an important role in facilitating patient engagement during menopause care[10,11-16].

Richardson et al.[17] used data from the Women Living Better (WLB) survey to document patient experiences in seeking care for perimenopausal symptoms. This large-scale qualitative dataset provided insight into how women perceive clinical encounters related to menopause care. Collectively, this body of evidence demonstrates growing attention to SDM as an essential component of menopause care. The included studies reflect an evolution from static educational materials toward interactive, web-based, and preparatory tools aimed at promoting more collaborative patient-provider encounters.

Shared Decision-Making and Patient Satisfaction

Seven of the eight studies addressed satisfaction-related outcomes; however, only a subset directly measured satisfaction using validated or explicit satisfaction metrics, while others inferred satisfaction through proxy indicators such as decisional conflict, knowledge, confidence, or perceived empowerment[10,11,13-17]. Satisfaction was therefore operationalized inconsistently across studies, reflecting both direct measures of patient-reported satisfaction and indirect indicators of decision quality. Studies that directly measured satisfaction consistently reported improvements following SDM interventions, while those using proxy outcomes demonstrated parallel trends suggesting enhanced decision quality and patient experience. This distinction is important for interpreting the strength and comparability of findings across the included studies.

Figure 1: PRISMA Flow Chart.



Structured decision aids consistently improved satisfaction-related outcomes. Rostom et al.[11] found that both computerized and audio-booklet decision aids enhanced satisfaction with the decision-making process among women considering hormone therapy. Similarly, Col et al.[10] reported lower decisional conflict and greater confidence in treatment decisions following use of a personalized computer-generated decision aid. Menard et al.[14] noted that women valued structured comparisons of natural health product options and felt more capable of making informed choices, although satisfaction was inferred through decisional conflict and confidence rather than directly measured. These findings highlight the role of decision aids in improving both perceived and measured aspects of satisfaction.

Table 1. Summary of studies examining shared decision-making and patient satisfaction.

Author, Year (Country)	Design	Population & Sample Size	SDM Intervention	Key Outcomes	Satisfaction Findings
Bailey et al., 2021 (USA)	Randomized controlled trial	n = 100 English-speaking women, age 45–60	Menopause Discussion Guide (health-literacy adapted) vs. ACOG material	• Knowledge • Material preference • Ease of understanding • Satisfaction	• Improved satisfaction • 68% preferred guide • Higher ratings for clarity and usability
Col et al., 2007 (USA)	Randomized controlled trial	n = 145 menopausal women, age 45–65, primary care settings	Computerized DA vs. DA + coaching vs. usual care	• Decisional conflict • Knowledge • Satisfaction	• Reduced decisional conflict • Improved satisfaction • Coaching added minimal additional benefit
Dayaratna et al., 2021 (USA)	Quasi-experimental	n = 48 women, age 35–60, VMS/GSM symptoms	Nurse-led decision counseling (phone) + educational booklet	• Treatment knowledge • Decisional conflict • Treatment preference clarity • Satisfaction	• 94% felt better prepared • 87% reported positive perceptions of counseling • Improved satisfaction
Menard et al., 2010 (Canada)	Quasi-experimental	n = 24 peri/postmenopausal women, age 45–64, considering NHPs	Self-administered DA for NHP decision-making	• Decisional conflict • Knowledge • Values clarity • Choice preference	• Decisional conflict reduced (63% to 24%) • Improved satisfaction • Increased confidence in decision-making
Richardson et al., 2023 (USA)	Qualitative content analysis	n = 964 women, age 35–55, menopause-related care	No formal intervention (qualitative exploration of healthcare interactions)	• Perceived satisfaction with care • Perceived dissatisfaction with care • Patient-provider interaction themes	• Validation and SDM associated with higher satisfaction • Dismissive care associated with dissatisfaction

Author, Year (Country)	Design	Population & Sample Size	SDM Intervention	Key Outcomes	Satisfaction Findings
Rostom et al., 2002 (Canada)	Randomized controlled trial	n = 51 peri/postmenopausal women, age 40–70	Computerized DA vs. audio-booklet DA	• Knowledge • Realistic expectations • Satisfaction	• Improved knowledge and expectations (computerized DA > audio-booklet • High acceptability across both formats
Snyder et al., 2025 (USA)	Randomized controlled trial	n = 410 women, age 40–60	Interactive website with values clarification tools (MyMenoplan.org)	• Knowledge • Decisional conflict • Behavioral intentions • Website satisfaction	• Improved satisfaction, clarity, and decision-making intent • 96% reported willingness to revisit site SS
Stute et al., 2025 **(Multi-country)**	Mixed-methods feasibility study	n = 172 women, age 45–61 + 49 HCPs across 7 countries	Menopause Treatment Tool (MTT) for patient-clinician use	• Tool feasibility • Symptom/risk identification • Consultation quality	• >85% perceived the tool as valuable • Improved confidence and patient-provider interaction • 93% reported ease of use

ACOG = American College of Obstetricians and Gynecologists; DA = decision aid; GSM = genitourinary syndrome of menopause; HCP = healthcare provider; NHP = natural health product; VSM = vasomotor symptoms

Interventions emphasizing patient-provider dialogue revealed the relational dimensions of satisfaction. Bailey et al.[15] found that women using the ACOG-endorsed discussion guide demonstrated greater knowledge and higher satisfaction with their decision-making process. Dayaratna et al.[16] showed that pre-consultation preparation enhanced women's readiness for engagement, with participants reporting greater satisfaction during nurse-led SDM encounters. In these studies, satisfaction was more often directly measured through patient-reported outcomes, though improvements in knowledge and alignment with treatment preferences also served as indirect indicators of enhanced decision quality.

Digital platforms also contributed to improved satisfaction by aligning information with patients' values. Snyder et al.[12] found that users of MyMenoplan.org reported higher knowledge, stronger alignment between treatment choices and personal preferences, and greater overall satisfaction with decision-making. Similarly, Stute et al.[13] demonstrated that both women and clinicians perceived their SDM tool as empowering and confidence-building during treatment discussions. These results suggest that both relational and technology-based interventions can enhance satisfaction, though they may do so through different mechanisms.

Finally, the WLB survey by Richardson et al.[17] revealed striking qualitative evidence that the absence of SDM was strongly associated with dissatisfaction and feelings of dismissal. Among more than 2400 participants, nearly half

described unsatisfactory healthcare experiences when seeking help for menopausal symptoms. In contrast, women who described their encounters as collaborative or respectful emphasized feeling validated and supported, highlighting the relational nature of satisfaction. These findings reinforce the importance of patient-provider interactions in shaping perceptions of care quality.

Although the survey did not systematically evaluate provider characteristics, women's narratives suggested that more satisfying encounters occurred when clinicians demonstrated menopause knowledge, listened without minimizing symptoms, invited patient input, and clearly explained treatment options. These findings highlight the importance of relational competencies such as empathy and validation in SDM interactions. They also suggest that satisfaction is influenced not only by the presence of decision-support tools but by the quality of interpersonal communication during clinical encounters. Across these studies, the relationship between SDM and satisfaction was consistent: when women were informed, heard, and invited into collaborative discussions, satisfaction with care and decision-making improved. Satisfaction was multidimensional, encompassing both information satisfaction (clarity, knowledge, decisional confidence) and relational satisfaction (validation, empathy, respect). This synthesis highlights that effective SDM in menopause care requires integration of both domains to optimize patient experience.

Discussion

The interpretation of findings in this review was informed by an emancipatory feminist lens. This perspective aligns with the review's aim to understand structural, relational, and contextual features of healthcare shape women's experiences of menopause care and SDM. It supported attention to power dynamics, validation, and the legitimacy of women's experiential knowledge without altering the methodological foundations of the review[18]. These interpretations represent a conceptual synthesis of the literature rather than findings directly measured in the included studies. This review examined patient satisfaction with SDM during menopause and identified consistent evidence that structured decision support tools enhance knowledge, reduce decisional conflict, and improve satisfaction with the decision-making process. Beyond these direct findings, several broader themes emerged.

Informational Support as a Foundation for Satisfaction

Decision aids and digital resources consistently improved satisfaction by clarifying treatment options, presenting risks and benefits, and supporting informed choice. From computerized and booklet-based aids[10,11] to more recent web-based interventions,[12,13] informational support emerged as a cornerstone of satisfaction with SDM. Similar patterns are observed across other healthcare domains[19-21], where informed patients are more likely to experience decision-making as collaborative. Thus, informational empowerment may be a key mechanism through which SDM interventions enhance satisfaction and trust.

Relational Dynamics as a Critical Determinant

While structured tools improved satisfaction, survey evidence highlighted that dissatisfaction persisted when women's symptoms were dismissed, inaccurately assessed, or inadequately acknowledged by health professionals[17]. This suggests that information alone is insufficient; the quality of the patient–provider relationship strongly influences perceptions of SDM. Similarly, Dayaratna et al.[16] showed that pre-consultation preparation not only improved patient readiness but also enhanced the quality of subsequent interactions with clinicians. Together, these findings emphasize the importance of empathy, validation, and respectful dialogue in shaping satisfaction and suggest that meaningful practice change will require attention to relational communication alongside decision-support tools.

Toward an Integrative Model of Patient Satisfaction in SDM

Together, the findings suggest that patient satisfaction with SDM during menopause arises from the intersection of: (1) information support (knowledge, clarity, and value alignment); and (2) relational dynamics (responsiveness, empathy, and validation). Informational components facilitate understanding of treatment options and reduce uncertainty, while relational components shape how information is received, interpreted, and integrated into decision-making. Across the included studies, interventions that address both domains appear most effective at fostering meaningful engagement in SDM and enhancing satisfaction with care. Notably, the presence of information alone was insufficient when not accompanied by supportive, patient-centered communication, underscoring the importance of interpersonal context in decision-making processes. This integrative perspective represents a conceptual synthesis of literature and offers a preliminary framework for understanding how informational and relational elements interact to influence patient satisfaction in menopause care.

Emerging Theoretical and Practical Implications

The literature included in this scoping review collectively suggests a developing conceptual framework in which decision aids act as mediators that enhance empowerment, while the patient-provider relationship determines whether the SDM process feels satisfactory and supportive. The inclusion of digital interventions signals a shift toward technology-enabled empowerment, though these tools must be complemented by relational training for clinicians[12]. This synthesis suggests that future interventions should not only focus on developing robust informational tools but also on strategies that train providers in relational communication and patient-centered care. Given persistent gaps in provider training related to menopause, these efforts should also include education on contemporary menopause science and evidence-based treatments, enabling clinicians to enter SDM conversations with both relational competence and adequate biomedical knowledge.

At the time of writing, it is also important to situate these findings within the evolving landscape of hormone therapy guidance. The initial publication of the WHI findings led many women and clinicians to discontinue hormone therapy without individualized discussions about age, timing since menopause, symptom severity, or personal risk profiles[4]. Contemporary evidence now provides a more nuanced understanding of hormone therapy safety, showing that risks differ substantially based on age and time since menopause. Professional organizations have issued updated clinical guidance reflecting these distinctions and emphasizing personalized counseling and shared decision making as best practice[5]. These shifts underscore the importance of ensuring that clinicians have access to up-to-date menopause education, so SDM conversations are grounded in current evidence rather than outdated interpretations of WHI-era messaging.

Theoretical Underpinnings and Gaps

Despite the long-standing use of decision aids in menopause care, relatively few studies have examined SDM within a comprehensive theoretical framework. None of the included studies explicitly applied nursing theories or feminist perspectives that could illuminate how power, autonomy, and validation shape women's satisfaction in menopause care. The absence of theoretical grounding limits understanding of the mechanisms through which SDM enhances satisfaction and empowerment. Future research could benefit from integrating theoretical frameworks or feminist perspectives that not only contextualize how women navigate this life stage and how clinical encounters affirm or undermine their autonomy, but also reframe menopause as a normal biological transition rather than an illness requiring treatment.

Gaps and Future Directions

Despite the advances in decision support, gaps remain. Few studies assess long-term outcomes of satisfaction with SDM or how satisfaction influences treatment adherence and health outcomes. There is also limited exploration of diverse populations, particularly in relation to cultural perspectives on menopause and decision making. Future research should examine how decision support tools can be tailored to individual contexts while maintaining inclusivity and accessibility. Additionally, integrating theories of patient empowerment, relational autonomy, and person-centered care may provide stronger foundations for intervention development.

Limitations

There are several limitations within this scoping review. First, although a comprehensive search strategy was used, screening and data extraction were conducted by a single reviewer, which may introduce selction bias and increase the risk of missed or inconsistently interpreted studies. Second, only English-language publications were included, which may have excluded relevant international perspectives and introduce language bias. Third, variability in how satisfaction was defined and measured across studies limits direct comparability of findings. Finally, most included studies were descriptive and conducted in Western contexts, which may limit the applicability of findings across diverse populations and healthcare settings. Future research should include more geographically and culturally diverse samples to build a more comprehensive understanding of SDM satisfaction in menopause care.

Conclusion

This review demonstrates that patient satisfaction with SDM in menopause is shaped by both the quality of informational support and the relational dynamics of care. Evidence supports a dual-focus approach in which interventions equip women with clear, structured, value-based decision aids while also fostering clinical environments that validate experiences and promote respectful dialogue. Beyond improving satisfaction, SDM can restore agency and normalize menopause as a natural life transition rather than a condition to be treated. When women are informed, heard, and respected, decision-making becomes empowering and contributes to greater trust in healthcare relationships. Because menopause is experienced differently, SDM must remain individualized and context-sensitive.

Future research should refine and evaluate SDM interventions that balance technological innovation with human connection. Studies that include diverse populations and care settings are needed to clarify how cultural, social, and systemic factors shape satisfaction with menopause care. Greater attention to how satisfaction is defined and measured is also warranted, particularly in distinguishing between directly assessed outcomes and those inferred from related constructs. Together, these elements can inform the development of more equitable and empowering care models that honor women's voices throughout the menopausal transition.

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