

Women and Equalities Committee

Oral evidence: Women's reproductive health, HC 1773

Wednesday 8 November 2023

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[Watch the meeting](#)

Members present: Caroline Nokes (Chair); Kim Johnson; Kate Osborne; Kirsten Oswald.

Questions 47 - 108

Witnesses

I: Janet Lindsay, Chief Executive, Wellbeing of Women; Rebekah Lloyd, Founder, This Independent Life; Dr Anne Connolly MBE, Co-Chair, Menstrual Health Coalition.

II: Dr Geeta Kumar, Vice President for Clinical Quality, Royal College of Obstetricians and Gynaecologists; Dr Michael Mulholland, Honorary Secretary, Royal College of General Practitioners; Professor Sue Carr, Deputy Medical Director, General Medical Council.

Written evidence from witnesses:

This Independent Life [[WRH0026](#)]

Menstrual Health Coalition [[WRH0020](#)]

Royal College of Obstetricians and Gynaecologists [[WRH0056](#)]

Royal College of General Practitioners [[WRH0034](#)]



Examination of witnesses

Witnesses: Janet Lindsay, Rebekah Lloyd and Dr Anne Connolly.

Q47 **Chair:** Good morning and welcome to the Women and Equalities Select Committee and the second evidence session of our inquiry into women's reproductive health. Please can I thank all of our witnesses for coming along today? We have Dr Anne Connolly MBE, co-chair of the Menstrual Health Coalition, Janet Lindsay, chief executive of Wellbeing of Women, and Rebekah Lloyd, founder of This Independent Life. As ever, members of the Committee will ask questions to each of you in turn. They will indicate which witness they are addressing the question to. If at any point you want to come in, just indicate and I will seek to include you at an appropriate moment.

Can I start with a question to first Janet and then Rebekah? It was two weeks or so ago that we had evidence from Vicky Pattison and Naga Munchetty, who were both talking to us about what they felt was the lack of information around what good menstrual health is. Janet, how can we make sure that women are well equipped to understand what good menstrual health is?

Janet Lindsay: First and foremost, there is the NHS website. If we look at NHS inform, the Scottish website, for period problems and menstrual health, it is making a good approach there. We need to do that on our own NHS website. Also, we need to use social media, so bite-sized information. Within our office itself, we have some young people. They are getting all their information from social media, from things like TikTok. We have to use all those different avenues to make sure that we get the information out there.

We have to start at the beginning in its life course, so education must start at school. We really need to make sure that we are educating not just girls but boys too. I know that there are things going on in that regard. If we do not get the information right at the first stages, when young people are growing up, what hope can we have as they grow up? It is about workplaces too, libraries and every possible avenue. We need to make sure that we are getting good, evidence-based information in the right form that is appropriate for age and different groups of people, so that we do not leave behind those women and girls who are just too easy to ignore as well.

Q48 **Chair:** This is a question specifically around education. We know that the Department for Education is carrying out its review into RSHE. Has Wellbeing of Women fed into that?

Janet Lindsay: Not directly, no. I believe that, as the reports come out, it will be opening that out to different organisations. I very much hope that we will be able to work very closely with all different stakeholders to make sure that we get it right this time.



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For me, fundamentally, we have to involve young people to make sure that we are listening to their voices. The other thing that we need to do is make sure that we involve parents, so that everybody feels that they are involved. Once you do that, you start to make great strides.

Q49 Chair: Rebekah, it is a similar question to you. One thing that alarmed me, and certainly alarmed the media—it was the quote that they all picked up on—was when Naga said that she felt that she had been told to “suck it up”, and that the problems that she was having were, effectively, just something she had to deal with. How can we help women better advocate for themselves?

Rebekah Lloyd: Again, it all comes back to education. First and foremost, that is the one thing that I hear time and time again in all the work that I do. Unfortunately—and I say this with love, because my mum is a nurse, my sister is a doctor and the NHS is an amazing thing—there is still a lot of medical misogyny, gaslighting and women not being listened to. There is something to be said there, in that, yes, we need to help women to advocate for themselves, or people who are struggling with these conditions, but it is both sides.

It is helping them help you in some ways. How can women and patients become better equipped to know their bodies, first and foremost, so that they even know what right or wrong, or abnormal or normal, is, to be even able to then think, “I should go and get help”? We normalise pain, particularly for women: “Suck it up. It is all in your head”. Again, this is not for everybody. There are of course an incredible number of really dedicated, supportive, committed healthcare professionals who genuinely listen, but there are a lot more who do not.

Trying to tackle it at the root and help all people in this space, from patients all the way through to clinicians and everyone along the way, be it at schools or universities, will empower women and help them to feel confident in what their body actually is. A lot of us are not taught. I do not know whether any of the people in this room had particularly good health education at school, and I know that it is improving, but there is a lot more that we can do, including on advocating for yourself and speaking up.

It is also very transferable into a lot of other parts of our lives. When you look at the impact of women’s health on things such as careers, that is a whole other conversation. We need to help women to speak their truth, for want of a better word, and have the language to speak about what is happening in their bodies in a way where they do not feel like that is going to be dismissed. There are a lot of people who have tried and they give up. Naga, for example, went back, and a lot of women do that, but a lot of women do not, so you have thousands of women in pain, living and suffering in silence because they think that it is normal. I really think that we have to go back to square one in some ways, lay that foundation and from there build up what good looks like.



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In future, we should not really even need women to advocate for themselves. If we are actually treating it at the cause, we should have people being listened to, heard and taken seriously, so that we are not having this cycle of dismissal and people being gaslighted and just not listened to when they are trying to ask for help. They are reaching out. They have got to that stage where it can be very hard to talk about these things. They are very personal. Some people have not even spoken to their partners, their family, their friends, let alone their colleagues. It goes back to addressing that root cause and tackling it from all different angles.

Dr Connolly: I recognise the fact that I am a clinician. I am a GP with a special interest in gynae. I have hysteroscoped and done sexual health clinics, coil fitting, et cetera, for years. I am not sitting here on behalf of the RCGP or the Primary Care Women's Health Forum today. I am sitting here on behalf of the Menstrual Health Coalition, in which case I would like to talk from a patient view. We have met before. We have had a discussion before.

I work in inner-city Bradford. I have always worked in inner-city Bradford, which has a very diverse, deprived population. I now work with the asylum seekers, refugees, homeless and sex workers. I completely endorse the point about education.

There are two other factors that we miss. One is about the importance of co-production of materials. It is very well for us as white women, writing stuff for women from Tigray, Eritrea, Syria, Kuwait or wherever it is. We spend a lot of time and effort making sure the wording and tone is right, and working with our population groups to make sure it is right, because otherwise it is just us telling people again. I know that it takes time and effort, but it is well worth the investment.

The other thing where we miss a trick is about our nurses. For me, women's health completely depends on our nurse workforce, because, if women decide that they want to come and see us, as healthcare professionals, they have to feel that it is bad enough. They do not know when bad enough is bad enough. If they are having their smears done or their asthma checks, or their kids are getting immunisations, they often feel empowered to test it out with the nurse.

I do a lot of nurse education. The nurses will say, "I don't know the answer, so I don't ask the questions". When they are doing smears, they do not feel able to talk about, "What are your periods like?" The nurse education funding pot is very prioritised for long-term conditions because that is where the funding is in primary care. We will fund our nurses to go on diabetes, respiratory disease and cardiovascular clinic courses, because that will then get the QOF moneys that help fund the practice, whereas we are not funded for women's health these days. Nurses will fight hard to go on nurse training courses and the training priorities will not be on women's health. That is a key thing that we miss, and for the



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extended multidisciplinary team, such as pharmacists and physician associates.

Q50 **Chair:** I have some follow-up questions. Menstrual Health Coalition, have you had any opportunity to feed into the RSHE review?

Dr Connolly: No, not through the Menstrual Health Coalition. The last time I was on the panel on behalf of the RCGP was when we had the Committee before covid. Lots of people were offering to help with education and DfE at the time was just saying very clearly, "We will write this". At the time when it was first being worked on, it was very much arm's length to healthcare. I know that the RCOG team were there at the time. It seemed very sad that we were not being asked to help. No, we have not been asked to help, but obviously we would.

Q51 **Chair:** Going back to your commentary around nurses and the previous evidence that the Committee had, it almost felt, from what we were being told, there was a barrier to moving on from primary healthcare. I think that it was Naga who told us that she had been complaining about problem periods for 32 years before she got a referral onwards. Where should treatment sit? Is it best diagnosed and treated in a primary or secondary setting? How can we make sure that the path to treatment is smooth and possible?

Dr Connolly: It is a little bit difficult, sitting here on behalf of the MHC, and I am conscious that the RCGP is behind me. For me, it is all about prevention, early intervention and early recognition. We will stop women having to go on to have interventional procedures if we can get early treatments done. That is about women understanding what the problem is, feeling empowered to come and talk to us in primary care and seeing the right healthcare professional early enough in the disease process so that the treatments can be started early. Be it polycystic ovary, heavy menstrual bleeding or endometriosis, the majority of women can be treated early to prevent long-term consequences.

We do not recognise enough that polycystic ovary syndrome is not really a gynae condition. It is diabetes in another hat. It is a long-term condition and it is all about insulin resistance. Endometriosis is a long-term condition if it is not treated early. If you treat it and manage it early, you prevent the consequences of infertility, chronic pain, et cetera. It should be done as early as possible, recognising that, in the primary care setting, if that treatment does not work, we should be handing on to secondary care, or if the patient chooses that. The earlier we treat, the less the consequences, so it is an invest to save, if you want.

Fragmentation in commissioning is the biggest barrier and particularly affected women's health more than any other aspect. You can get a coil, a Mirena or an intrauterine system fitted here but you cannot have your smear. You can have your smear done there but you cannot have it done, or you could have it done for contraception there, but you cannot have it done for heavy menstrual bleeding. There you go. You are on an awful



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long waiting list, which are getting longer and longer all the time for gynae, to have somebody in the hospital fit your intrauterine system, which you should have had done there by the person who put a speculum in and abused you the first time. That is where the problem has been.

As you just rightly said, the women who see it through are the ones who are educated and empowered. They have a car, the internet and the money. The women who hit the first barrier, my Mrs Begum from inner-city Bradford, cannot go to the sex clinic. She is not allowed to go to the sex clinic, culturally. Even if she did get there, they would say, "You cannot have it for your heavy menstrual bleeding". She has hit the first barrier and she will not go and find another one. There is a real inequality about the fragmentation.

Rebekah Lloyd: We need to think about women's health as a whole and care pathways as a whole. When I worked in the NHS, we had the two-week wait pathway referral. It is very well established and works very well. We need to almost take a look at the journeys and steps that need to be taken. Yes, in the long-term view there are things that would be amazing to happen, if we can increase the awareness, investment and innovation to relook at the NHS as our biggest economic asset. A healthy population is a healthy economy. If we can tackle things early, it is almost that the problems will not exist anymore.

To build on what you were saying, Anne, we hear about women's health hubs, which is an incredible idea, a really amazing initiative. Unfortunately, the numbers do not really add up to make it actually viable and the resources are not there. Thinking about the wider impact of women's health on women's lives, the amount of time that it takes to go through this process should not be underestimated: asking for days off work, needing time off for surgery, being on waiting lists for years. All this has a knock-on effect to the financial stability of people and wellbeing. There are so many different things.

We could bring it all together and have a place where women, or people suffering with these conditions or experiences, could go, almost like a one-stop shop really, where it is not about being bounced around different places and being told, "You have to go here to get this thing and this thing over here". It costs energy, time and money for everybody involved. We could bring it together under one roof, if you like.

This speaks to a wider issue in terms of collaboration across the women's health space. We have research over here, start-ups and innovation over here, and patients over here. It is all very siloed. If we bring it all together and have a patient-centred approach, how can we tackle it at the cause? How can we listen to women and almost build it around them, so that it is not this thing that takes up all this time in someone's life? It is not even a thing that we need to think about. It is just dealt with and you can move on.



We need end-to-end continuity of care. Think about things such as the postcode lottery as well. If you move to a different place in the country, it is very likely that your notes do not follow you. There are a lot of women I know who are still trying to chase them. You have to repeat your experience over and over again to somebody new. I feel like we could remove all that and save a lot of time, energy and money if we could bring it all together and make that more of a seamless experience, with proper training along the way, proper specialists, non-invasive ways of looking at things and proper pain management for procedures that can be very painful.

It goes back to normalising women being in pain. There is no reason why we should be doing that in 2023. There are things available. There are medications and ways of doing things, whether it is a smaller speculum or anaesthetic. Why can we not be offering those? There is still this real, "Women just have to put up with it. You just have to deal with it", because that is how it has always been.

Q52 Kim Johnson: Good morning, panel. We heard from Naga and Vicky at our first evidence session about having to go private to seek the support they needed. I have a couple of questions about treatment. Anne, you have already touched on it a little bit already. Can you say how hard it is to treat women's gynaecological conditions and are doctors getting the treatment right? You have touched on that a little bit. Are women adequately informed about their treatment options? Often, it's, "Have a hysterectomy". What other options are available and how do they access them?

Dr Connolly: Again, it is about patient information, and decent patient information, so that women are aware that they have choices. In primary care—I am sure that you are going to hear this more—it is extremely busy at the moment. Because of expectations and priorities, women's health is not one at the moment. The opportunity is now. We have never had an opportunity like this in my career. Women's health has suddenly become something that women are starting to shout much more about.

We know, with the menopause revolution that we have just had, the amount of extra prescribing that is happening. Clinicians learned very quickly, because they have had to. People who had not done women's health previously are now having a different banter about how they deliver those messages in a very short time.

By the time you come in and we have talked about your problem, often if you have had a wait, it will be a very emotional time, so it is about unpicking that. It is about unpicking the impact and how it is affecting your life. It is about what you know, and then about how we can talk about treatment options and think about whether it is a referral, investigation or management. I have to do that in 10 or 15 minutes. A lot of it is about where to signpost to, so that women can get more information, and making another appointment, so that they can come



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back and have another much more balanced discussion about what they choose.

That information has to be in a format that they can understand. It does not have to be, "Your choice is pills, coil, operation or having your womb lining burned off". It needs to be much more what would be right for you at this particular time of your life, because that will change. What will be right for you going through your education times, if you have painful periods, will be very different to a choice you might make just before you have your family, which will be different to a choice you make once you have completed your family, which will be different to a choice when you get to menopause. It is lifelong.

Q53 Kim Johnson: We know that, for black women, diagnosis of endometriosis is five times less likely. What needs to happen to make sure that all women have the right diagnosis at the right time?

Dr Connolly: Again, it is about appropriate information. I do not look at a woman who comes into my clinic and think, "You are this colour. You are that colour. You are that colour". It is about how we unpick the problem that she sees. If she has always had heavy, painful periods and her mum did, she does not know any different. She does not sit there and talk to her mate: "By the way, how bad are your periods?" She just tolerates her own periods.

Something may trigger, "Actually, this is not right". It may be that she has lost her job or failed an exam that she could not revise for. This is a huge generalisation that I am about to make now, but we know that there is inequality for women who are in lower-paid jobs about painful or heavier periods. All of us women have time in our roles to go to the toilet to change a pad if we have to, because I will not flood in the middle of a clinic, unlike if I am on the checkout in Morrisons or on a factory floor. I heard from a teacher who flooded. They are not allowed to leave their job and if they leave their job to go to the toilet all the time they might be reprimanded.

How do they get time off work? The system does not work with fit notes. If somebody is poorly, they come and I give them a fit note after the first week. Of course, with periods it is usually four or five days that they will need off work. In that time, they say, "Can I have a fit note?" "No, you don't need a fit note because you can sign yourself off", but if they are signing themselves off every single month, eventually they lose employment, maybe change employment, become part time or get sacked. There is an inequality and some women will be in harder jobs.

Q54 Kim Johnson: There is an impact on both the woman and the wider economy in terms of not being diagnosed and treated quickly enough.

Dr Connolly: Yes, exactly. There is not enough research. Endometriosis and heavy menstrual bleeding affects one in 10 women, and that is probably an underestimate. Why is there no decent research?



Q55 Kim Johnson: We will probably come to those questions later on. Janet, you wanted to come in on that point.

Janet Lindsay: There are a couple of things I would like to go into on that. To make progress, there needs to be much better collaboration. I am not going to focus on the work that has been done, but there has been some great work done with the CRG for menopause. Between the NHSE and Wellbeing of Women, we have created something called virtual engagement events, which they are presenting to the new ICBs—integrated care boards.

The most important thing there is that these are pulling together groups of GP practices. They will have specialists, GPs, physios and dieticians talking about menopause, but the beauty of this is that it can be used across so many different aspects of healthcare. Immediately, we are thinking of period problems and menstrual health. You can also look at those regionally. You can create these virtual engagement events using different language. You could take them into schools or workplaces.

This feeds into the idea that we all need to work together when it comes to making progress and having a positive impact. That is one small thing that we have done, working with NHSE. I understand that the group of people who have been working on that, including Anne, is going to disband because of budgets and things, which will be incredibly sad, because it is going to make big progress.

We have also created something called the health collective, which we have done with our ambassador, Dr Nighat Arif. We started it originally to bring together women and girls from different ethnicities and communities. These are spokespeople, networks and people who are working on the front line in the areas of women's health. It is general. It is breast cancer, menstrual problems, menopause and much more.

We had our first meeting in September. We have created something called the health collective. We are now going to expand that to include many more marginalised and disadvantaged groups, so it will be refugees, the Traveller community, LGBTQ and much more. That is something that we want to feed into the women's health strategy as well, so that their voices are heard and, most importantly, the good work that they are doing is heard. That means, hopefully, that the strategy will then be able to support them going forward in the good work that they are doing. We must not forget the voluntary and community sector.

Q56 Kim Johnson: Earlier you touched on the treatment options available to women in terms of heavy periods. They are often painful, but that is often not recognised. Do you think that more work needs to be done in terms of the medical profession understanding the level of pain that women go through during these painful cycles?

Janet Lindsay: Absolutely, yes. We are all very lucky to have Anne in our lives. All women and girls are. There are some fantastic healthcare



professionals out there, but we need to make sure that everybody who is front facing with women when they come through the door understands this. Nurses are a classic example. They see women all the time because women are coming, as you say, for smears. You are taking your children in for vaccinations. If we make sure that they are informed, trained and educated, they can be the first port of call, front line, and that then relieves GPs. It is a must. Midwives are another group of people who do such fantastic work.

Absolutely, we have to get better training for all healthcare professionals when it comes to women's health so that we stop normalising the pain and the heavy menstrual bleeding. As Anne has said, most of us will be able to go and deal with any problems that we might have, but a huge amount of people just cannot. That affects their life. It will affect their education if they cannot go to school, which means that their life chances could be compromised. It means that at work they may well not be able to stay in positions. They might not be able to take up promotions.

That has a huge effect on the economy. We know the figure of £8.2 billion that endometriosis costs the UK economy, but that is just one area. If we put together all the different areas of menstrual health and things like urogynaecology as well, the effect is enormous. It also affects women's individual finances and pensions. We need to make changes so that, frankly, everything is equitable.

Rebekah Lloyd: I have one thing to add on the treatment options. One thing that we also need to think about is that there is a limitation on what is available within the NHS at the moment. One thing is, yes, making sure that every healthcare professional who is coming into contact with somebody knows the options available, but there are a lot of other options. I know that we are going to come on to research and looking at that. Holistic alternatives—

Q57 **Kim Johnson:** That was my next question.

Rebekah Lloyd: I will not jump ahead, but we should make sure that there is education on those options as well. It is about women having awareness of what those options are.

Kim Johnson: It is also for it to be available across the NHS. As was mentioned earlier, both Naga and Vicky talked about having to go down the private route to be able to be treated. It took a long time to get their diagnosis as well. Thank you for your responses, panel.

Q58 **Kate Osborne:** Good morning, everybody. Before I ask a question, I want to make the point that we have heard some hugely distressing reports from women as a Committee and, I am sure, individually as Members. I certainly have. There are two that stick with me. One is a women who is 42 who every month is in excruciating pain. After eight years of pushing and managing to see three consultants, they all told her that the answer was to get a Mirena coil, despite a long history of



knowing that this often makes things worse.

The other example I wanted to mention is a 13-year-old—you mentioned the impact that it can have on young women—in significant pain, reporting heavy periods, which seemed so much worse than her friendship group, and yet her GP said, “You just have to put up with it. You have decades of this ahead of you. Get on with it”, basically.

This is across the spectrum of women’s health. There is endometriosis, as you said, PCOS and lipoedema. With IVF, as we heard in the debate that I held last week, so many women are facing huge hurdles because of lack of knowledge and adequate information around all areas of women’s health. With all that in mind, my first question to Anne, please, and then Rebekah, is how we should tackle the gaps in GPs’ and other professionals’ knowledge about women’s reproductive health.

Dr Connolly: This is a very difficult question for me to answer because I am sitting here on behalf of the Menstrual Health Coalition. I am the RCGP women’s health champion, so I have done lots of GP education over the years. For those women who have been so poorly served, as a GP I apologise, because it is not satisfactory.

How do we improve the education? It is about prioritisation. There is very little prioritisation for women’s health, considering that they are 51% of the population, in our primary care workload. It is very focused on long-term condition management, as we have said, cancer, emergencies and firefighting. Women’s health is something that, until recently, has not been prioritised in education.

As a GP, we have to know something about everything. Just think to yourself about the last 10 times you have been to your GP. My guess is that it has been with 10 different things. We have to know enough. It is not an excuse, however, not to listen to the impact. We have to be, and I think that we are all being, better at really listening and changing to, “What matters to you? What is it about your periods that matters to you? What is that impact?” How it will affect one person in their workplace or their life will be very different to how it affects another one.

All I can say is that we have developed a lot of education for the whole workforce through the RCGP, through the Primary Care Women’s Health Forum, which I just recently stopped chairing, and through the Faculty of Sexual and Reproductive Healthcare. There is no justification for being told that you have to tolerate it, none at all.

Rebekah Lloyd: One thing we need to look at is medical school and right at that early stage when we are training healthcare professionals, be it nurses, practitioners, doctors, surgeons or whoever. I know through the work that I do that there is, arguably, not sufficient education given at that stage. That also leads into people deciding what route they are going to go down. If they are not aware of this huge area that could do with a lot more people, support, commitment and dedication, that could impact things in the future. Medical school is a really important one.



Another one that is really important is guidelines and signposting. For example, we have the ESHRE guidelines for endometriosis. Yes, they were updated recently, but they say that you do not recommend having psychotherapy or psychological support following a diagnosis. Looking at that objectively, when being diagnosed with a chronic condition, living with pain and all the other things that come with that, it seems crazy to me, to be honest, that you would not think that you would need psychotherapy and support in that way. Having asked about that in my own experience, I know that I am not here to speak about that, but it would be remiss to not acknowledge that.

Really clear guidelines are needed, as well as signposting, because we can educate people but, as Anne said, we are human. Healthcare professionals are human beings. We are not robots. We have a limitation of what we can retain in our brains, so we should make it easier and put those things in place that can help and take a bit of that pressure off, whether it is simple flowcharts or simple instructions: "You see this. Refer for this. You have seen X, Y, Z. Now you refer". If we keep saying, "You need to learn more", people are going to stop trying. That human-centred approach and helping people to help themselves to ultimately help the patients who are in front of them is really important.

The final one to mention is events and conferences. There are a lot of scientific and medical conferences, but taking endometriosis, for example, there is only one that happens in Edinburgh once a year. It is very scientific community-focused. There is definitely space for that. I am not at all saying that there is not, but we do not have spaces where healthcare professionals, patients, researchers, start-ups and all the different stakeholders in the space can come together. It is a different way of learning. We think about learning and it is education, yes, but there are different ways of approaching education. There are different ways of learning, so it is really important to acknowledge that when we think about how we can create and build a better future when it comes to women's health.

Q59 **Kate Osborne:** Although we are talking about education here, rather than accessing actual help, it goes back to what Anne was saying earlier about the fragmentation of the whole thing. Janet, did you want to say anything on this?

Janet Lindsay: No, because I am just agreeing with everything that Anne and Rebekah have said.

Q60 **Kate Osborne:** Do you think that there is evidence that women's reproductive health conditions are deprioritised? I know that we talk about the education part, but do you think that there is a conscious decision, I suppose, at times by the medical profession to deprioritise? If you do think so, why do you think this is and what role should the General Medical Council and any other bodies have in improving training and knowledge of medical professionals?



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Dr Connolly: There are two points that I would make. One is, as I say, the funding for primary care. A lot of it is about long-term conditions and being rewarded for getting your diabetes and this, that and the other better. A few years ago, we actually had some QOF points for women's health and talking about long-acting reversible contraception. They were taken away after a couple of years because we had actually done so well. They said, "It now becomes norm that people are saying that", but since the funding has gone we have seen the impact and the numbers reduce, so there is something about not being prioritised enough. With that, we lose the enthusiasm. We do not have the funding to send our nurses or doctors on training. It is prioritised wrongly, for me.

The other one, again, goes back to fragmentation of commissioning. Before the Health and Social Care Act, as women in local communities, you could get your women's health dealt with in local contraceptive clinic. If you went with period problems, you could talk to the clinicians there, who were funded to do intrauterine system fittings for Mirenas for heavy menstrual bleeding as well as other issues. Now it is about, "You go to the sex clinic and get your information about sex, but please do not talk to me about your other gynae problems", or you go to the gynae clinic.

The problem is that health is becoming so siloed once you get out of primary care. Having worked in the hysteroscopy clinic for many years, I know that I could hysteroscope. I have to say that I hope that they were not all that painful, but I hysteroscoped. If somebody there tried to talk to me about their mental wellbeing, I said, "Back to your GP", even though I am a GP and it may even have been my patient I was doing. If they said, "By the way, can I just tell you about my incontinence?", which is another gynae bit, I said, "No, I am afraid you cannot. I am here to sort out your heavy periods".

The pressure and the funding is not around the woman. We have said it enough times since the Health and Social Care Act. We have said it again and again. If you are designing a health service around women's health, put the woman at the centre of it and let us see how it works for her and not make it about the funding.

Rebekah Lloyd: One thing that comes to mind is that there was a study done, I think by UCL, that found that period pain is as painful as heart attacks. That sums up and goes back to the point I made earlier around this normalisation of pain. That is something that we really need to address at all stages, be it procedural or long-term management—all aspects—while looking at that psychological aspect as well.

We have made great progress in mental health and that area as a whole. We need to start bridging those siloes again, looking at other departments and specialities within the healthcare sector, looking at that multidisciplinary approach and making sure every stakeholder and every touchpoint that those women or people who are struggling with these conditions come into contact with has that same awareness and



understanding. On pain, we need to try to remove that concept and acceptance that that is just what we are supposed to deal with.

Q61 **Kate Osborne:** What role do you see that the General Medical Council could play in this?

Rebekah Lloyd: Like I said, medical school is really important. I will admit that I am not an expert on the General Medical Council and how it operates. There is a degree of responsibility and support that it can provide to healthcare professionals, which is looking at a different way of doing things and innovating, not just doing the same old thing. I am not saying that that is necessarily what it is doing.

Looking at other countries, how are other countries that are really, arguably, far ahead and doing a better job, if you look at it statistically, managing women's health and treating these types of issues? There should be learning from other sectors. One example is that the aerospace industry was used to look at surgical pathways and how we can improve that.

I am not saying that the GMC needs to turn into the aerospace industry, but we need to be asking the questions first and foremost, actually listening and maybe doing an exercise around whether healthcare professionals feel like there are any gaps that they could have support with, and then going from there. It is really important that we learn to listen as well and use a patient-centred approach, 100%. If we can empower people within the GMC and everything that comes after that in the support that they are providing, I hope that that knock-on, ripple effect will trickle through to the end patient who we are trying to support.

Janet Lindsay: There is a phrase, which is "benign gynaecology". It is frequently used inside the NHS and it is a sort of medical shorthand to refer to issues such as gynaecological conditions, so heavy menstrual bleeding, et cetera, that are not cancers. "Benign" here was understood as being not serious or harmless. If you combine that with the normalisation of things such as pelvic pain, really severe period pain, incontinence and heavy bleeding, it is going to contribute to the fact that they are less prioritised for care and support, unless we make some systemic changes.

I know that the Royal College of Obstetricians and Gynaecologists and Endometriosis UK are trying to do something about benign gynaecology. Again, it is about us coming together and working together to make sure that women's health is prioritised.

Q62 **Kate Osborne:** We know stigma and misinformation play a large role in the lack of menstrual and gynaecological health knowledge among the population. I have spoken to women who buy and use protection pads every day because they believe that nothing can be done about their pelvic floor dysfunction or whatever. We hear many reports of women being denied pain relief and not being listened to. Do you think that these



stigmas play a part in diagnosis and treatment? Are there any other biases that also come into play when diagnosing and treating women's reproductive health issues?

Rebekah Lloyd: Yes, in short. I know that through the work I do. I did a survey recently, over the summer actually, and 100% of the women I spoke to said that they felt that there was a stigma in the workplace. That was specifically looking at the workplace, but that is just one example. If we are not able to talk about these things and they are still stigmatised and taboo, they are just going to remain this quiet, silent thing that women have to deal with. I strongly believe that we need to eradicate and remove that stigma.

Again, it is about going back to that root cause. Why are we all sitting in this room today? We need to be addressing these very generational and institutional things—sexism, racism. We have a lot of things that are not necessarily any particular person's fault. We need to look at why we still have this stigma and understand that from a cross-sectional, diverse perspective, culturally taking in everybody's perspectives, because it is different culturally. It is different based on where you are from. That is just the reality.

Dealing with that stigma, which definitely prevails, unfortunately, would help eradicate a lot of the issues that we have. For example, take the work that I do in workplaces. If I go in, I am educating the women and the men. I actively welcome anyone in the organisation. This is not just women in a corner saying, "We need help". We need to help educate everybody about it. If that one person in that talk is going to go and say, "Actually, I should probably do something about this pain that I have," or, "Maybe I should go and speak to someone about this", because actually it is okay to talk about it, that ripple effect is huge.

I do not think that we need to be reinventing the wheel with everything. There is a lot that we need to change, but when it comes to things such as stigma it is normalising the conversation and not feeling that feeling that a lot of us have because that is how we have been brought up. We have been told, "That is something you deal with. We do not talk about it". We need to start talking about these things as if we have broken our leg or we have a migraine. We would not even question it. We should be having the same approach when it comes to women's health.

Q63 **Kate Osborne:** Rebekah is speaking there about stigma or bias in the workplace. What about within the NHS and the medical profession? Do you think that that is the case?

Dr Connolly: Yes, there definitely need to be improvements in the medical profession, as I think we have discussed. The other lesson that we do not learn is how the teen pregnancy strategy worked so well. We more than halved the number of teen pregnancies. The teen pregnancy strategy was a cross-system working. It was not just health's business, education's business or whoever's business. It was everybody's business.



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The voluntary sector was very much involved. It was the young people themselves, education, social care, health and access to contraception.

Everybody knew what the vision was and everybody took down their egos and did it right, because it was right. That is the way to improve women's health. It is not just about fixing this little bit there. It is about, as we have talked about, education, involving the voluntary sector, which may have to be the women's advocates if they are non-English speaking, have learning disabilities, are deaf or are LGBT. It is about us all saying, "This is something that needs fixing. How can we fix it?" and taking down egos. Funding needs to follow.

Janet Lindsay: I totally agree with everything that they have said. Also, from Wellbeing of Women's point of view, the reason we started our "Just a Period" campaign was that we had heard from many women and girls, and on top of that we surveyed another 3,000 women aged between 16 and 40 about their health. The common themes were that painful periods are commonplace, but girls and women felt that they were ignored. Bleeding is often heavy. That in itself can create a huge amount of stigma and embarrassment. Young women, particularly, were not going to seek help. Mental health is affected. Long term, this can be avoided. All this stigma, taboo and normalisation means that women's and girl's lives are affected, so we need to all come together to do something about it.

Q64 **Chair:** Anne, can I take you back to your comments about QOF points and long-acting contraception? The GPs were too successful in that. Well done. Is there a challenge that women's health gets too generalised around contraception? The be-all and end-all is that we do not get pregnant when we do not want to and therefore everything else gets overlooked because it is not as serious.

Dr Connolly: I do not think so. I would hope not. I have been having a lot of discussion about what training people need to do the women's health hub work. The women's health hubs, as you know, is the current initiative. We can debate the risks and benefits of them. There is an issue about what workforce you would need from them if you were driving it from the bottom, which is driving it from primary care, rather than them becoming little mini outpatients.

There are well-established contraception training pathways through the diploma through the Faculty of Sexual and Reproductive Healthcare. You cannot access them, but they are well established and very expensive. There are well-established menopause training pathways to do menopause specialist work through the British Menopause Society and the faculty, but it is about where the training for period problems is. How do you upskill that workforce in the middle there for the period problems, PCOS, if you still want to leave it in gynae, endometriosis, PMS and urogynae?

The enhanced training programmes are not there as such. People go to conferences. They will either go to a women's health conference to learn



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or they will go to a more general conference and go into a session. That bit in the middle is core GP really, which we all do. I wonder if that is where the issues are.

Chair: That is where the missing bit is.

Dr Connolly: I think so, yes.

Chair: That's quite terrifying, isn't it? Core GP is where the missing bit is.

Q65 **Kirsten Oswald:** Anne, you mentioned PCOS there. You mentioned that previously. Before I get into my question, I have spoken about this in the Commons before and been overwhelmed by a deluge of women who have been in touch with me because they had never heard anyone mention it, including in here, in the past. To some extent, it would be good to hear a little bit about that in answer to this question to you first, Anne. Do you think research into women's reproductive health is enough of a priority?

Dr Connolly: If your question is, "Is it not being prioritised?", the answer is definitely yes. Should it be prioritised? The answer is definitely yes. The latest guidance on PCOS has just been published. I bet that not many people know that. There is a new diagnostic test in that on a blood test, which is going to make life so much easier, but you can bet your life that it will only be the private labs at the moment that are doing that in the UK.

The guidance is there. There is not enough research, particularly about how it affects the different groups and how we get the right information to the different groups. I will sit there with a young south Asian woman, Pakistani, who has come to the UK. Because of her diet, lack of exercise and the cultural changes, she will put on a bit of weight and suddenly the PCOS that she has always had becomes exposed and she thinks that it is because she has come to the UK. Do you know what I mean? It is, because of her whole lifestyle change. It is completely undervalued or under-recognised that we should just treat the majority as diabetes or pre-diabetes.

Q66 **Kirsten Oswald:** More broadly in terms of research into women's reproductive health, do you think that that is given the priority that it ought to be?

Dr Connolly: Women's health, end of, is not given the priority it ought to have. When we do not have the data and we do not have numbers, we cannot collect the impact and we do not have that bigger cost efficiency.

The other point that I was going to come back to about bias, maybe about the GMC, even, is that, if you have a dodgy hip operation, you will stand up and shout about it because it is quite clear. If you have a painful coil fitting or you feel that your GP said, "You are 30 and you have to tolerate this", where do you shout about that? It's a bit embarrassing, isn't it? You have period problems and why are you making a fuss about it? No one else makes a fuss about it. It is about how women are



disempowered and how they shout for themselves. We are not shouting for them because we do not have the research. We do not have the numbers.

Q67 Kirsten Oswald: Whose responsibility do you think it should be to make sure that we have that research?

Dr Connolly: It is for all of us. It is NIHR. It is NICE. NICE has just decided, I think—maybe someone else knows—that we do not need PCOS guidance because there is an international one. If there is an international one, unless NICE says loudly and proudly, “This is what we should follow”, it will not be followed. It is all of our job. It is your jobs as much as my job.

Q68 Kirsten Oswald: Janet, can I pose the same questions to you?

Janet Lindsay: Obviously I am going to say that, no, there is not enough women’s health research. For those who do not know, Wellbeing of Women is 60 years old next year. We started by funding research into maternal death in childbirth. Our remit has expanded and now we do research, education and advocacy, but less than 2.2% of publicly funded research is dedicated solely to reproductive health and childbirth, which is extraordinary when we are 51% of the population and we are the ones who give birth. It is really sad that five times more research—you know this—is conducted on erectile dysfunction, which affects 19% of men, than on premenstrual syndrome, which affects 90% of women.

What do we need? We need dedicated Government funding. I know that the Government have invested £53 million into the NIHR programmes. I very much hope that we will see the benefit of that coming through, but it simply is not enough, because that represents something like 4% of the total of the funding there. We need dedicated women’s health experts on the NIHR panels. We are very lucky that Lucy Chappell and Marian Knight are both very much involved, but that is not enough. We have a dedicated research advisory committee and have done for nearly 60 years. We certainly need more women’s research fellowships so that we are bringing the scientists and experts into the field of research, and we need much better inclusion. Women need to play a much greater role in clinical trials too. It is literally important that we do that.

In the field of menstrual health, I will give you a figure. In 2018, searching for endometriosis in the UK Research and Innovation awards database, there were 35 hits, meaning that it had funded 35 endometriosis-related projects since 2003. On the other hand, if you search diabetes, a condition with the same incidence rate but one that affects both sexes, it has funded a total of 1,758 projects in the same period, and the amount of money is much bigger. This gives you a flavour of how little money is invested in research. We are the only voluntary body that is funding research across women’s health across the life course. There are individual charities that will do some research, but certainly not in menstrual health.



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We are funding a number of projects on menstrual health. One is looking at the crucial first step to developing a test that can be carried out by GPs for heavy menstrual bleeding. We are doing another project, co-funded with the Scottish Government, who have set aside money for one of their priority areas, which is endometriosis. We are looking, again, at a new treatment there. That is something that Wellbeing of Women has funded over four different times to get to this stage.

Our contribution is relatively small, but to give you an idea, this year we will be making available just short of £1.5 million. It is a drop in the ocean. Our strike rate is relatively low. What I mean by that is that the researchers who apply to us know that there is quite a small chance of them getting a Wellbeing of Women grant, but they still do that. They will still apply to us. Last year, we had to turn down two fellowships because we just did not have the budget. That is sad, because one of them was in ovarian cancer and the other was in endometriosis, so areas that are of vital importance.

There is so much work that needs to be done. We are still at the very earliest stages with women's health. We do not understand an awful lot about heavy menstrual bleeding, for instance, so we are really at the beginning. Much more needs to be done in this area.

Rebekah Lloyd: My first answer would be no. I do not think there is. There are two main areas we need to look at in terms of research. I know I have said it 100 times, but one is the root cause and what the problems are that we are dealing with.

We do not know the cause for a lot of things, and endometriosis is a good example of that. There is a lot of research that has happened to date. We have theories, and there are certain things that we know about how it works, but we do not really know. I will not repeat the stats that Janet mentioned, but there are a lot of different things that we need to be looking at, whether that is, at cellular level, inflammation, hormonal, or our gut microbiome, on which a study came out recently.

First and foremost, in anything, if we do not understand a problem, how are we going to create a sustainable solution that is not just putting a plaster on it? This goes back to your question around contraceptives. In my experience, being told that you are at the end of the road because you have tried all the hormonal options, and that is it, is just not good enough. It is about understanding what is causing these conditions and why are women experiencing these things, at the very simplest and most basic level.

Then, on the other side, how can we look at viable, sustainable solutions? By "sustainable" I mean that it is not just a plaster. We know about things like acupuncture, cryotherapy, THC and CBD. There are all these different things that need research to understand if they are viable and if they are going to work. Look at things like ayurvedic medicine and



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holistic medicine. They are all seen as not viable because we do not have that large-scale clinical trial data.

All of this goes back to the huge data gap we have when it comes to women's health. We do not have the information and the data, at its core, to understand what is going on. It is about understanding the problem, defining and creating real solutions so that in future we are not having this conversation and it is not a generational thing that keeps happening.

We are looking at ways to allow women to get back to living their lives and contributing to society and the economy. One stat from the Centre for Economics and Business Research is that £22.2 billion is lost from women's sick days annually. There are so many stats that we could show, but there are also a lot of stats that we do not have because we have not looked into it.

Research is absolutely at the core. We need a dedicated research institute. In the UK, we are leading in so many areas. We could and should be leading in women's health. Given the collaboration and the opportunity that that can bring in every way, if we can prioritise research, everything else will follow.

Q69 **Kirsten Oswald:** Is there anything positive that you have not been able to highlight in terms of women's reproductive healthcare that you want to mention briefly?

Rebekah Lloyd: First and foremost, I would say this discussion and this inquiry. It might seem obvious, but the fact that we are having this conversation and sitting in this room today is a huge milestone and a huge step.

The Oxford Care Centre is doing an incredible job of looking at that multidisciplinary, multi-stakeholder approach, looking at pain receptors and pathways, and really getting into the weeds of all the things we have talked about today. We need more institutes like that, bringing people together in all areas and facets of women's health. They are doing it really well, so we can use those examples of what good looks like and keep aiming for that and pushing for better.

Janet Lindsay: I would add collaboration, not being frightened of working with industry, and not working in silos. We have seen some great work come through on research where we are working with industry and, as I say, with the CRG for menopause. There are some learnings from that that we can bring into menstrual health, which is not just for research but for care and support.

Dr Connolly: I am looking at some examples of the women's health hub work that is being done. There is a worry that it will try to do too much too quickly with no long-term funding, but there are some great examples where people are working across the system and working



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together to try to get it right for women, and particularly for local women, to try to reduce some of those hurdles that they have.

Chair: Thank you. I am going to suspend the meeting so we can bring in the second panel, but can I thank all of you for your evidence? If there is anything you wish to add in writing, please do so.



Examination of witnesses

Witnesses: Dr Geeta Kumar, Dr Michael Mulholland and Professor Sue Carr.

Q70 **Chair:** Can I welcome our second panel for this morning's session on women's reproductive health, Professor Sue Carr, Dr Geeta Kumar and Dr Michael Mulholland? I am going to pose this question to Michael. We have heard from previous witnesses that it can take multiple visits to GPs, sometimes over many years, for a woman to even have her pain acknowledged. What can we do better?

Dr Mulholland: Thank you for the conversation, because it is really important that we recognise that women are not always being heard when they come to a GP the first time. From the first point someone comes to me with pain, bleeding or whatever the issue is, we should be hearing that, listening to the woman's experience and starting from that point.

In general practice, we work in quite a different model to secondary care. We start with the symptoms. We should be acknowledging those symptoms, dealing with them, and starting to build them into patterns that we recognise. Some of those are things that we will be able to manage in primary care. Some of them we will need to have more information about with different tests or history checking as time goes on, but we should not be leaving people feeling that they have not been heard. Some things will take time, particularly if we need a referrals process that goes on to secondary care, but the decision on that should be taken with the woman as they go through their time.

As was said in the previous panel, what a woman might want may vary depending on the time she has the symptoms in her life. If fertility is the issue, it may be a very quick referral to secondary care to investigate whether something is abnormal. If it is someone much younger, they may decide that they do not want to go through a procedure like a laparoscopy at that stage in their career or their life, but they want to have management of the symptoms, whether it is pain, bleeding or whatever it is. It will vary from woman to woman, but, in initial consultations, we should be able to listen and give due credence to that, and then act as the woman needs it.

The caveat to that is that general practice is so pressured at the moment. The drive for access is so strong. We know that, since the pandemic started, we have had a 10% increase in consultations, with a 7% increase in patients registered with GPs, at the same time as there has been a decrease in the full-time equivalent GP numbers. The pressure is there, so we know that people are not getting the time, the ease of consultation or the ease of access to us to allow that period of time in which they can be seen again and followed up within quite a short space. Sometimes things are taking longer.

Q71 **Chair:** If we were to use the evidence of Vicky Pattison and Naga



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Munchetty, Naga's symptoms have been enduring for 32 years. That is not the pandemic causing pressures.

Dr Mulholland: No, and those are symptoms that we should be listening to and dealing with as they present. They should not be waiting. We should not be dismissing things. As was referred to before, education on the reproductive health of women needs to start right the way from schools, so women recognise early that things are abnormal. GPs should also be recognising what a normal period or an abnormal story is. That should be happening right from the start. We recognise that, and we teach GPs in consultation to listen to the ideas, concerns and expectations of the patient. That is part of our model of consultation, and that is what should be happening as someone approaches their GP.

Q72 **Chair:** Geeta, turning to exactly that point, why is there such an expectation on women that, when they present at their GP, they are already informed themselves that they are able to demand and articulate what their own problem is? Are we putting too much pressure on the patient?

Dr Kumar: It is a difficult question, but the simple answer is yes. I strongly believe that we have to empower our women and girls, and the public in general, to be more aware of their health conditions. On gynaecological health in particular, we know that there is a lack of awareness. It is our responsibility to make them more aware, but that does not take away the responsibility of the healthcare professional at all. It is about awareness so that they can present early.

We heard from the previous panel about the stigmatisation, and we know from various studies about the normalisation of symptoms. Sometimes, by the time they present to a healthcare professional, it can be quite late, and hence there is a role for women to play in being aware of it. Again, that responsibility, to a large extent, lies with us, but there is a bigger role for the healthcare professionals to listen, as Michael says. Unfortunately, not being actively listened to is a theme from various safety reports and inquiries that we have known, so we need to raise awareness that listening to the individual person in front of you and the impact that a particular symptom has on that particular woman is the most important thing. Efforts are being made towards that, but I am sure that there is significant scope for improvement on that.

Q73 **Chair:** We have heard a lot today about education. I am going to ask you the same question that I asked our previous panellists. Did the Royal College have any opportunity to feed into the Government's review of RSHE? We have heard how important it is to educate girls about what constitutes a normal period. Did anybody come to you asking for advice?

Dr Kumar: Not yet, but we would like to have an opportunity to do that.

Q74 **Chair:** What about the Royal College of GPs?

Dr Mulholland: Not that I am aware of, no.



Q75 **Chair:** Sue, can I ask you what role the GMC has in making sure that doctors are well equipped to accurately diagnose and treat women who present with symptoms of PCOS, adenomyosis or endometriosis?

Professor Carr: The GMC, as the regulator of doctors in the UK, sets the standards for education and training throughout undergraduate and postgraduate education. We also set the professional standards for doctors through “Good medical practice” and through the advice and guidance that we produce to support that.

Within all those standards for undergraduate and postgraduate education, it is embedded that doctors should listen to patients, working on communication skills, that they should not make assumptions about patients, and that we should work together in partnership with patients. That is a theme that runs all the way through a doctor’s education and through their lifelong practice, but clearly there are instances where women are not listened to.

Q76 **Chair:** I was going to say that, yes. It is a theme that runs through lifelong practice. How does it make the GMC feel when we have two women in front of us who say that the message they received loud and clear was “suck it up”?

Professor Carr: As a woman, a doctor and somebody who works for the GMC, that is awful to hear. The GMC sets the standards, but we recognise that there is work to do to implement those better. I can describe for you what we are doing in that respect.

In terms of the education, we work with other agencies to quality assure the education, to make sure that the standards are met in medical schools with our outcomes for graduates, and that they are met for the postgraduate curricula, working with the deaneries and the statutory education bodies. Then in later practice, we work with doctors and employers to embed the standards in practice.

We do that in a couple of ways. We have a GMC outreach team. They go out into organisations and talk about the professional standards. We run various workshops, but then the other way that we implement this from the GMC perspective is through appraisal and revalidation. Doctors have to have an annual appraisal where they demonstrate that they are meeting “Good medical practice”, and then every five years they have a revalidation to confirm that they remain on the register.

Despite saying all that, we recognise that there are instances where the standards are not met, and we have to work harder to get those standards met in respect of the communication skills, listening skills, and working in partnership with women. The new “Good medical practice” guidance has a particular focus on that, as does the shared decision-making guidance, which has come out—I cannot remember the exact date—in the last year or so.

Q77 **Chair:** All of us, as members of this Committee, will have had individual



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stories from our constituents. Kate referred to some earlier. Does the reappraisal and revalidation process specifically include any reference at all to women's sexual and reproductive health?

Professor Carr: No. It is with respect to the doctor's scope of practice.

Q78 **Chair:** If the doctor is a GP, 51% of their patients will be women.

Professor Carr: Then it would be part of their scope of practice. There is not a specific section, but there are sections in which a doctor has to make sure they are keeping up with their knowledge, skills and experience. If they are dealing with women's issues, they should be doing education in that respect, and they have to be able to demonstrate that they are working in partnership with patients. We have to do patient feedback exercises. We have to do colleague feedback exercises.

Q79 **Chair:** Do you have to do a patient feedback exercise with a female patient?

Professor Carr: It is not specified. It says, "With a variety of patients". I cannot remember the exact wording. I am thinking of when I do mine as a consultant. It says that you have to use a diverse range of patients, so that would include women.

Q80 **Chair:** Should there be more? In the appraisal and revalidation process, should there be something specifically? We have heard, on a range of issues, that women are being ignored, and that women are feeling that their conditions are less important. "It is benign. It is just a bit of pain". Should there be something specific?

Professor Carr: Most of the guidance the GMC produces does not identify women as a group. It talks about the population of people and thinks about diversity within that. When you have that situation, there can be a tendency to have a male health bias. That is something that we recognise. People have recognised that and are considering that, because there can be that health bias. I certainly recall, during my own training, that the opportunities to engage in female health issues were quite opportunistic, so there are a couple of things there that we need to consider.

Q81 **Chair:** That's not good enough, is it? "There are a couple of things that we need to consider". I'm going to be really rude now, Sue, and I do not mean to. How long ago did you do your training?

Professor Carr: We are training all our lives, but if you mean my undergraduate training, I did it 40 years ago.

Q82 **Chair:** Is it okay that the GMC is still considering that it now understands that there is a male bias? It is having a bit of a think about it, but does not appear to be doing anything.

Professor Carr: The outcomes for graduates that we are talking about were produced in 2018, so they are not outcomes that were produced at the time of my training. These are quite current outcomes, but the GMC



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recognises, as I say, the possibility of a male health bias, and recognises that we need to do more on implementing the standards in that respect.

Q83 Chair: The GMC recognises the possibility of a male health bias and that it needs to do more. Where is the action plan?

Professor Carr: The action plan is that we are reviewing our standards, including outcomes for graduates, in the next few years. They will be reviewed. Maybe “recognise” is not the right word to use. People know that we need to review these issues when the guidance is reviewed.

Q84 Chair: We heard from previous witnesses that it is not easy to diagnose these conditions, but how could diagnosis be better, quicker and, to be quite frank, less difficult for female patients?

Dr Mulholland: We have women present to us with symptoms, and we treat them. We know that for many of the symptoms of menstrual health and dysmenorrhea, such as pain or heavy bleeding, one of the treatments that we can do from general practice is using hormonal contraception—the pill—to reduce the pain and reduce the bleeding.

What we need to do better is to have that shared decision-making process that goes on. In the past, possibly in my training, you were told that this was a helpful thing for heavy bleeding or periods. We were not as focused back then on shared decision-making. Over the past decade or two, we have got much better at discussing shared decision-making and the decision we have with the patient, which also is informing the patient or the woman who comes to us about the reasons we are doing things.

We have been very good at hearing what the patient’s ideas, concerns and expectations are. We do not often share as many of our own ideas and concerns, which may say, “I will treat you for the heavy period, but it is not just for the symptoms of this. The reasons you might have this could be because of endometriosis, and we will take steps to try to both diagnose those and help your symptoms as we go forward”.

When we reach a point where there is a decision to be made about whether this could go to a hospital specialist, or whether you want to continue the expectant management in general practice that the European guidelines for endometriosis still say are appropriate, we then need to share that uncertainty and that decision-making point with patients so that they have a choice, and they make the decisions with support from a GP with the knowledge base to make the right choice for them at that stage in life.

The time bit may still be there, but we would hope that the time is because it suits the woman’s life choice and her gynaecological history at that point rather than because a doctor has not said, “It is time to do it” or we have dismissed anything. The pain should be managed as needed. We should not dismiss pain. I have heard many times, “I just have heavy periods and painful periods like my mum did, but she said, ‘Just get on’”. That culture needs to change. We cannot treat people based on historical



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events. We need to treat people for the problems that are presented to us now.

We know there is often something behind it. It could be endometriosis; it could be something else. We need to take those symptoms not just as, "This happens in my family", but as something that we manage expectantly as we would any other condition at the time.

Q85 Chair: Geeta, it is the same question to you. How can we make women's experiences better?

Dr Kumar: First and foremost, as we talked about, is listening. That is where the good history-taking comes in. Certainly, as a practising clinician, for me it is about taking a very detailed history on the symptoms. That might be pain, because pain could be a non-specific symptom, but certainly in relation to periods, or sex, the impact that symptom has on the woman's quality of life is absolutely vital.

There should be evidence-based, clear guidelines and pathways, integrated from primary care to secondary care and to tertiary care. In my own practice, I very much like going through the guidelines and discussing that openly with the patient in front of me. "This is where you are. These are your symptoms from what you have told me, and hence this is the kind of pathway that we would like to follow". That would therefore be informed discussion about the choice of options that are available for them.

Q86 Chair: You may have noticed some frantic Googling going on over here. When we had Naga Munchetty in front of us, she was talking about having been on the Depo long-acting contraception. Because she was in her early 40s, she was taken off it because of concerns about osteoporosis.

I am not going to sit here and rewrite NICE guidelines; do not fret on that score, but what was very obvious was that she felt that she was not allowed to be engaged in a conversation about the possible risks and benefits of the Depo, which had worked for her adenomyosis. I am almost at the point where I can pronounce that. She just felt that she was told, "You are in your early 40s. Forget it. You cannot take extra calcium supplements. You cannot decide to make a judgment about the risk yourself", which obviously left her feeling absolutely desperate. How can we make sure that those conversations around treatment feel more inclusive?

Dr Kumar: Absolutely, that is the key. That is what we want as the Royal College in terms of education for our members and fellows. There is no right treatment option for everything. One size does not fit all. That is the information that is cascaded.

Personally, speaking from my own experience, I would never be saying, "This option is absolutely not available for you". Everything comes with benefits and risks. Yes, long-term continuation of Depo-Provera has a



known risk of osteoporosis, but these are the other treatment options, and the woman must have the choice to weigh up the options and to decide which is best for her. One may be willing to take some benefits for some potential risk, and there are ways of monitoring that risk.

It is all about having that detailed discussion with the available information that we have on the pros and cons of each action. I certainly, in my 30-plus years of practice, cannot recall saying, "This option is absolutely not available for you". It is about cascading that information, and that is the kind of education that is important for us to go forward.

Q87 Kirsten Oswald: I am interested in what you think the challenges and barriers are to treating the conditions that we have thought about, and how access to the right treatment first time can be improved. I am thinking about things like postcode lotteries, women's health hubs and so on. Geeta, are you able to give me your thoughts on that?

Dr Kumar: Yes, there is no second fact about postcode lottery. There is a huge amount of variation, and not just within England but across our devolved nations as well, depending upon where we live. Certainly, as someone practising as a clinician in Wales, having moved from the north-west to Wales, I can see the difference even between those two regions, and we know that there are huge disparities in that. We definitely call for a national level of discussion on that to tackle those variations.

Dr Mulholland: From the primary care perspective, we train our GPs in the curriculum. The curriculum has women's health and gynaecology as large topic guides in it. Every trainee who comes out and gets their certificate in training is expected to be able to manage these conditions. The factual knowledge and the skills to do it will all have been examined.

We need to then make sure that the guidelines that people follow are up to date and relevant. It was described earlier that there was some PCOS guidance that may or may not be redone by NICE. We need that guidance there. The clinical knowledge summaries in general practice are key to how we practise these days and how we look up what we are meant to do. We train our trainees and increasingly, with non-GPs in primary care, AHPs of different types, we expect them to be able to follow the same guidance so we know what we are doing on an evidence basis.

Then the next step is often the hard one where we need to get gynaecological expertise, whether it is through an intermediate care service, a secondary care service or a women's health hub in an area. There is some hope if it is designed around the community and the context of that area. They cannot be the same everywhere, because some people live in cities and some live in very rural populations. Then we would be able to access that next bit of investigation where a hysteroscopy might be needed, or a vaginal or pelvic ultrasound, to diagnose some of these conditions.



That is often a gap that we find is difficult to access. As a college, we would want to see that diagnostic space closer. We feel that, if primary care or general practice is well funded, GPs have the skills to do an awful lot of those steps and to organise the investigations before secondary care referral is needed, which is often to do the treatment that is more complicated if it is beyond what a GP does, or for surgical procedure, to diagnose.

Q88 Kirsten Oswald: Women are reporting that their treatment can often be painful. They are not offered anaesthesia, unlike the situation that a man might face if he was having a procedure. Why are women not offered more pain relief? To what extent do you think it is recognised by doctors that women experience pain differently to men?

Dr Mulholland: I do not think women should be experiencing pain during procedures. Whoever is doing the procedure should be trained in that, in terms of the analgesia or anaesthesia required, or whatever it is. We should not be expecting people to have pain during a procedure.

When we teach even simple examination, if pain is something that a patient is experiencing as you examine them, that is not the way you should be examining. We need to make sure that the people who are doing more complicated procedures, such as inserting coils, which not everybody does, have their certificates of competence and understand, within that, that they should be offering pain relief at the time and how to make sure that a woman does not go through any pain during those procedures or that it is minimised to whatever the limit is.

Once you reach the secondary care setting, things are done differently. There is more opportunity for anaesthesia and stronger pain relief than we have in primary care, and we should recognise when a procedure should be done and in which setting. Whatever she is going through, it should not be painful.

Dr Kumar: This is very close to my heart, so I can go on and on. As a doctor doing the outpatient procedures and as a patient on the other side as well, I cannot speak more about the distress that I experience hearing of the traumatic experiences that some women describe. I absolutely do not think that anyone should be going through such experiences.

It is true that pain during the gynaecological intervention procedures, whether it is hysteroscopy, inserting a coil or colposcopy, is often difficult to predict. That is true, but a lot is to do with the information provided and the discussion that takes place prior to even reaching the stage of the procedure, and making sure that the options are available, if the treatment options include no treatment and the various other options. Once the woman has decided, with support from the healthcare professional, we talk about the pros and cons of the procedure and which setting would be ideal for the woman. Again, the woman sat in front of me is the most important person there.



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From my experience, the majority of women would want to have it done as an outpatient, because there are other factors influencing their decision. Pain is extremely important, and I will come back to that. They may decide that outpatient is the setting, as long as they are informed and aware that there are other settings available. It may be a procedure that can be done under general or regional anaesthesia. Even in an outpatient setting there could be different forms of pain relief that they can take beforehand, apart from oral pain relief, such as the local anaesthetic gel and local anaesthetic injection forms that are available.

It is true that there is still a lot more work and more research to be done on the pain relief options, but, based on whatever information we have, it has to be that informed chat about what the woman wants, and it does not stop there. To me, if I am doing the procedure and the woman is very keen, and there are mitigating factors from the history, I will probably be able to know, to some extent, that, for that particular woman, this may not be the best procedure based on her previous experience of a cervical smear, childbirth or anything.

It is our duty as healthcare professionals to guide them—to say that this may not be ideal, but if they still wish to go ahead, which some women do, then absolutely it is about staying in touch with the whole team over there so that they have the confidence that they can say, “Stop the procedure”. That is the one advantage of outpatient, and it is about listening to that.

There is absolutely no point in time where I would continue the procedure. The woman might say, “No, carry on”, but, if it does not feel right to carry on, that is not right. Stop, reassess and explain the choices that are available to go ahead. There is absolutely no doubt that there is a lot more research to be done on both the woman’s experiences and the types of pain relief options available. That is one area that needs looking into.

Professor Carr: From the GMC perspective, as we have heard from Michael and Geeta, making a shared decision about care with the patient is the most important. As Geeta said, it is about making sure the person understands that there is an option for a different setting or a different type of treatment, so the woman can make an informed decision.

Coming to the point that you asked about pain, within the “Good medical practice” guidance and within the general duties of a doctor, good care, good communication and alleviating pain is all covered as a general duty. We should not have patients in pain. We should alleviate distress as a fundamental duty of a doctor.

Q89 **Kim Johnson:** Good morning, panel. Michael, you have just touched on issues around training and biases. Would you say there is sufficient training for doctors on women’s health issues, and do you think that women’s health should be integral to medical training and not seen as a specialist add-on, the way it is at the moment?



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Dr Mulholland: Yes, I can speak from the general practice perspective where women's health is seen as integral to our curriculum. Some 60% of our trainees are women. More than 50% of GPs are women. Probably over 60% of our patients are women, so women's health is integral to everything that we do. We do not see it as an add-on, and so we make sure that, before a trainee gets their certificate of specialist training completed, women's health is a core part of what they have been assessed on and have learned about. It then continues throughout your career.

It was mentioned earlier that the appraisal and revalidation looks at your scope of practice, so, for every GP, there is an awareness that women's health, and having a knowledge of that and an ability to work appropriately in that field, is part of what we do. In general practice, it is part of the whole person. We look at birth to end of life, and that is for women as well. We just see everybody as part of that holistic care.

Q90 **Kim Johnson:** Thanks, Michael, but we know and we have heard evidence, both from the first panel and from Naga and Vicky, in terms of the multiple visits to their GPs before they were actually diagnosed. Would you say that the training at the moment is sufficient in providing that level of understanding?

Dr Mulholland: In general practice, it is the shortest training in any speciality and yet the broadest speciality, so the amount that GPs will know about everything is obviously less than a hospital specialist in any area. We know from the GMC's assessment of our curriculum and specialist training that we have an appropriate training for somebody going into the speciality. It depends on the patients you see more of. Some GPs will see more women than men. Some will see more palliative care than others.

We need to make sure that we are up to date in those skills as we go through it as well, and so there are lots of training opportunities. As a college, we have lots of continuing professional development that we produce. Anne referred to it earlier. She had produced a lot of it for us over the years. GPs can access that extra education that they might need to maintain their knowledge, build on their knowledge or fill gaps in it.

We are also aware from our recent surveys that over 60% of GPs do not feel they have time to adequately give themselves the professional development training they need in a year, because the demands of access are so much now. As a college, we would feel that more protected time for general practice education for those in post, not just those in training, is a key ask for every part of it, but particularly for women's health.

Q91 **Kim Johnson:** We know at the moment that there is a shortage of GPs, and an issue in terms of getting doctors into the profession. Having access to a GP appointment is very difficult at the moment as well. The Government have talked about developing increased numbers of medical



schools. Would you say that prioritising women's health is something that should be included in those medical schools going forward?

Dr Mulholland: Definitely, women's health should be taught much more as an integrated, whole-of-life approach now compared with when I was at medical school, where it was an eight-week block, or a 16-week block in my case, where you learned about obstetrics, in the same way as I might have learned about haematology or some more specialised medical condition.

Now it should be that we look at a whole-of-life training for everybody. Women's health obviously covers more than 50% of the population. We should be looking at women as a life group, as we describe them in our curriculum, from birth to death, and then all the things that can affect people, not just reproductive health but also the mental health issues and medical things that happen to women as well as men in those parts. It is about making sure that the reproductive side is covered.

Q92 **Kim Johnson:** Geeta and Sue, would you like to contribute on those questions about training and biases?

Dr Kumar: For us, it is all about women's health training, but I cannot agree more that it must be a lot more integral to the medical curriculum and should not be left to choice. As Michael mentions, it is about lifelong learning. There are GPs who may not have had that much experience, but it is about providing time for them to attend the courses.

We recently did a menopause conference. As we were speaking about earlier, that was attended by women, primary care, secondary care, sexual health—everybody. It is also about multidisciplinary teaching. Women may present to a surgeon with pain, which may be related to a gynaecological problem, so more integrated education among specialities is key.

Professor Carr: There needs to be a greater awareness of women's health issues, as you describe. As we have talked about, in undergraduate medical education the medical schools themselves set the syllabus for the course. The GMC sets the standards, and we expect within that syllabus that women's health issues will be covered.

The other thing about undergraduate education is that, from next year, there will be a new medical licensing assessment introduced for all doctors working in the UK. That exam has a content map, which specifically identifies some women's health issues for testing in the exam, so that will bring more of a focus on to women's health issues in undergraduate medical education.

In postgraduate medical education, as we have heard from Michael and Geeta, the GMC sets the standards for education and the colleges write the curriculum. In addition to the speciality content of the curriculum, the GMC has standards called generic professional capabilities, and they are the standards around professionalism and dealing with different groups of



patients. We ensure that those standards are woven throughout the training. It is in that way that issues around women's health are covered, but we would believe too that education and training needs to be more explicit in preparing doctors to deal with women's health issues. The MLA is the most recent introduction we are doing towards supporting that.

Q93 Kim Johnson: Are you confident that new doctors are receiving sufficient levels of training in women's healthcare at this moment in time?

Professor Carr: In terms of medical students, we have heard that placements tend to be of short length, and sometimes that experience can be quite opportunistic. We believe that the new medical licensing exam—MLA—will drive the medical school curricula and syllabi to include more women's health issues, so that, at the point that doctors qualify, they will have more competence in women's health issues.

In terms of postgraduate education, we approved the curricula that the colleges produce, and they have those competencies articulated, but we clearly need to work more with organisations and other stakeholders to make sure those standards are met.

Q94 Kim Johnson: Geeta, women's health conditions are often considered as benign and not life-threatening, and often deprioritised, so what needs to happen to change this mindset?

Dr Kumar: We heard from the earlier panel about "benign" and how it can misconstrue the actual condition. From my years of experience, on any theatre list that is stood down, benign tends to be stood down for gynaecology very quickly. We are working and supporting Endometriosis UK in trying to educate people about not using that terminology.

It is about assessing the impact of the particular diagnosis that it has. It may be fibroids, but that would have a very different impact on a particular woman, depending upon the size and various other things. Similarly, endometriosis could be mild endometriosis, which does not impact the woman in the same way as severe endometriosis. It should be an impact assessment on the quality of life rather than the terminology of "benign" or anything. There is more work being done on this.

If I could go back to the question that Sue was asked about education, again, I am declaring a conflict of interest as the mum of a GP trainee. My daughter grew up here and studied here. We have to boast about our education. I know there are definitely things that can be done to improve, but students who are coming up now are better aware of women's reproductive issues, maybe because of everything that we are doing as the Government and the public.

Let us not forget that a significant proportion of our medical healthcare professionals are international medical graduates from overseas, and there is a lot more that can or should be done to improve their awareness, knowledge and cultural beliefs about women's health issues.



Q95 **Kim Johnson:** Does that take into account the issues that we have raised earlier about pain management and some of those cultural issues, particularly when we refer to black women having greater pain thresholds? What needs to be done to change those myths and misinformation about women?

Professor Carr: Can I just add something to what Geeta said? The medical licensing examination will also replace the PLAB exam that international medical graduates take when they come to the UK, so we will have some assurance that doctors who become registered to work in the UK will also have passed that test that includes specific items on women's health.

Q96 **Kim Johnson:** Going back to that question I just mentioned about women's health and the difference between how women and men are treated in terms of pain thresholds, we talked about pain and pain management in terms of women and their medical health conditions. For some women, particularly black women, there is a myth and misinformation that they have greater pain thresholds than men, and women are treated very differently. What needs to happen in terms of the training that medical professionals go through to address those issues and concerns?

Dr Kumar: First, as you were saying, it is about raising the awareness that there is a difference in ethnic variations and racial differences, which must be understood by the healthcare professional and managed accordingly. It is all about education and, again, more funding into research on that. We know that women from different races are underrepresented in research settings as well. We have to work with NIHR on promoting their inclusion in the various research into women's health topics, which are definitely under-researched.

Dr Mulholland: In general practice, we are very aware that there may have been biases in curricula and other things. We are currently going through a process in our college of decolonising the curriculum that we had, and it is a two-year process that I set up in a previous role. We are now much more mindful, and our younger trainees and doctors coming through are much more aware of the biases that they might hold, or that others might have held in the past, and are prepared to challenge these.

As a profession, it feels as though we are starting to address the issue of assuming what someone might feel or thinking that we understand their experience without actually asking, listening and then working with them to understand that better. We are very much focused on the shared decision-making and shared understanding, without making assumptions about what any one population might believe.

Q97 **Kim Johnson:** Sue, in terms of women's confidence in doctors, would you say that the GMC needs to investigate more where women are in terms of the confidence they have in how doctors are treating women's health issues?



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Professor Carr: We know that women make more complaints to the GMC than men, which suggests that they are not having good experiences. We need to listen to women more. The GMC is quite active in engaging with various patient forums and patient groups. Every year they have patient days with patient engagement, so the GMC is very much listening to women and wants to do more to improve women's experiences of healthcare.

Women's experience of healthcare is a systemwide issue as well. Yes, it is about doctors, but there are issues across the system that need to be addressed, so the GMC is working with other regulators and partners in the system towards improving women's experiences of healthcare.

Q98 **Kim Johnson:** Would you say that the GMC is doing a good job in terms of investigating these complaints and issues?

Professor Carr: Yes, every complaint the GMC receives is investigated. There is a set process. Irrespective of who the complaint came from, it goes through a set investigation process, but we know that there are more women. I have the numbers if you want.

Q99 **Chair:** Could you let us have that?

Professor Carr: We will forward that in writing to you.

Q100 **Chair:** Do you know whether the proportion of women complaining is going up or down?

Professor Carr: I can look at that.

Q101 **Chair:** It would be interesting to know if it was headed in one direction or the other and, if it was not going down, what you were doing to address the fundamental problem that more women are complaining.

I am going to go back to what Michael said: 60% of patients are women. Presumably, that means 60% of appointments are women, and therefore it could well be that you would expect a disparity, but it would be very interesting to learn that the GMC has not just recognised an issue and done nothing about it.

Professor Carr: I do not have that to hand. I am sorry. We can send that.

Chair: Perhaps you could provide that afterwards.

Professor Carr: Yes, I will make a note of that.

Q102 **Kim Johnson:** My final question is about training. Do we need more research and funding for women's health conditions and, if so, what specific areas should be prioritised at this moment in time? What difference would research into non-invasive testing make, and how easy would that research be?

Dr Kumar: Yes, absolutely, we need more funding. We know that currently less than 2.5% of the publicly funded research is dedicated



towards women's health. There is optimism in the air because I am aware that NIHR is opening a new policy research unit, which will be focusing on reproductive health, so that is positive.

In terms of what areas to focus upon, this is partly my personal view, but it is largely about women's experiences with medications. I heard Naga and Vicky mentioning the treatment options. Hormonal contraception remains key in the management of problems, just because the problems are largely related to hormones, but there is so much more that can be done in terms of finding out more medications and non-interventional strategies, as you mentioned.

I know that there is research, which I am taking part in as well, on early diagnosis of endometriosis. At the moment, we know that, on average, it can take up to eight to nine years to reach a diagnosis, partly due to various causes that we are aware of, but partly also due to the lack of any specific method of diagnosis apart from laparoscopy, which is not always the safest. Some women may not want to go through it, so more research into diagnostic techniques and pain relief options would be key areas.

Dr Mulholland: From our perspective, more research is definitely important. As we talked about, the difficulty in general practice is always the early diagnosis. In every disease we look at, it is always a challenge for the GP to pick up a non-specific symptom, which could be due to lots of things, and narrow it down to one, particularly for reproductive health where the symptoms are very similar for a number of conditions.

It would be very helpful early on in a woman's reproductive lifecycle to be able to narrow it down and say, "These are the real options you have based on the disease we think you have", rather than saying, "These are the treatment options we have based on the symptoms you have". We would then be able to have a very different, nuanced conversation about what someone wanted when they were thinking about their fertility and how it was impacting their life. It might be different for a teenager with endometriosis diagnosed to a woman in her 20s or 30s with a career or looking at children. All those things will come into it. The more we can get around that on the early diagnosis, the better for general practice.

Professor Carr: I can tell you about some of the things that we are doing at the GMC with respect to research. When we think about medical education and training, it is really important that doctors experience research from very early in their careers. That is inherent in the standards for undergraduate training and in the curricula for postgraduate training. We know that there are quite a lot of barriers to doctors getting that experience in research. If they do not get that early research, they do not get that curiosity and understanding of research, and then they are less likely to engage in it later in their careers.

Q103 **Kim Johnson:** What would you identify as those barriers to accessing that early on?



Professor Carr: It is interesting that there are barriers for certain groups of doctors, particularly women, ethnic doctors and international medical graduates. Doctors who work in rural areas are less likely to get opportunities to engage in research. Therefore, their patients get less opportunity to engage in research too. We heard from Michael about time in doctors' job plans. Under the current pressures in the NHS, at the moment the time that doctors have to engage in research, education and professional development is being squashed. People need time to engage in those professional activities like research, so the GMC has published some principles about research, which are on our website. We engage with lots of stakeholders and we are making good progress with that.

In the new "Good medical practice" guidance, which is published now but comes into effect in January 2024, there is a new duty that, if there are opportunities to engage in research, doctors should engage in it, and they should also offer their patients the opportunity to engage in research. That has been welcomed.

Q104 **Kim Johnson:** Is that a recent thing?

Professor Carr: It was published in August, but it comes into effect in January, so that is a recent thing, and that has been welcomed by the research organisations that we are working with closely.

A final point that is important about research, in a generic sense, is that our principles and standards outline that all doctors should engage in research throughout their careers, but we know that some doctors become clinical academic doctors. We need people to be able to do that, and we know there are far fewer women who stay in that pathway. They may enter the pathway, but there is an attrition rate. These things impact research into women's health issues and women researchers.

Dr Kumar: At the RCOG, we are working with the James Lind Alliance on partnerships involving our women's network to help prioritise the topics for research as well, and that is key.

Q105 **Chair:** Sue, you just said that fewer women were staying in research pathways. Is the GMC doing anything to support women to stay in research pathways?

Professor Carr: There are a lot of people involved in research, and the GMC has a very particular role. In terms of our role around the standards, as you know, we have put it in "Good medical practice" that there is now a duty around engaging in research.

Q106 **Chair:** You put a duty on female doctors to engage in research.

Professor Carr: All doctors, not just female.

Q107 **Chair:** That will include the women who you know are not sticking in the research pathways.



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Professor Carr: If it is in the curriculum that women should engage in research in their training, and then in “Good medical practice” that they should in their practice, that empowers women to demand that opportunity then to have those experiences, and it allows them to get into research. If there is a woman in a district general hospital and she cannot get access to research, she can say, “I need to do this. It is a requirement of ‘Good medical practice’”. It empowers women to participate in research. It gives them more opportunities to speak up about it.

The clinical academic training pathway is a separate thing that people opt to do, and so we are working closely with other organisations to address some of the challenges that we can from the GMC side. The national training survey data identified that there were fewer women in clinical academic training. Other organisations, such as the Medical Schools Council, have detailed data about the trajectory of women in clinical academic training. That would not be the remit of the GMC.

Q108 **Chair:** Finally, while I have you here, we heard a couple of weeks ago from *Surviving in Scrubs* and the Royal College of Surgeons about sexual harassment of GPs, surgeons, nurses and people working across the profession. Why did it take the GMC until August of this year to explicitly include a zero-tolerance approach to sexual harassment?

Professor Carr: I cannot tell you why it took until August, but it certainly is inherent in the new “Good medical practice” standards. There is a specific statement about not tolerating sexual harassment, speaking up and improving workplace cultures. We have been engaging in different activities to stop sexual harassment.

The GMC is very passionate about this. As I say, I have worked in the NHS for 40 years. It is a topic fairly close to my heart too. It is not acceptable. It needs to be stopped, and the GMC has made a strong statement in the “Good medical practice” guidance, and also in the clinical placement guidance for medical students, to say that medical students must not tolerate sexual harassment either, because it is at early careers too.

Chair: Thank you. It was an unfair question that was off the topic, but I appreciate you answering it.

Can I thank all the witnesses for your evidence today? It has been hugely appreciated. If there is anything you wish to add in writing, please do so after the meeting. In particular, some of those stats from you, Sue, would be very useful.