# HYSTERICAL HEALTH

## Unpicking the cultural beliefs that shape women's healthcare

GAME CHANGERS

**"I think sometimes perhaps myself and definitely colleagues would be more likely to believe a man if they said they had pain…in general, people are more reluctant to believe women when they say they have got pain"**

General surgeon, female





**This quote from a surgeon currently practising in the UK may reflect a wider cultural pattern influencing the way women are perceived by healthcare professionals (HCPs) and therefore their experiences of healthcare.**

This paper explores how culturally embedded beliefs about gender, as well as gender and ethnicity, might be shaping healthcare practices and therefore their experiences of healthcare in the UK.

To place this in a broader context, whilst women in the UK have a longer life expectancy than men, they spend comparatively more of their lives in poor health[1]. Analysis carried out by the men's health company Manual[2] in 2021 shows the UK gender health gap to be the worst amongst G20 countries. And with Black women four times more likely than White Women to die in childbirth in the UK,[3] experiences of healthcare can be exacerbated when gender and ethnicity intersect.

Whilst the focus of this paper is to help uncover how cultural patterns and beliefs may be affecting women, it is important to acknowledge that those in other social groups may also experience challenges. As Professor Jane Ussher, Western Sydney University, told us in an interview, trans and non-binary experiences also need further unpicking – as well as men's experiences. In our survey of UK adults who had spoken to a doctor, while 32% of women felt they had not been fully listened to in their last doctor's appointment, this also applied to 39% of men - demonstrating wider issues than gender alone.

These issues, along with a standalone focus on ethnicity, race and health deserve a degree of focus and urgency to which this report, with its broader remit on gender, cannot do justice.

When Professor of Epidemiology Ian Roberts, Professor Tim Nutbeam and their colleagues discovered that the medication Tranexamic acid (TXA), once used for heavy menstrual periods, could also be used to help prevent bleeding in trauma victims, they were thrilled:

"It was the only proven treatment for injuries that involved heavy blood loss, such as car crashes, shootings, or stabbings."

It cut the risk of bleeding to death by 30%. Given the dramatic public health benefits it carried, they initially thought this drug would have been distributed as widely as possible. However, when they investigated, they were surprised to find that men were much more likely to be given the drug than women. They investigated further and found the drug worked the same way in both sexes.[4] So why was there a difference in prescribing?

Ian Roberts explained his theory in an interview with us:

"When I go to a trauma meeting, I ask the emergency physicians and paramedics to imagine a trauma patient. They all see a man lying on the road with a motorcycle helmet and leather jacket. What they don't see is an older woman who's had a fall in the home. What they see as a trauma patient is gendered."

The differential treatment of trauma victims is hardly an isolated phenomenon. Additional analyses carried out on research conducted by the University of Leeds, using the UK national heart attack register MINAP[5], has shown that women are 50% more likely to receive an incorrect initial diagnosis following a heart attack, with people initially misdiagnosed having a 70% higher risk of mortality.[6]

These stories and statistics beg the questions: what are the beliefs around gender that influence healthcare professionals' (HCPs') behaviours and what needs to change to potentially level the playing field?

To help answer these questions, Ipsos has brought together findings from a programme of research including (more detail in the technical notes at the end of the document):

- Quantitative survey of 250 healthcare professionals in the UK who hold treatment decision responsibilities from a panel of HCPs who chose to take part
- A representative online survey of 978 UK adults aged 18-75 who have spoken with a doctor
- Qualitative interviews with 12 healthcare professionals in the UK who have treated a minimum number of women over the last year, either for specific issues or overall health and wellness

- Ethnographic research with 8 women ranging from 20-80 years old, selected to demonstrate specific experience of health services
- Expert interviews with 8 experts who research and write about health
  - Angela Saini, Science Journalist and Author
  - Ian Roberts, Professor of Epidemiology at the London School of Hygiene and Tropical Medicine
  - Joy Francis, Co-founder of Words of Colour, Digital Women UK and the award-winning Synergi Collaborative Centre
  - Stephanie De Giorgio, portfolio GP and women's health specialist
  - Elinor Cleghorn, Historian and Author
  - Kate Jarman, Director of Corporate Affairs at Milton Keynes University Hospital
  - Sarah Richardson, Director of Harvard GenderSci Lab
  - Professor Jane Ussher, Professor, Western Sydney University

This report will help show how an engrained legacy of cultural assumptions about how what it means to be a woman, in particular a woman from an ethnic minority background, may contribute to underdiagnosis and undertreatment, and how these beliefs are often so embedded that they may sometimes be difficult to see.

**A short history of women as 'other' to the male standard norm**

Despite the increased attention this issue has recently received, reports of the inferior treatment of women within the medical sphere is hardly 'new news'. As historian and author Elinor Cleghorn told us in an interview, there is a long legacy of dismissal around women's pain and health issues:

> *"When it comes to women and their bodies, we still tend to link many symptoms women experience back to their reproductive organs, or if not reproductive organs, then the general state of 'being female'."*

As Elinor Cleghorn writes in her book, 'Unwell Women', one of the

most alarming examples of women's healthcare is from the 1940s and '50s where an estimated 40,000-50,000 lobotomies (using an ice pick or drilling into the brain and severing the pre-frontal cortex) took place in the US, and around 17,000 in the UK. At least 75% of these lobotomy patients were estimated to be women.[7]

As Elinor Cleghorn writes:

> *"In an era where a mentally healthy woman was a serene housewife and mother, almost any behaviour or emotion that disrupted domestic harmony could be interpreted as justification for a lobotomy."*

It was sometimes used as a tool to 'treat' women who expressed pain, distress, or unhappiness, as Cleghorn suggests, making them more palatable and 'feminine'.

The notion that women and their bodies are somehow 'other' can be traced back to Plato and Hippocrates, who suggested that the womb travelled around the body, causing emotional and physical illnesses. In an interview with Ipsos, Professor of Women's Health Psychology, Jane Ussher, emphasises that these beliefs have set the context for deeply held cultural beliefs that can persist today, namely that women are beholden to their reproductive organs:

> *"The wandering womb became 'hysteria' in the 19th century and what we have in the 20th and 21st centuries is [that] we blame it on women's hormones, or we blame it on their neurotransmitters. But it's the same notion, the same discourse that positions the problem within the women, as 'other'."*

This cultural belief of the male body as 'the norm' and the female body as 'other' has also been borne out in the legacy of women's exclusion from some clinical trials.[8] Historically, it was often assumed that women would have the same response as men to a particular drug, or that the expense of including women in clinical trials was too great to bear due to their fluctuating hormone levels[9], or too risky due to their childbearing potential.[10] These contrasting perspectives ultimately led to a lack of sex-specific analyses of drug efficacy and safety[11], helping to explain evidence that women experience adverse drug reactions nearly twice as often as men.[12,13]

As Stephanie De Giorgio, portfolio GP and women's health specialist, tells us in an interview:

> *"Textbooks always talk about a 70 kilogram man as the norm, and that's what drug doses are generally based on. Women are much more of an afterthought".*

The historic lack of women in clinical trials is being addressed today with more equal representation[14] and the problems caused by the 'male as default' model is now recognised by the UK government in their Women's Health Strategy for England.[15]

**Are women unreliable witnesses?**

We can see how historical perspectives on women's bodies have perhaps set the stage for some of the deep-seated cultural assumptions we see today. One example of this is that perhaps women are not reliable witnesses of their own experiences. One of the surgeons we interviewed gave us her candid views of what she had experienced within the medical system:

> *"I think a lot of the time women are written off a bit, their pain or their symptoms are dismissed and men are more likely to be believed and investigated."*
> *General Surgeon, female*

In the case of endometriosis (a condition where tissue similar





**"Women's confidence in healthcare is undermined if they do not consider their needs sufficiently represented in medical science"**

# Figure 1: **HCPs' assessment of how well their colleagues understand different conditions**

| Conditions | Very well | Fairly well | Not very | Not at all | Don't know |
|---|---|---|---|---|---|
| **Endometriosis** | 8% | 40% | 41% | 8% | 4% |
| **Menopause** | 14% | 48% | 32% | 4% | 2% |
| **Premenstrual Tension** | 7% | 29% | 46% | 13% | 5% |
| **Benign Prostatic Hyperplasia (enlarged prostate)** | 32% | 43% | 11% | 1% | 12% |
| **Erectile dysfunction** | 21% | 43% | 20% | 5% | 11% |

***Question:*** *Thinking about the same conditions, in general, how well understood, or not, do you believe they are among your colleagues who are in a similar role in your speciality? Please think about all aspects of the condition, including the treatment and management of these patients. 5 out of 8 conditions shown – sex-agnostic conditions not shown.* ***Base:*** *250 HCPs in the UK surveyed online 28 September – 24 October 2022*

to the lining of the womb grows elsewhere, such as the ovaries and fallopian tubes)[16], reports of women's pain not being believed are well documented to be one of the factors that hinder diagnosis, with some women returning to their doctors multiple times before being referred to a specialist.[17] As reported in 2020 by an All Party Parliamentary Group, "those with endometriosis are waiting an average of 8 years for a diagnosis, despite over 58% visiting their GP 10 or more times with symptoms, 53% visiting A&E with symptoms, and 21% seeing doctors in hospital 10 or more times with symptoms".

During our ethnographic research, we spent time with Marie, a 46-year-old woman, who, when experiencing pelvic pain, worried that she might have a cyst, so went to the doctor:

> *"[The doctor] poked around my abdomen for a little while and asked me if I had any pain…and when he eventually poked on something sore and I said yes, he then said "cysts don't hurt so it must be stress"! And that was the end of it. As a woman, the view is that you are an inexplicable bundle of nerves or at the mercy of your hormones!"*

Marie was eventually diagnosed with endometriosis a few years later.

From our survey with HCPs (Figure 1 above) we found endometriosis was considered to be less understood by colleagues (48% "not very" or "not at all understood") than certain male-related conditions such as benign prostatic hyperplasia (12%), or erectile dysfunction (25%). Premenstrual tension was even less well understood (59%) and, while menopause was thought to be better understood than endometriosis or premenstrual tension, still 36% thought it was not very or not at all well understood amongst their colleagues. (Note that we asked HCPs about the understanding of their colleagues in a similar role to avoid social desirability impacting their assessments of their own understanding). Various interpretations of this data are possible: for example, there may be something particular about endometriosis, premenstrual tension or menopause that means they are not as well understood as some of the male-related conditions we asked about. But it does not seem unreasonable to consider that this might also be the result of widespread systemic shortcomings based on ideas around gender.

Marie's experience of feeling unheard or dismissed chimes with the experiences of one of our other ethnographic research participants, Lucie. Lucie has a painful autoimmune disease that affects her bone cartilage. When she felt worried about what the change in her nose shape signified and why it was happening, she was sent by her doctor to a plastic surgeon who told her that she was "a pretty woman" and that "there was no need to be so anxious… he told me to go home and enjoy your husband." As she explained:

> *"I went to see the doctor to work out what was happening – not to be questioned and told that I'm pretty or anxious. They just assumed I was making a fuss about my appearance. They didn't believe me."*

In our HCP survey, we asked about perceptions of the behaviours that men and women display in consultation, as shown in Figure 2 below. Women were considered far more likely than men to appear emotional when they experience a health issue (74% vs. 3% who believed men were more likely than women) and to come forward with mild symptoms (65% vs. 8% who think men are more likely to). Of these HCPs, 50% also thought women are more likely than men to appear anxious about their health, with only 9% believing men are more likely than women to appear anxious. While the healthcare professionals surveyed generally thought women and men are as likely as each other to need reassurance or to over-exaggerate their symptoms, women were seen as more likely to do so (44% thought women are more likely to need reassurance vs. 7% thinking men are more likely to, and 43% thought women over-exaggerate symptoms vs. 5% thinking men are more likely to). They were also seen as more likely to explain their symptoms clearly (39%, while just 14% thought men are more likely to explain their symptoms clearly).

The only behaviour men were considered more likely than women to display is only visiting a doctor when experiencing more severe symptoms (75% think men are more likely to do this vs. 8% who think women are more likely to).

There are, of course, a variety of possible interpretations of this, one of which is that women may be more likely to display some of these behaviours during consultations. But given the wider context, it is reasonable to ask whether cultural beliefs about women being emotional and exaggerating symptoms might be an obstacle to them being taken as seriously as they could be.

While the medical consequences of this are the subject of a much-needed debate, women's confidence in healthcare might also be

# Figure 2: **HCPs' surveyed perception of gender differences in how patients present themselves present themselves**

| Behaviours | Women more likely | Equal | Men more likely | Don't know |
|---|---|---|---|---|
| **Appear emotional when they experience a health issue** | 74% | 22% | 3% | 1% |
| **Come forward with mild symptoms they are experiencing** | 65% | 26% | 8% | 1% |
| **Appear anxious about their health** | 50% | 41% | 9% | 0% |
| **Need reassurance about their health** | 44% | 49% | 7% | 0% |
| **Over-exaggerate the symptoms they are experiencing** | 43% | 46% | 5% | 7% |
| **Explain their symptoms clearly to me** | 39% | 46% | 14% | 1% |
| **Only visit a doctor when experiencing more severe symptoms** | 8% | 16% | 75% | 1% |

***Question:*** *Typically, when in consultation on health matters or issues with your patients, are women or men more likely to display the behaviours listed below, or do they behave the same?* ***Base:*** *250 HCPs in the UK surveyed online 28 September – 24 October 2022*

undermined if they do not always consider themselves taken seriously.

One of the interesting patterns our survey with UK adults (aged 18-75) who have spoken with a doctor showed was that people (irrespective of gender) felt that female GPs have a better understanding of female health, as shown in Figure 3 below.

This perhaps reflects a certain level of perceived gendered expertise relating to these issues which, at the very least, merits further attention.

Another area for exploration that emerged from our quantitative research with the general public was to the question on whether people believe they are taken less seriously by doctors because of their gender. Whilst 17% of women agreed with this statement, believing they are taken less seriously, 21% of men also believe they are taken less seriously by doctors because of their gender. This suggests a need to understand whether this is an indication of a patient population who equally need to feel taken seriously, but we cannot rule out that women could be treated differently, but do not realise that they are.

**Are women just built for pain?**

As Elinor Cleghorn told us in an interview, one of the explanations for these gendered experiences might be a cultural belief that women's bodies are built to experience more pain than men's. As she explained, these beliefs are rooted in attitudes and beliefs that stem back centuries; they are:

> *“…a hangover from the wandering womb theory that because our bodies are universally and inherently meant to experience pain, to bleed, that very little care or attention needs to be paid to what our bodies do, because that is our natural state – to be unwell.”*

As one of the HCPs we interviewed as part of our qualitative research reported:

> *“Females have a different threshold to pain. The same situation or the same disease causes more pain in a man than a woman. This is because women are more used to pain, more used to dealing with it, whilst men are not used to it.”*
> *General Surgeon, male*

Kate Jarman, Director of Corporate Affairs at Milton Keynes University

## Figure 3: **UK adults' perceptions of male/female GPs' understanding of health matters when treating women**

| | Male GPs | | | | | Female GPs | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Perceived level of understanding** | **Very good** | **Fairly good** | **Fairly poor** | **Very poor** | **Don't know** | **Very good** | **Fairly good** | **Fairly poor** | **Very poor** | **Don't know** |
| **Menopause** | 12% | 35% | 23% | 10% | 20% | 28% | 42% | 10% | 4% | 16% |
| **Menstruation (periods)** | 13% | 36% | 24% | 7% | 20% | 34% | 39% | 9% | 4% | 15% |
| **Childbirth** | 14% | 42% | 20% | 6% | 18% | 33% | 41% | 8% | 3% | 16% |
| **Gynaecological issues** | 13% | 43% | 18% | 6% | 20% | 30% | 41% | 11% | 3% | 15% |
| **Breast cancer** | 20% | 45% | 12% | 5% | 18% | 30% | 44% | 9% | 3% | 14% |

***Question:*** *Typically, when in consultation on health matters or issues with your patients, are women or men more likely to display the behaviours listed below, or do they behave the same?* ***Base:*** *250 HCPs in the UK surveyed online 28 September – 24 October 2022*

## “This idea that women are in some way built to withstand more pain is also brought to life by the belief that women's threshold for pain increases after childbirth”

Hospital told us in an interview, that there is an expectation that women should just “get on with it” when they might be experiencing pain or need more emotional care. As she explains, this expectation is not the same for men. As she told us in an interview:

> *“I would propose that every woman or every person who has experienced periods, pregnancy, menopause have had their experiences minimised or dismissed in some way. Starting with periods we say it's just period pain, why are you complaining?”*

Jane, one of our ethnographic research participants who is in her 60s, told us about her experience of childbirth; she was instructed to slow down her pushing of a breech baby so medical students could be summoned to observe. This, she felt, was at the exclusion of her receiving the support she needed whilst in pain and feeling vulnerable – it was less about her experience, and more about her as a spectacle:

> *“It was quite humiliating as so many people came into the room. I wasn't asked. It wasn't about me. It was a woman giving a breech birth, let's have a look.”*

Stephanie De Giorgio, portfolio GP and women's health specialist points out that not only is there “a long list of things where women are expected just to ‘suck it up'” but that the very structure of our healthcare systems often fails to cater for women's needs or women's pain. As she told us in an interview:

> *“Even when we think about services that are for women, the idea that women might need somebody with them or the idea that if a woman needs to be admitted postnatally, there might not be room for her child, for example if a breastfeeding woman needs her appendix removed. There's no system easily for that to be done.”*

This idea that women are in some way built to withstand more pain is also brought to life by the belief that women's threshold for pain increases after childbirth. In our HCP survey, we found that 45% of HCPs surveyed agree that ‘Women's threshold for pain increases after childbirth', compared to just 15% disagreeing.

It is far worse for women from ethnic minority backgrounds.

Angela Saini, Science Journalist and Author, asserted in conversation that scientific research can be prone to overly attributing differences to biology rather than the social determinants of health, arguing that this needs discussion. Saini sets out a compelling case for understanding the biases that sometimes exist in scientific studies:

> *“We're taught that science is objective, that it doesn't matter what your background is, or how you feel politically, that you are doing science and you are dealing with objective truth.”*

The problem is that if we focus too much on essentialising bodies and differences in terms of gender or ethnicity (i.e. assuming that incorrect social and cultural perceptions have a physical basis in bodies), this means we can miss what is really going on. One example recounted by Saini is of a young Black girl whose cystic fibrosis (CF) remained undiagnosed until she was 8 years old; a very late diagnosis for the disease. The reason, Saini tells us, is because this child was Black, and CF can often be seen as a ‘White condition'. Indeed, Saini suggests that her diagnosis was almost incidental:

> *“It's only when her x-ray happened to be up on a screen, so nobody could see what colour she was, a passing doctor said this person obviously has CF, that she finally got diagnosed.”*





In the UK, Black women are four times more likely to die in childbirth than White women, and women from other ethnic minority groups also have a heightened risk.[18] Saini outlined in the interview that:

> *“... it's only been in the last couple of years that there's been some pushback to the idea that Black women's bodies are different and that's what's leading to this enormous gap that we see, and that maybe it's the level of care they're receiving that might be to blame. There's no logic in assuming that all ethnic minority women, for some reason, are genetically more likely to die in pregnancy than other women... So of course, we need to look at the social determinants.”*

Another essentialising belief is that Black and White people have different levels of pain tolerance based on biology.

Joy Francis, Co-founder of Words of Colour, Digital Women UK and the award-winning Synergi Collaborative Centre recently stated in an Ipsos webinar, Black women are often seen as “pain absorbers.” She remarked that there are so many “unhelpful tropes around the strong Black woman or mild Asian woman” that need challenging.

These beliefs can have very real consequences. For example, the international Parkinson and Movement Disorder Society recently published research in February 2022 showing that people from ethnic minority groups are far less likely than White people to receive pain medication.[19]

The dismissal of pain is brought to life by one of our ethnographic research participants, Rhondi, a Black woman in her 20s who suffers from debilitating migraines that can put her daily life on hold. During a consultation, she was asked what her pain levels were and reported them to be an eight out of ten. But when she saw the doctor's notes and saw a six written down, she questioned why a different number was noted. The response from the doctor was:

> *“I thought it was more like a six.”*

This experience has only served to confirm Rhondi's fears as a Black woman, of being seen as “exaggerating or amplifying pain”; a perception clearly articulated by an obstetrician-gynaecologist:

> *“Afro-Caribbean women are number one at reporting pain, even before they come, I know they are going to scream. Asians are number two and then Caucasians are far better.”*
> *Obstetrician-gynaecologist, female*

When undergoing a painful medical procedure or experience, two-thirds (66%) of HCPs surveyed thought that the pain felt by both White and Black women was equal, see Figure 4 overleaf. There was little difference between the proportion who thought White women feel more pain than Black women (10%) and Black women feel more pain than White women (9%).

However, whilst based on small sample sizes care needs to be exercised over the interpretation of the findings, there is a notable difference across the specialities with Obstetrician/ Gynaecologists (28%) being more likely than Endocrinologists (10%), General surgeons (6%) or GPs (4%) to believe White women feel more pain than Black women.

Similarly, our survey with UK adults (aged 18-75) who have spoken with a doctor showed that both those from an ethnic minority background and those from a White ethnic background tended not to think that they are taken less seriously by doctors because of their ethnicity (50% and 65%, respectively). However, those from an ethnic minority background were significantly more likely than those from a White background to believe they are taken less seriously by doctors because of their ethnicity (27% and 12%, respectively).

**There is a pattern of internalising the narrative of dismissal**

Narratives about women's bodies being ‘other' or different to men's can be held by some women, as well as by some men. Kate Jarman, Director of Corporate Affairs, Milton Keynes University Hospital, told us in an interview:

> *“We minimise our own pain as it is so often minimised around us. We say things like ‘it's just a coil fitting', ‘it's just a smear test'.”*

This perception of women internalising the blame or self-pathologising is, as Jane Ussher points out in an expert interview, a

## Figure 4: **Level of pain believed by HCPs surveyed to be felt by Black vs. White women**

| Specialty | White women feel more pain than Black women | White and Black women feel pain equally | Black women feel more pain than White women | Don't know | Prefer not to say |
|---|---|---|---|---|---|
| **All HCPs (n=250)** | 10% | 66% | 9% | 14% | 1% |
| **Obstetrician-Gynaecologist (n=50)** | 28% | 62% | 6% | 4% | 0% |
| **Endocrinologist (n=50)** | 10% | 68% | 4% | 16% | 2% |
| **General Surgeon (n=50)** | 6% | 70% | 18% | 4% | 2% |
| **General Practitioner (n=100)** | 4% | 64% | 9% | 22% | 1% |

***Question:*** *Typically, when undergoing a painful medical procedure or experience, do you think White women feel more pain than Black women, Black women feel more pain than White women, or is the pain felt by both White and Black women equal?* ***Base:*** *250 HCPs in the UK surveyed online 28 September – 24 October 2022*

reaction to messages everywhere that tell us how women should be, from cartoons to medical diagnoses. If women express pain and discomfort, it is considered as demanding too much or expressing too much emotion.

> *"We hear it in terms of popular culture. We see it in cartoons. We see it in magazines that tell us about how we should be as women. And we internalize it. We believe it. And if we are not good enough, if we are not calm enough, if we're not in control enough…if our moods feel out of control, then we think actually there's something wrong with us. What we don't do is we don't step outside of it and say actually the expectations of how women are supposed to be are completely unreasonable."*

**Moving forward**

The findings of this research are clearly concerning and may well be difficult reading for many – not only women who have had difficult experiences, but also for healthcare providers. The challenge is, if we do not see some of these cultural beliefs, then they can shape our attitudes and behaviours in ways we do not always recognise.

Having identified these issues, we want to discuss how they might be addressed. Of course, we are not the first people to have identified this issue and there are many individuals and bodies working to address it.

We propose building on this through four focus areas:

**1. Addressing how women from ethnic minority backgrounds can be treated in the healthcare system**

Our HCP survey showed that, although a majority of 78% were "very" or "fairly confident" that their education and training had prepared them to treat people of different ethnicities effectively, a significant minority of 22% of HCPs surveyed were "not at all" or "not very confident" that their education and training had prepared them to treat people of different ethnicities effectively, indicating that there may be scope to improve training.

Joy Francis makes the case for a more complete overhaul:

> *"…for me it's about the narrative hierarchy that exists that doesn't privilege the lived experience of women, especially Black and Brown women…I would say our lived experiences are on the bottom rung of the ladder, if they are on the ladder at all… The starting point is looking at the reality of misogyny and ethnic inequalities and the realities of how institutional and interpersonal racism operate."*

She argues that cultural transformation is needed, including challenging and interrogating what she describes as the current normalised behaviours of racism. As she remarks, in order to tackle this, change and rebuilding needs to be centred around collaboration and bringing intersectional perspectives into the room – making sure people are culturally informed and the healthcare system works for ethnic minority women.

**2. Examine the role of cultural beliefs in medical science**

As others have pointed out before, science does not always sit above societies' cultural beliefs around gender. Cultural beliefs permeate science and, of course, medical science. These considerations need to be brought directly into medical science rather than assuming the discipline is impervious to deeply held cultural beliefs.

One example of work in this area is the Harvard GenderSci lab,[20] directed by Sarah Richardson. This is where, Sarah Richardson tells us in an interview, scientists as well as humanities and social science scholars work together to "think more critically about claims of sex differences emanating from the biomedical sciences."

**3. Influence the culture for those working within the healthcare system**

The idea that the culture of medicine is still more male-oriented,[21] and excluding of women[22], was remarked on by some of the HCPs we interviewed as part of our qualitative research:

> *"During my career I have noticed males who are given far more preference. It is expected that they will be more academic than women. I trained part-time so there was always a bias that I was not committed to the profession."*
> *Endocrinologist, female*

Another of the HCPs we interviewed told us:

> *"There is still a backroom boys' mentality prevalence in certain circles, where for a woman a promotion is harder."*
> *Consultant Obstetrician-Gynaecologist, male*

To help tackle this, Kate Jarman is working on a number of campaigns to help facilitate change – one of them is NHS Flex,[23] a campaign to encourage and support flexible working – particularly in light of the fact that the NHS is predominantly a female workforce and flexible working is heavily taken up by women.

For Stephanie De Giorgio, one of the changes that she wants to see is more diversity in specialities. She feels that there are new generations of HCPs who are less afraid to challenge the norms and that this needs to be supported and built on.

**4. Influence the cultural discourse**

One of the ways to challenge some of the beliefs we have explored in this report is to bring them further into public debate. There are people trying to raise public awareness, HCPs who are championing change along with science journalists such as Angela Saini leading attempts to raise public awareness.

There has been widespread media attention on women's health issues such as menopause, spearheaded by public figures such as Davina McCall.[24] We are also seeing many workplaces introducing empathetic policies around baby loss and menopause, which may help in addressing the fact that one in 10 women quit their jobs during menopause due to their symptoms.[25]

Kate Jarman's Twitter campaign also aims to change the public discourse, for example moving away from the current norm of minimising certain procedures that women go through, and re-framing how women might be supported.[26] She told us:

> ***"We have to trust women. We have to trust that they are reliable narrators and witnesses to their own bodies and health…we need practitioners to help women move beyond the social conditioning women have in minimising their own pain"***

**Final thought**

This report has covered some longstanding, deep-seated cultural beliefs with roots dating back far in history that require some reconsideration to level the playing field for women's experiences of healthcare.





# Contributors

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# Technical note

The findings of this report are based on a multi-method research programme which explored the topic from multiple angles. The full details of the different methodologies employed is included below:

**Qualitative Interviews with HCPs**
Ipsos conducted 12 X 1-hour online interviews with healthcare professionals (HCPs) across the United Kingdom between 4 - 14 April 2022. To be eligible for interview, HCPs needed to be either an obstetrician-gynaecologist, endocrinologist, general surgeon, general practitioner or psychiatrist (for full breakdown see the table below).

They also needed to have between 5-30 years' experience in practice, spend over 75% of their time in clinical practice and be senior members of practice (specialist physicians or above). The general practitioners we interviewed were required to have treated at least 20 patients relating to women's overall health and wellness in the last 12 months and the secondary care HCPs we spoke to needed to have treated at least 10 patients relating to women's overall health and wellness in the last 12 months.

| Specialty Base (n) | Man (n) | Woman (n) | Total (n) |
|---|---|---|---|
| **Obstetrician-Gynaecologist** | 2 | 2 | 4 |
| **Endocrinologist** | 1 | 1 | 2 |
| **General Surgeon** | 1 | 1 | 2 |
| **General Practitioner** | 2 | 1 | 3 |
| **Psychiatrist** | 0 | 1 | 1 |
| **Total** | **6** | **6** | **n=12** |

**Quantitative survey of UK adults (18-75 years old)**
Ipsos surveyed a representative quota sample of 1,157 adults across the United Kingdom, 978 of whom had experience of speaking with a doctor. The sample was made up of 466 males and 504 females. Surveys took place online on the Ipsos Omnibus between 23 - 29 September 2022. Data has been weighted to the known offline population proportions of adults aged 18-75.

**Quantitative survey of HCPs**
Ipsos surveyed a sample of 250 healthcare professionals who chose to take part in our survey across the United Kingdom from a panel of healthcare professionals.
All HCPs surveyed held all or part treatment decision responsibilities for their patients and spend at least 75% of their professional time in direct patient care. The sample breakdown of specialty and gender is shown in the table below. Surveys took place between 28 September - 24 October 2022.

| Specialty Base (n) | Man (n) | Woman (n) | Prefer not to say (n) | Total (n) |
|---|---|---|---|---|
| **Obstetrician-Gynaecologist** | 21 | 28 | 1 | 50 |
| **Endocrinologist** | 37 | 12 | 1 | 50 |
| **General Surgeon** | 39 | 10 | 1 | 50 |
| **General Practitioner** | 50 | 50 | 0 | 100 |
| **Total** | **147** | **100** | **3** | **n=250** |

**Hysterical Health** Unpicking the cultural beliefs that shape women's healthcare

# Ethnography

Ipsos carried out ethnographic research with nine female participants, all based in the UK. Our participants ranged from 20-81 years. Those recruited were participants who had a variety of health issues. We used a mixture of digital and face-to-face ethnography.

Ethnography is a form of qualitative research that is typically more open ended and observational. By its very nature, ethnographic research focuses on the experiences of a small number of people, capturing depth and allowing participants to describe things in their own words. The ethnography involved recruiting via personal contact to locate women with a range of experiences with the health system.

Digital ethnography involves an initial informal discussion with our participants after which the participants self-filmed their experiences and sent us their videos.

**Experts interviewed**
Ipsos conducted eight hour-long interviews online with a sample of experts in the area of gender and healthcare over the course of 2022. These are a variety of experts who research and write about health, giving their opinions on their own behalf (rather than the opinion of their organisation):

- Angela Saini, Science Journalist and author
- Ian Roberts, Professor of Epidemiology at the London School of Hygiene and Tropical Medicine
- Joy Francis, Co-founder of Words of Colour, Digital Women UK and the award-winning Synergi Collaborative Centre
- Stephanie De Giorgio, portfolio GP and women's health specialist
- Elinor Cleghorn, Historian and author
- Kate Jarman, Director of Corporate Affairs at Milton Keynes University Hospital
- Sarah Richardson, Director of Harvard GenderSci Lab
- Professor Jane Ussher, Professor, Western Sydney University

# Footnotes


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## ABOUT IPSOS

In our world of rapid change, the need for reliable information to make confident decisions has never been greater.

At Ipsos we believe our clients need more than a data supplier, they need a partner who can produce accurate and relevant information and turn it into actionable truth.

This is why our passionately curious experts not only provide the most precise measurement, but shape it to provide a true understanding of society, markets and people.

To do this, we use the best of science, technology and know-how and apply the principles of security, simplicity, speed and substance to everything we do.

So that our clients can act faster, smarter and bolder.

Ultimately, success comes down to a simple truth:

**You act better when you are sure.**

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