We must validate the painful experiences of many women using intrauterine devices

Davina McCall’s documentary *Pill Revolution* missed an opportunity to validate painful experiences of intrauterine devices and promote better practice, writes Stephanie O'Donohue

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I had mixed feelings watching Davina McCall’s recent documentary *Pill Revolution.*¹ The programme did well to raise awareness of often unknown side effects of hormonal contraceptive pills, systematic cuts to sexual health services, and the dangers of misinformation influencing younger generations. But the segment on intrauterine devices (IUDs) left me mystified.

Davina tells how the Mirena coil has suited her well, both as a form of contraception and as part of her hormone replacement therapy. Positive accounts about IUDs are common. Many women choose them as their preferred method of contraception or to alleviate health issues such as heavy periods. Recent data tell us that IUDs are the main method of contraception for 11% of women and girls accessing sexual and reproductive health services.²

Davina was filmed having her IUD replaced by Lesley Regan, the UK’s first women’s health ambassador. The camera remained on Davina’s face, as we saw her smile and barely flinch at the procedure, with the worst pain being a brief moment which she described as “very sore” and a feeling of period-like cramps. This was counterbalanced with positive feedback and her summary that, for her, 10 minutes of “discomfort” was a small price to pay for the benefits.

Afterwards she raised concerns around systemic barriers and a postcode lottery for access, with some patients waiting months to have an IUD fitted. Lesley Regan explained that there is a shortage of trained staff and lack of funding for training and that staff also need to have “a bit of practice.” She went on to say that there are many pain relief options for women having an IUD fitted.

However, the segment did little to acknowledge less positive experiences and the concerns raised by thousands of patients who have undergone extremely painful IUD procedures.³ I am one of these women and have written about the impact that extremely painful gynaecological experiences can have physically and psychologically.⁴ Not to mention the violation of trust felt by many who were not forewarned of the risk of pain or provided appropriate support during and after the procedure. The impact of this can be long lasting, deterring some from accessing important health checks in the future.

Women deserve to be seen by well trained, experienced healthcare staff for invasive procedures such as IUD insertions and removals. For years, many organisations have been calling for higher standards in gynaecological training and highlighting the harm that persists when this is absent.⁵⁻⁸ We must push for comprehensive clinical training in this area, co-designed with patients who have lived experience to share. Appropriate prioritisation and funding can ensure this does not create further delays to women’s ability to access IUDs.

The segment in the documentary also missed an opportunity to promote informed consent in healthcare. All patients, particularly young girls who are increasingly having IUDs fitted, should be supported and empowered to make the right choice for them, after discussing the options, risks, and being well informed.

We know from women who have shared their IUD experiences that information about the risk of substantial pain, and the care given if this does happen, is patchy at best and leaves long lasting psychological and/or physical trauma at worst.

In my view, the context of Davina’s IUD replacement procedure was unreflective of reality. She was treated in a private hospital by an experienced gynaecologist and had numbing gel applied and anaesthetic injected. We know from patients’ accounts that pain relief is not always offered or given, despite guidance, and when used it does not always prevent high levels of pain.⁵ Many of us remain unaware that other pain relief options are available—this is itself a breach of informed consent. We don’t know who is being offered pain relief because no data is available around standards of care in this area.

If women’s lived experiences were valued as integral to improving practice there would be more funding directed at tackling gaps in research and solving unanswered questions.

We need an independent audit of patient reported experiences and outcomes of IUD procedures, co-designed with patients to capture meaningful data. This should include the equipment and pain relief used, information provided beforehand, and data on protected characteristics so that inequalities are not missed. Only then can the scale of the problem be understood, areas for improvement identified, and action taken. Importantly, this may also reveal areas of good practice that can be shared among clinicians to improve patient experiences.

It is clear more research is needed to understand women’s varying experiences of pain during gynaecological procedures. All women should be able to access reproductive healthcare promptly without the risk of significant pain or trauma.
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