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Q1 Much of your work has focused on reproductive endocrinology and complex fertility care. Where do you see the most persistent gaps between guideline-based evidence and everyday clinical practice?

One of the biggest misconceptions is that reproductive endocrinology is simply fertility care. In reality, it spans the entire reproductive lifespan, from menarche through fertility and pregnancy to perimenopause and menopause. It is about a woman's hormonal journey across her life.

There are significant gaps in research across this spectrum. Historically, women's health research has been underfunded. We still lack robust data in many areas, particularly in ethnically diverse populations. For example, we do not have enough high-quality research on women of Southeast Asian origin, women of Black Afro-Caribbean origin, or other minority groups. That makes it harder to provide truly evidence-based, individualised counselling.

There are also grey areas at the forefront of fertility treatment, such as sperm DNA fragmentation testing, preimplantation genetic testing for aneuploidy, immunological testing, or IVF add-ons. Guidelines may state that there is insufficient evidence, yet these tests are widely used in clinical practice. The challenge is explaining uncertainty to patients, while still offering clear, honest guidance about potential benefits and risks. Until we have stronger data, these grey areas will remain.

Q2 You have been closely involved in fertility preservation and counselling across different patient groups. How has that conversation evolved?

This is one area where we have seen real progress. In the past, women undergoing cancer treatment or ovarian surgery often had little discussion about future fertility. Now, many are offered a choice before starting treatment, whether that is egg freezing or ovarian tissue preservation.

Across the UK, more centres are offering fertility preservation, which is a positive step forward. However, access is still not uniform. Ovarian tissue preservation, for example, is available only in a limited number of centres. Funding also varies by region. While there is NHS funding for fertility preservation when ovarian damage is anticipated, such as in oncology cases, provision is not always equitable across the country.

So, while more women now have options, we are not yet at a stage of fully equal access.

Q3 Is fertility preservation covered by the NHS?

Yes. When there is a medical indication, for example, cancer treatment or surgery that may damage the ovaries, egg or tissue preservation is funded by the NHS.

Timing can be a limiting factor. If cancer treatment must begin urgently, there may not be

sufficient time to complete a stimulation cycle. In other cases, a patient's clinical condition may not allow it, but for the majority of women who can safely undergo treatment, and where time permits, fertility preservation is now funded. Social egg freezing, however, is not covered by the NHS.

Q4 Menopause care has gained renewed attention both clinically and publicly. What misconceptions do you encounter most often?

The most persistent misconception is the fear of cancer associated with hormone replacement therapy (HRT). This fear remains common among both the public and healthcare professionals. Many women believe that HRT will inevitably cause breast cancer. That is not true. The increased risk associated with HRT is small, and a woman's background health factors play a much greater role in determining her overall risk.

Another misconception is that menopause is brief. For some women, symptoms can last 5, 10, 15 years, or even longer, and they can be debilitating. It is not simply a short transitional phase for everyone.

It is also important to recognise that HRT is not the right choice for every woman. Some prefer non-hormonal options or lifestyle approaches, but women who wish to consider HRT should receive balanced, up-to-date information. Unfortunately, not all healthcare professionals are fully aligned with current guidance, and that is an area where continued education is needed.

Q5 If a woman feels well on HRT, when would you consider reducing or stopping it?

It is entirely individual and there is no arbitrary limit. Many women take HRT for 5–10 years and then try stopping to see whether symptoms return. If symptoms have resolved, they may not need to continue. If symptoms recur, they may restart and reassess again later. Long-term benefits of hormones for heart, bone, and genitourinary health should also be factored in when making decisions about continuing HRT.

Some women feel so well on treatment, and have minimal risk factors, that they choose to continue long-term. The key is informed decision-making. As long as a woman understands the benefits and potential risks, the decision should be hers.

Q6 Your work often emphasises individualised care rather than purely protocol-driven approaches. How do you balance guidelines with personalised treatment?

Guidelines provide a framework based on large population studies. They tell us what is generally safe, what the statistical benefits and risks are, and what the evidence shows at a population level, but no guideline can fully account for the individual sitting in front of you. Women come from different genetic, social, and cultural backgrounds. They have different

comorbidities, such as diabetes, hypertension, or high BMI, and very different life experiences.

My approach is to start with the guideline as a foundation. If it fits the individual, we follow it. If the situation is nuanced and the guideline does not perfectly apply, I explain that openly. I discuss the evidence, the uncertainties, and my clinical judgement. Shared decision-making is essential. Guidelines should not be used rigidly to deny or automatically impose treatment without considering the person.

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Q7 What aspects of reproductive endocrinology remain underrepresented in training pathways?

Traditionally, menopause and reproductive endocrinology have not received sufficient emphasis in undergraduate and postgraduate medical training. My own pathway was slightly different, training in India and then completing the Membership of the Royal College of Obstetricians and Gynaecologists (MRCOG) training in the UK before specialising further.

Historically, both endocrinology and gynaecology training have given relatively limited focus to reproductive endocrinology, particularly menopause. That is changing. There is now far greater awareness of menstrual disorders, polycystic ovary syndrome, endometriosis, and menopause. Colleges and training programmes are increasing exposure in these areas, which is encouraging for the future.

> **Shared decision-making has been the biggest transformation in women's health**

Q8 Looking back at your career, what shift in clinical thinking has had the greatest positive impact on patient outcomes?

Listening to patients. Medicine used to be very unidirectional: doctors told patients what to do. That is changing. Patients now have access to information and come prepared with questions. They participate in decisions about their care.

There can be misinformation, particularly on social media, and sometimes patients may request treatments that are not appropriate, but, overall, increased access to evidence-based information has empowered women. Professional bodies, royal colleges, and NHS resources provide reliable guidance. Shared decision-making has been the biggest transformation in women's health.

Q9 Where do you anticipate the most meaningful advances in reproductive health in the near future?

In fertility, we will likely continue refining IVF protocols to better individualise treatment and improve outcomes. We may develop improved options for women with premature ovarian insufficiency or those at risk of early menopause.

In menopause research, we still need to understand the basics more thoroughly. Why do women with similar backgrounds experience symptoms so differently? Why does HRT work well for one woman and not for another? We are now studying the effects of menopause on the brain, heart, and bone in far greater depth. In the next 5–10 years, we will have much more detailed data.

There is still a great deal of work to do, but there is also much to be optimistic about.