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Primary care clinicians' perspectives on interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions: A scoping review of qualitative studies

Final Report

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Data-sharing statement

Requests for access to data should be addressed to the corresponding author.

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Contributions

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Abbreviations

DHSC	Department of Health and Social Care
GP	General Practitioner
HRT	Hormone replacement therapy
HMB	Heavy menstrual bleeding
LGBTQ+	Lesbian, gay, bisexual, transgender, queer/ questioning and others
NICE	National Institute for Health and Care Excellence
MeSH	Medical Subject Headings
PICo	Population/problem, phenomenon of Interest, Context
PCOS	Polycystic ovary syndrome
PMDD	Premenstrual dysphoric disorder
PMS	Premenstrual symptoms
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PRP	Policy Research Programme
UK	United Kingdom
USA	United States of America

Report structure

This report is divided into three sections with the aim of making the most relevant information about the findings easily accessible:

1. **Summary:** An overview of the background, methods and findings of the report.
2. **Part 1:** Includes the background to the report, a brief methods section, the findings, an interpretative discussion of the findings, and conclusion.
3. **Part 2:** Includes the methods in full, the search results and study identification process, and a detailed narrative description of the characteristics of included studies. Part 2 also contains the appendices which include (a) the search strategies, (b) a list of the studies excluded at full-text screening with reasons for exclusion, (c) the aims and results of the included studies, (d) quality appraisal scores of the included studies and (e) comprehensive tables of the themes and subthemes.

Summary

In recent years several reports have found that women do not feel listened to either by clinicians or at the system level when discussing health care concerns.[1-6] In particular, women perceive that they are treated dismissively and that their symptoms are not taken seriously. This finding is reflected both in reports on health care conditions which specifically affect women, such as endometriosis, heavy menstrual bleeding and menopause,[1, 2, 5, 6] and in reports which explore failures of the health care system to listen and intervene when patients feel they are experiencing harm.[3, 4] A particular issue has been highlighted around women not feeling listened to by primary care clinicians, who are seen as the 'gatekeepers' to the more specialist care available in secondary care services.[1-3, 6] This can lead to patients feeling that their health concerns are being dismissed without due consideration. What is less well-known is why this occurs and in what circumstances, or indeed to what extent primary care clinicians perceive that there are problems around listening to women patients.

What do we want to know?

In order to better understand this issue from the perspective of primary care clinicians, we were asked to carry out a scoping review of evidence on primary care clinicians' views on listening to and, more broadly, interacting with women patients, including with specific groups of women patients such as ethnic minority women, LGBTQ+, older/younger and disabled women. Following initial exploratory work, we developed a protocol for a scoping review of the qualitative research evidence with the following aim and research questions:

Aim

To identify and summarise qualitative evidence on primary care clinicians' perspectives on interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions.

Research questions

1. What evidence is there about primary care clinicians' perspectives on interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions?
2. What key themes have been raised about challenges of interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions?

What did we find?

Twenty-three papers, from 18 unique studies, were included in the qualitative scoping review. Most papers (n=8) were about clinicians' experiences with diagnosing and managing endometriosis, with smaller numbers of papers discussing menopause (n=4), menorrhagia (n=3), polycystic ovary syndrome (n=3) and chronic pelvic pain (n=2). Infertility disease, menstrual disorders and premenstrual symptoms each were discussed in one paper. The papers reported data collected in the UK (n=8), Australia (n=7), US (n=3), Netherlands (n=2), Sweden (n=2) and Norway (n=1). Primary care clinicians who participated in the studies included GPs, nurse practitioners, internists/family practitioners, pharmacists and a community gynaecologist. GPs were included in the majority of papers (n=20).

We also identified a selection of themes and subthemes on or related to the challenge of interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions. Subthemes were organised within four thematic 'levels': the individual clinician; structural and organisational factors; community and external factors; and factors specific to gynaecological conditions and symptoms. The most widely supported subthemes (which were supported by four or more studies in the review) are listed in Table 1 within the four organising themes. For a full list of themes and subthemes, including subthemes supported by fewer than four studies, see Table 7 and Table 8 in Appendix E.

What are the implications?

The importance of listening to and communication with women was identified by clinicians in many of the included studies. This included the importance of treating women patients with empathy and respect, and listening to women's perspectives of what they considered normal or abnormal pain or symptoms when considering a diagnosis of a gynaecological condition. A full and open clinician-patient dialogue when discussing potential diagnoses and management of symptoms was seen as an important part of the consultation process.

However, these findings are in contrast to reports which indicate that women do not feel listened to by primary care clinicians.[1, 2, 6] We identified a number of factors in the included studies which may help to understand why this is the case. These related to:

- Socio-cultural factors affecting the consultation experience;
- The need for further education, training or guidance for clinicians in managing these conditions;
- Factors affecting the decision to refer women, including obtaining a definitive diagnosis;

- Factors related to service structure and organisations.

Socio-cultural factors included clinicians' perspectives that there is a sense of stigma and embarrassment about gynaecological conditions and symptoms amongst women patients. This sometimes meant that women took time to seek help, or that full and open discussion of conditions and symptoms was only achieved over the course of several consultation meetings. It was also perceived by clinicians that some women felt that it was not necessary to seek help, even when their symptoms were severe. It was suggested that this was because the difference between normal and abnormal pain or bleeding was not widely understood. There were also differences between female and male clinician perspectives on diagnoses and management of gynaecological conditions, with female clinicians appearing more adept at investigating symptoms and exploring patients' experiences than male clinicians.

Factors related to education, training and guidance included the perception amongst clinicians that they lacked sufficient knowledge and understanding of gynaecological conditions. This was sometimes due to perceived lack of training or guidance, but could also be related to infrequent exposure to these conditions. This appeared to be more of an issue for male clinicians than female clinicians as, due to patient preference, female clinicians typically saw more women patients than male clinicians.

Factors relating to diagnosis and referral of women included the perception amongst clinicians that diagnosis was not always necessary if the symptoms could be controlled in primary care. This could be to avoid giving a patient a 'label' too early, particularly if the patient was young, and it was also suggested that, for some conditions, a diagnosis does not necessarily alter the treatment for symptoms but can create unnecessary anxiety for the patient. In cases where a referral was needed for a diagnosis, clinicians were sometimes reluctant to pursue this course because investigations in secondary care can have adverse effects, particularly laparoscopy. Furthermore, there could be delays to seeing a secondary care specialist, and some clinicians perceived pressure to reduce referrals. Young women were seen as less likely to be referred than older women, but if a patient expressed a concern about fertility this was perceived by clinicians to be a reason for a more urgent referral.

Factors relating to service structure and organisation related to a perception that GP consultation time was too short. This made it difficult for GPs to determine the best course of action. This was made harder by a lack of continuity of care, for example, if patients were unable to see the same GP on successive occasions, and the perception that nurses were unable to deal with some conditions or symptoms, which were referred to GPs thus increasing their workload.

Table 1: Themes and subthemes with four or more supporting papers, and country settings of subthemes

	Themes and subthemes*	Supporting studies	Country settings
1.	**Individual clinician level**		
1.1.	Clinician's role in validating there is an issue and being the provider of a solution or signposting to other services	Chapple 2001[7]; Rowe 2021[8]; Young 2017[9]; Young 2019[10]	UK, Australia
1.2.	Concern about investigations required for diagnosis	Bertero 2019[11]; Dixon 2021[12]; Rowe 2021[8]; van der Zanden 2020[13]	UK, Australia, Netherlands, Sweden
1.3.	Infrequent clinical exposure to menstrual problems or gynaecology	Chapple 1998[14]; Davis 2021[15]; Dixon 2021[12]; van der Zandern 2020[13]	UK, Australia, Netherlands
1.4.	Lacking knowledge or awareness of gynaecological conditions and secondary care options	Bush 2007[16]; Copp 2021[17]; Dixon 2021[12]; O'Flynn 2004[18]; Rowe 2021[8]; van der Zandern 2020[13]; Young 2017[9]	UK, Australia, Netherlands, USA
1.5.	May not feel diagnosis needed if adequate symptom control achieved	Dixon 2021[12]; Grundstrom 2016[19]; Labots-Vogelesang 2021[20]; Rowe 2021[8]	UK, Australia, Netherlands, Sweden
1.6.	Not wanting to give patients a 'label' too early	Bertero 2019[11]; Copp 2020[21]; Dixon 2021[12]; van der Zander[13]; Young 2019[10]	UK, Australia, Netherlands, Sweden
1.7.	Reluctance for referral because lack of gain perceived	Copp 2021[17]; Copp 2020[21]; Dixon 2021[12]; McGowan 2010[22]; van der Zanden 2020[13]	UK, Australia, Netherlands
1.8.	Treating women with empathy and respect	Bertero 2019[11]; Copp 2020[21]; Davis 2021[15]; Dixon 2021[12]; Grundstrom 2016[19]; Labots-Vogelesang 2021[20]; May 2004[23]; McGowan 2010[22]; Rowe 2021[8]; Sefle 1998[24]	UK, Australia, Netherlands, Sweden
1.9.	Understanding the psychosocial impacts of gynaecological conditions	Bertero 2019[11]; Chapple 1998[14]; Copp 2020[21]; Davis 2021[15]; Dixon 2021[12]; Fernandes 2020[25]; Grundstrom 2016[19]; Labots-Vogelesang	UK, Australia, Netherlands, Norway, Sweden

		2021[20]; May 2004[23]; McGowan 2010[22]; Rowe 2021[8]; Selfe 1998[24]; Young 2017[9]	
1.10.	Using women's subjective awareness of what is normal or abnormal to inform decision making	Bertero 2019[11]; Bullo 2021[26]; Chapple 1998[14]; Chapple 2001[7]; Grundstrom 2016[19]; May 2004[23]; McGowan 2010[22]; O'Flynn 2004[18]; Rowe 2021[8]; Young 2019[10]	UK, Australia, Sweden
1.11.	Young women less likely to be considered for pathological condition	Copp 2020[21]; Dixon 2021[12]; O'Flynn 2004[18]; Rowe 2021[8]; van der Zanden 2020[13]	UK, Australia, Netherlands
2.	**Structural and organisational factors**		
2.1.	Limited education for primary care clinical team	Davis 2021[15]; Dixon 2021[12]; Grundstrom 2016[19]; McGowan 2010[22]; Rowe 2021[8]; van der Zanden 2020[13]	UK, Australia, Netherlands, Sweden
2.2.	Long delays and limited access to secondary care	Arasu 2019[27]; Chapple 1998[14]; Dixon 2021[12]; Rowe 2021[8]	UK, Australia
2.3.	Recognition of the importance of a multi-disciplinary approach	Bertero 2019[11]; Copp 2020[21]; Grundstrom 2016[19]; Rowe 2021[8]; van der Zanden 2020[13]	Australia, Netherlands, Sweden
2.4.	Recognition that continuity of care is important and frustration that this is difficult to achieve	Bertero 2019[11] Dixon 2021[12]; Esposito 2005[28]; Grundstrom 2016[19]	UK, Sweden, USA
2.5.	Unmanageable GP workload	Arasu 2019[27]; Chapple 2001[7]; Davis 2021[15]; Dixon 2021[12]; Esposito 2005[28]; Selfe 1998[24]; Young 2017[9]	UK, Australia, USA
3.	**Community and external factors**		
3.1.	Normalisation of pain/symptoms in wider society and amongst clinicians	Chapple 1998[14]; Dixon 2021[12]; Esposito 2005[28]; Grundstrom 2016[19]; Rowe 2021[8]; Young 2019[10]	UK, Australia, Sweden, USA
3.2.	Stigma or embarrassment of menstrual conditions and symptoms amongst patients	Bullo 2021[26]; Chapple 1998[14]; Chapple	UK, Australia

		2001[7]; Davis 2021[15]; Dixon 2021[8, 12, 13, 25]	
3.3.	Web-based sources of accurate information are needed to correct misinformation which is a cause of anxiety and mistaken beliefs amongst patients	Bertero 2019[11]; Copp 2021[17]; Copp 2020[21]; Dixon 2021[12]; Rowe 2021[8] Young 2017[9]	UK, Australia, Sweden
4.	**Multiple conditions**		
4.1.	Gynaecological conditions can be difficult to definitively diagnose	Bertero 2019[11]; Bullo 2021[26]; Copp 2020[21]; Dixon 2021[12]; Fernandes 2020[25]; McGowan 2010[22]; O'Flynn 2004[18]; van der Zanden 2020[13]; Young 2017[9]	UK, Australia, Netherlands, Norway, Sweden
4.2.	Lack of GP guideline	Bush 2007[16]; Chapple 2001[7]; O'Flynn 2004[18] van der Zanden 2010[13]	UK, Netherlands, USA
4.3.	Medicalisation of social phenomenon / Not believing there to be a physical issue	Copp 2020[21]; Labots-Vogelesang 2021[20]; McGowan 2010[22]; Rowe 2021[8]; Selfe 1998[24]; Young 2017[9]; Young 2019[10]	UK, Australia, Netherlands
4.4.	Need to follow a diagnostic hierarchy and exclude 'red flags' first	Copp 2020[21]; Dixon 2021[12]; Esposito 2005[28]; Grundstrom 2016[19]; McGowan 2010[22]; Rowe 2021[8]; Selfe 1998[24]; van der Zanden 2020[13]	UK, Australia, Netherlands, Sweden, USA
4.5.	Trying but not succeeding to find solutions for patients who are dissatisfied with care	McGowan 2010[22]; Rowe 2021[8]; Selfe 1998[24]; Young 2016[10]	UK, Australia

*Themes are in bold text and subthemes are in normal text.

How did we get these results?

We developed a detailed search strategy applied across multiple bibliographic databases and other sources, including sources which index grey literature, in order to identify relevant studies. The results of this search were uploaded into reference management software and screened by two reviewers independently in two stages – at title and abstract, and then full text – to assess their eligibility for inclusion. From an initial 1956 unique study records identified, 23 papers, based on data from 18 unique studies, met our inclusion criteria and were included in the scoping review. Included studies reported data collected from primary care clinicians solely, or data collected from both primary and secondary care clinicians, but we were careful not to include data in the review that was solely related to secondary care clinicians. Key data about study characteristics were extracted by one reviewer and checked by one of the other members of the review team. The quality of these papers was appraised using the Wallace criteria by one reviewer and checked by a second.[29]

In order to summarise and present the findings of the studies, we selected an ‘index paper’ to provide the initial framework against which findings of the other papers were coded.[12] Additional themes were added as required. The coding was undertaken by one reviewer and checked by one of the other members of the review team. An interpretive discussion was written with a focus on how the themes and subthemes might relate to the issues of listening to and communicating with women.

Stakeholder engagement involved meetings with four primary care clinicians (two men and two women; meetings were single sex) to discuss their perspectives on interacting with women patients with gynaecological conditions or symptoms suggestive of gynaecological conditions. The meetings involved a discussion on clinicians’ perspectives and sense check of the index paper coding framework we used to code included studies.

Part 1: Background, brief methods, findings, discussion and conclusion

Background

In recent years several reports have found that women do not feel listened to, either by clinicians or at the system level, when discussing health care concerns.[1-6] In particular, women perceive that they are treated dismissively and that their symptoms are not taken seriously. This finding is reflected both in reports on health care conditions which specifically affect women, such as endometriosis, heavy menstrual bleeding and menopause,[1, 2, 5, 6] and in reports which explore failures of the health care system to listen and intervene when patients feel they are experiencing harm.[3, 4]

Endometriosis is a debilitating gynaecological condition which affects 10% of women between the ages of puberty and menopause.[1] NICE guidelines recommend that a diagnosis of endometriosis should be suspected if one or more common symptoms are presented, including chronic pelvic, period pain which affects daily living, and deep pain during or after sexual intercourse.[30] However, the recent report *Endometriosis in the UK: time for change* found that on average a diagnosis of endometriosis takes eight years from the onset of symptoms, the same length of time as it did ten years ago.[1] When discussing endometriosis with their GP, 46% of women consulted for the review found their GP to be unhelpful or very unhelpful, and 58% needed to visit their GP over ten times before a diagnosis was made.[1] A similar number (53%) went to A&E as a result suffering with endometriosis symptoms before they were diagnosed, including 27% who went to A&E three or more times.[1] The report called for women presenting with symptoms suggestive of endometriosis to be recognised and supported for a prompt diagnosis, with a target set by the All-Party Parliamentary Group on Endometriosis for diagnosis time of four years by 2025 and under one year by 2030.[1]

Heavy menstrual bleeding (HMB) is another common gynaecological condition which impacts on the personal and professional lives of women. HMB is experienced by one in five women, with one in 20 aged between 30 and 49 years old presenting to primary care each year.[2] The NHS defines HMB as the loss of 80ml of blood or more in each period, but diagnosis is subjective as the typical amount of menstrual blood loss varies between women.[31] Accordingly NICE guidance defines HMB as excessive menstrual blood loss which interferes with physical, emotional, social and material quality of life.[32] In part due to embarrassment and stigma, women are often reluctant to seek medical advice for HMB, with three in ten women suffering for three or more years before seeking medical help.[33] A recent report on heavy menstrual bleeding, *Heavy Menstrual Bleeding – breaking silence and stigma*, noted that in this context it is important that primary care providers are well-informed and supportive, but found that GPs were perceived by women seeking help for HMB to lack empathy and understanding.[2] Amongst its recommendations, the report proposed the creation of a more supportive environment for patients by improving training for primary care clinicians, including the development of specialist GPs and nurses with an interest in women's health.[2]

The diagnosis and effective management of menopause is also an area of concern. Most women (eight out of ten) experience symptoms, of which those who ask for support receive variable advice which can lead to harmful and life changing consequences.[5, 34] In particular, confusion about the appropriate use of hormone replacement therapy both amongst patients and clinicians has led to a reduction in prescriptions, which is likely to have led to women suffering with symptoms unnecessarily.[34, 35] NICE guidance has been developed to address this issue,[34] but there is an ongoing need to ensure that women feel equipped to recognise and ask for help with symptoms of menopause, and that clinicians are sufficiently trained to offer appropriate support and advice. A survey by Mumsnet and Gransnet found that 26% of women who sought help with menopause symptoms needed to make three or more visits to their GP before appropriate support or medication was provided.[6] The *Better for Women* report highlighted that women are often unable to access the care and support that they need for menopausal symptoms, and in particular noted that this can lead to reduced working capacity and in some cases loss of employment where their needs are not recognised and accommodated by employers.[5]

Reports that have investigated how the health and social care system listens as a whole have also found that women have been disproportionately affected. For example, the *Independent Medicines and Medical Devices Safety Review* was commissioned in 2018 to investigate how the health care system in England responds to emerging information about adverse events from medicines and medical devices.[3] The review focused on three interventions which are all used by women: hormone pregnancy tests, sodium valproate, and pelvic mesh. [3] The report found that women felt they were dismissed by clinicians when raising concerns about these interventions, citing particular frustration with GPs who they felt were preventing them for obtaining specialist help from secondary services.[3] The report also found that the system as whole failed to listen to patients, and that patients found it difficult to navigate the system when trying to raise a complaint.[3] Similarly, the *Paterson Inquiry* report describes how women patients were not listened to when querying or seeking to complain about Paterson's behaviour.[4] The report notes that the majority of people mistreated by Paterson were women undergoing breast surgery, although men were also mistreated. Throughout the report, evidence from women is quoted on how they raised concerns about Paterson's treatment of them but were dismissed by Paterson, the wider medical profession and NHS complaints bodies.[4]

These reports illustrate how clinicians' attitudes towards patient concerns are sometimes perceived as dismissive, and highlight that there is an issue around perceived clinicians' attitudes towards women patients. Most of these reports also highlight a particular issue around women not feeling listened to by primary care clinicians, who are seen as the 'gatekeepers' to the more specialist care available in secondary care services.[1-3, 6] What is less well-known is why this occurs and in what circumstances, or indeed to what extent primary care clinicians perceive that there are problems around listening to women patients. In order to better understand this issue from the perspective of primary care clinicians, we were asked to carry out a scoping review of evidence on primary care clinicians' views on listening to and, more broadly, interacting with women patients, including with specific groups of women such as ethnic minority women, LGBTQ+, older/younger and disabled women. Specific questions we were asked to consider include:

- How do clinicians view interactions with women patients?
- Are there challenges clinicians identify that affect them being able to listen effectively and do barriers/issues exist in relation to particular health problems (e.g. female-specific issues such as menstrual health and menopause, or general symptoms)?
- Is there a listening/communication issue or a medical education issue?

Refining the scope

In order to sensitise ourselves to the available literature on clinicians' perspectives on listening to women in primary care settings, we carried out background searches of the topic area. These searches did not identify any studies from the perspective of clinicians that specifically focused on whether, and to what extent, clinicians listen to women patients. However, we did identify studies on primary care clinicians' perspectives on interactions with women who present with conditions for which there is evidence that women perceive that they are dismissed and not listened to. In particular, we found studies of clinicians' perspectives on the presentation, diagnosis and management of patients with gynaecological conditions and symptoms suggestive of gynaecological conditions.

Within these studies we identified some data on whether and to what extent clinicians feel able to take account of women's viewpoints in the diagnosis and management of gynaecological conditions, which affords a window into some of the issues that women have raised about perceived dismissive attitudes within clinician-patient interaction. Thus we refined the aim and scope of our review to focus on clinicians' perspectives on interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions. Our overall approach is a scoping review which summarises the extent of the available evidence with a view to recommending further avenues for research.[36, 37]

Aim

To identify and summarise qualitative evidence on primary care clinicians' perspectives on interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions.

Research questions

1. What evidence is there about primary care clinicians' perspectives on interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions?
2. What key themes have been raised about challenges of interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions?

Wherever possible we have been sensitive to issues related to consultations with different groups of women (such as ethnic minority women, LGBTQ+, older/younger and disabled women) in our analysis.

Brief methods

In this brief methods section we summarise the main components of the methods. Full details of the methods are provided in Part 2 of this report with additional detail on the search methods reported in Appendix A.

Our review protocol was prospectively registered on Open Science Framework and Open Repository Exeter.[38] The review commenced on 25th October 2021 and the initial draft was submitted for client feedback on 21st December. The final draft was submitted to the client and for peer review concurrently on 4th March 2022.

Type of review

This is a scoping review which includes the following stages:

1. Identify relevant primary qualitative studies;
2. Carry out data extraction and quality appraisal of relevant studies
3. Code key themes using a coding framework and summarise the findings.
4. Highlight areas of uncertainty that require additional evidence.

Study identification

We developed a detailed bibliographic database search strategy which was executed in CINAHL (via EBSCO), Embase (via Ovid), the Health Management Information Consortium database (HMIC) (via Ovid), MEDLINE (via Ovid) and ASSIA (via ProQuest). We also checked the reference lists of included studies, carried out forward citation searching on included studies, and searched topically relevant websites and the Google Search (www.google.co.uk) and Google Scholar (https://scholar.google.com/) search engines. Whenever possible, the results of the searches were uploaded into reference management software (Endnote X8, Clarivate Analytics, Philadelphia, PA, USA). The search results were screened by two reviewers independently in two stages – first, at title and abstract, secondly, full text – to assess their eligibility for inclusion.

Data extraction and quality appraisal

A bespoke data extraction form was developed. Key data about study characteristics were extracted by one reviewer and checked by a second reviewer. The quality of the studies was appraised using the Wallace criteria by one reviewer and checked by a second.[29]

Coding of key themes and summary of findings

In order to summarise and present the findings of the studies, we selected an ‘index paper’ to provide the initial framework against which key themes and subthemes in the other papers were coded.[12] Additional themes and subthemes were added as the papers were successively coded. The coding was undertaken by one reviewer and checked by one of the other members of the review team. Iterative coding ensured that themes and subthemes which were added later in the coding process were checked against papers which had been previously coded. Once the coding was completed, themes and subthemes were merged if they were considered to overlap. The themes and subthemes were narratively summarised and tabulated. A second stage of interpretative coding was then undertaken to see how the themes and subthemes could be understood in relation to the Women’s Health team’s interest in patient-clinician interaction, specifically focusing on issues relating to listening to and communication with women. This is presented in the discussion section.

Stakeholder engagement

Stakeholder engagement involved two meetings with four primary care clinicians (two men and two women - meetings were single sex) to discuss their perspectives on interacting with women patients with gynaecological conditions or symptoms suggestive of gynaecological conditions. The meetings involved a discussion on clinicians’ perspectives and sense check of the index paper coding framework we used to code included studies.

Findings

Overview

In total 23, full-text papers were identified which met our inclusion criteria, which reported data from 18 individual studies.[7-28, 39] The PRISMA flow diagram in Figure 1 summarises the full-text article selection process. In total, 1956 unique references were retrieved by the searches. Of these, 62 were deemed potentially relevant to the review based on the data in the titles and abstracts. Inspection of full-text copies of these 62 papers identified the 23 papers which were included in the review. A more detailed narrative summary of the study selection process is provided in Part 2 of this report.

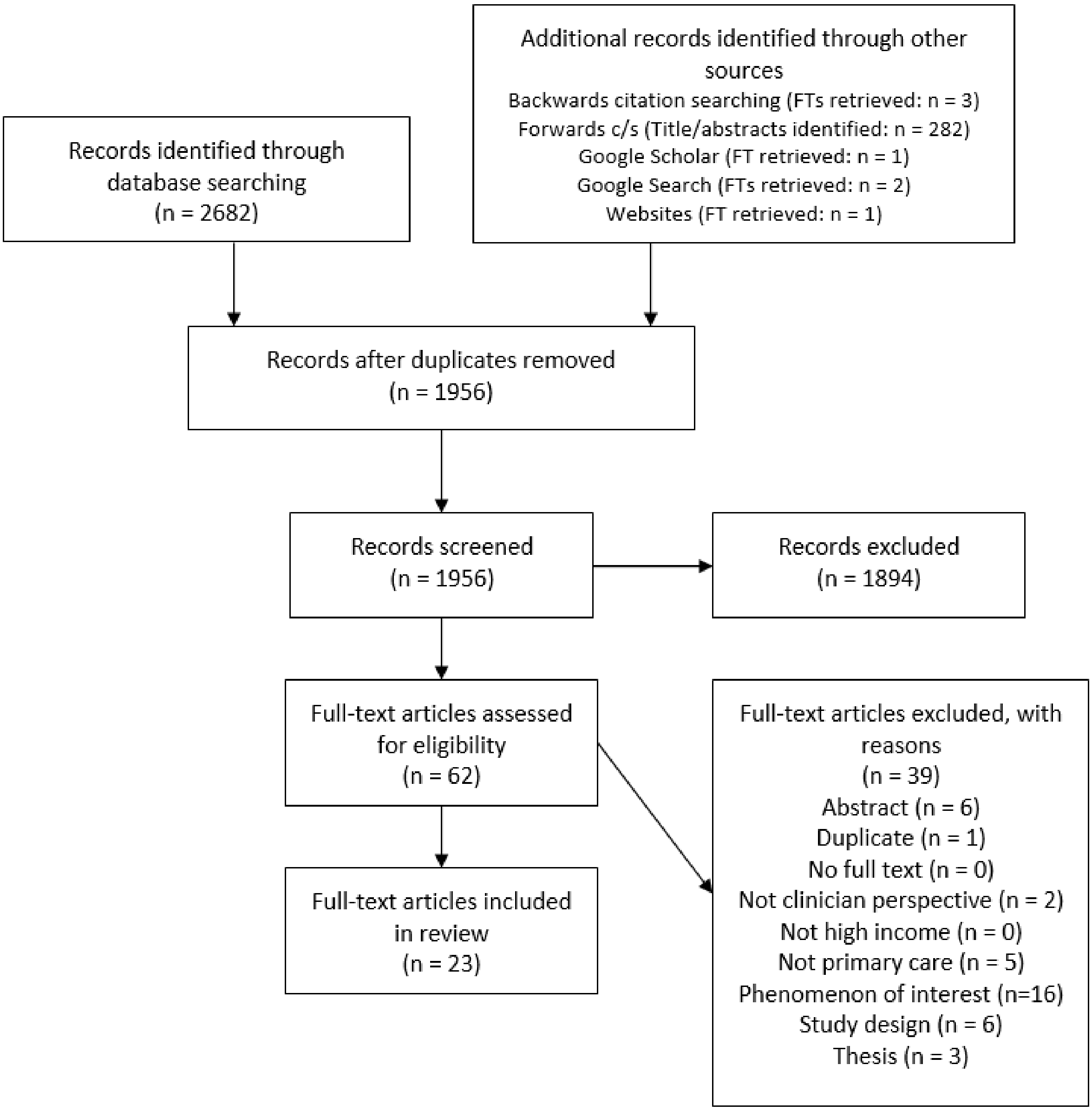

Figure 1. PRISMA flow diagram

The study characteristics of the 23 included papers are summarised in Table 2. The most frequently discussed condition in the included papers was endometriosis (n=8)[8-13, 19, 26] and smaller groups of papers discussed menopause (n=4),[15, 16, 28, 39] menorrhagia (n=3),[7, 14, 23] PCOS (n=3)[17, 21, 27] and chronic pelvic pain (n=2).[22, 24] Infertility disease (which included consideration of patients with endometriosis, PCOS and vulvodynia),[25] menstrual disorders[18] and premenstrual symptoms[20] were each discussed in one paper. Studies were set in the UK (n=8), Australia (n=7), US (n=3), Netherlands (n=2), Sweden (n=2) and Norway (n=1). Primary care clinicians who participated in the studies included GPs, nurse practitioners, internists/family practitioners, pharmacists and a community gynaecologist. GPs were included in the majority of papers (n=20). A full narrative summary of the study characteristics is provided in Part 2 of this report.

Quality of the evidence

Overall, the papers were assessed as being of good quality. As a whole, the evidence base was judged as poor in relation to describing the theoretical or ideological position of the authors, and subsequently also in relation to whether or not this influenced study design, methods or its findings. The quality appraisal for each study is presented in Table 6 in Appendix D.

Table 2. Characteristics of included studies

Study	Country setting	Year of data collection	Clinician sample size, n (% primary care)	Type of clinicians in sample, n	Gender of clinicians in sample, n(%)	Patient gender of interest	Patients included in study, Y/N
Chronic pelvic pain							
McGowan 2010[22]	UK	NR	41 (100%)	GPs (21); practice nurses (20)	Female: 37 (90.2%); Male: 4 (9.8%)	Female; male	N
Selfe 1998[24]	UK	NR	NR	GPs (NR); gynaecologists (NR)	NR	Female	Y
Endometriosis							
Bertero 2019[11]	Sweden	2013-2015	16 (37.5%)	Gynaecologists (10); GPs (6)	Female: 10 (62.5%); Males: 6 (37.5%)	Female	Y
Bullo 2021[26]	UK	NR	11 (100%)	GPs (11)	Female: 11 (100%)	Female	Y
Dixon 2021[12]	UK	2019-2020	42 (100%)	GPs (42)	Female: 23 (54.8%); Male: 19 (45.2%)	Female	N
Grundstrom 2016[19]	Sweden	2012-2013	25 (24%)	GPs (6); gynaecologists (10); midwives (9)	Female: 18, 72%; Male: 7, 28%	Female	N
Rowe 2021[8]	Australia	2018	13 (92.3%)	GPs (12); gynaecologists (1)	NR	Female	Y
Van der Zanden 2020[13]	Netherlands	2016-2017	43 (100%)	GPs (43, including GPs in training: 12)	Female: 33 (76.7%); Male: 10 (23.3%)	Female	N
Young 2017[9]	Australia	2014	12 (33.3%)	GPs (4); gynaecologists (8)	Female: 8 (66.7%); Male 4 (33.3%)	Female	N
Young 2019[10]	Australia	2014	12 (33.3%)	GPs (4); gynaecologists (8)	Female: 8 (66.7%); Male 4 (33.3%)	Female	N
Infertility disease							
Fernandes 2020[25]	Norway	2019	13 (38.5%)	GPs (5); gynaecologists (8)	Female: 10 (76.9%); Male: 3 (23.1%)	Female	N
Menopause							

Study	Country setting	Year of data collection	Clinician sample size, n (% primary care)	Type of clinicians in sample, n	Gender of clinicians in sample, n(%)	Patient gender of interest	Patients included in study, Y/N
Bush 2007[16]	USA	2005	22 (50%)	Family practice/internal medicine (11); obstetrics and gynaecology (11)	Female: 17 (77.3%); Male: 5 (22.7%)	Female	N
Davis 2021[15]	Australia	NR	30 (66.7%)	GPs (10); gynaecologists (10); Pharmacists (10)	Female: 15 (50%); Male: 15 (50%)	Female	N
Esposito 2005[28]	USA	1999-2000	6 (100%)	Nurse practitioners (5); physicians (1)	NR	Female*	Y*
Nekhlyudov 2009[39]	USA	2005	22 (50%)	Internist/family practitioner (11); gynaecologist (11)	Female: 17 (77.3%); Male: 5 (22.7%)	Female	Y
Menorrhagia							
Chapple 1998[14]	UK	1995-1996	50 (100%)	GPs (50)	Female: 16, 32%; Male: 34, 68%	Female**	N
Chapple 2001[7]	UK	1995-1996	73 (100%)	GPs (73)	Female: 28, 38.4%; Male: 45, 61.6%	Female**	N
May 2004[23] [a]	UK	1995-1996[b]	65 (100%)[c]	GPs (65)[c]	NR	NR[d]	N
Menstrual disorders							
O'Flynn 2004[18]	UK	2000-2001	21 (100%)	GPs (13); nurses (7); community gynaecologist (1)	Female: 13 (61.9%); Male: 8 (38.1%)	Female	N
PCOS							
Arasu 2019[27]	Australia	NR	15 (100%)	GPs (15)	Female: 11 (74%); Male: 4 (26%)	Female	N
Copp 2020[21]	Australia	2017-2018	36 (41.7%)	GPs (15); gynaecologists (10); endocrinologists (11)	Female: 26 (72.2%); Male: 10 (27.8%)	Female	N
Copp 2021[17]	Australia	2017-2018	36 (41.7%)	GPs (15); gynaecologists (10); endocrinologists (11)	Female: 26 (72.2%); Male: 10 (27.8%)	Female	Y

Study	Country setting	Year of data collection	Clinician sample size, n (% primary care)	Type of clinicians in sample, n	Gender of clinicians in sample, n(%)	Patient gender of interest	Patients included in study, Y/N
PMS							
Labots-Vogelsang 2021[20]	Netherlands	2017	27 (100%)	GPs (27)	Female: 17, (63%); 10 (37%)	Female	N

Abbreviations: HRT=hormone replacement therapy; GP=general practitioner; NR=not reported; PCOS=polycystic ovary syndrome;

Key: *=ethnic minority population, specifically, immigrant Spanish speaking Hispanic population in New York; **=ethnic minority population, specifically, South Asian population in North West of UK.

Footnotes: [a] May 2004 is secondary analysis of four primary studies reporting data on menorrhagia, chronic pelvic pain, depression and medically unexplained symptoms. Only the study on menorrhagia (Chapple 1997 thesis)[40] contains data which is eligible for inclusion in this review; [b] Dates of data collection for Chapple 1997 (thesis),[40] which is the source of data on menorrhagia in this paper; [c] Inclusive of clinicians in all four studies in the secondary analysis; [d] Patient gender not reported but conditions in secondary analysis are not gender specific, so likely to be female and male.

Summary of themes

Factors which influenced clinicians' perspectives of interacting with patients with gynaecological conditions or symptoms suggestive of them, were seen at four levels:

1. the individual clinician;
2. structural and organisational factors;
3. community and external factors;
4. condition specific factors

The subthemes within each overarching thematic level are presented below. Themes which were mentioned in 4 or more studies are listed in alphabetical order *and* summarised narratively. Themes which were mentioned in fewer than 4 studies are listed in alphabetical order *without* a narrative summary unless further explanation was required, in which case a short summary is provided. See also Table 7 in Appendix E for a list of themes and subthemes with additional data on which gynaecological conditions and types of clinicians were included in the supporting studies for each subtheme, and the country settings of supporting studies.

Condition specific factors (thematic 'level' 4) are divided into (i) factors which are relevant to *multiple* conditions and (ii) factors which are specific to a *single* condition. Factors which are relevant to a single condition were supported by relatively few studies and are not detailed in this section, but are presented in Table 8 in Appendix E.

1. Individual clinician level

Individual clinician level themes describe how the individual perspectives of primary care clinicians on diagnosing and managing gynaecological conditions and symptoms inform decisions about patient care. The focus is on clinicians meeting one to one with patients in consultations and routine appointments. There were 18 subthemes within this set including 11 which were mentioned in four or more studies. These are listed alphabetically, below.

1.1. Clinician's role in validating there is an issue and being the provider of a solution, or signposting to other services (n=4 studies)[7-10]

This subtheme describes clinicians' self-perceived role in determining whether or not a patient has a condition, and knowing what course of action to take. This was interpreted by some studies as exacerbating a sense of power divide between the clinician and patient, and threatening the collaborative aspect of the clinician-patient interaction.[10]

1.2. Concern about investigation required for diagnosis (n=4 studies)[8, 11-13]

Concern was reported about procedures required for diagnosis which are invasive, e.g. laparoscopy. In particular, GPs reported that the potential risks of invasive procedures, such as pain and adhesions, meant that they would only consider referring a woman if there was a high probability that they were at risk from a condition.

1.3. Infrequent clinical exposure to menstrual problems or gynaecology (n=4 studies)[12-15]

Primary care clinicians reported that patients with gynaecological conditions often preferred to see female clinicians. This meant that male clinicians were less frequently exposed to gynaecological conditions, and were subsequently relatively unfamiliar with making a diagnosis and treatment options compared to female clinicians.

1.4. Lacking knowledge or awareness of gynaecological conditions and secondary care options (n=7 studies)[8, 9, 12, 13, 16-18]

Clinicians recognised a lack of knowledge of gynaecological conditions and the range of symptoms that are suggestive of gynaecological conditions, as well as a lack of awareness of guidance to help inform diagnosis and management, both in primary care and secondary care settings.

1.5. May not feel diagnosis needed if adequate symptom control achieved (n=4 studies)[8, 12, 19, 20]

Some primary care clinicians considered that referral to secondary care for diagnosis was not necessary if adequate symptom control could be achieved through treatment options in a primary care setting. Clinicians perceived that some women did not want to be referred to secondary care, which added weight to their view that controlling symptoms in primary care settings was the best outcome for some patients.

1.6. Not wanting to give patients a 'label' too early (n=5 studies)[10-13, 21]

Concerns were raised by some clinicians about giving a diagnosis too early. In particular, the risk that a clinician faces in making a diagnosis which causes the patient to worry about their condition, particularly for conditions which are hard to diagnose definitively.

1.7. Reluctance for referral because of lack of gain perceived (n=5 studies)[12, 13, 17, 21, 22]

Primary care clinicians worried that referral to secondary care could lead to extensive investigations which did not find anything conclusive.[22] They also had experience of women being discharged from secondary care where the secondary care clinician had chosen to focus on symptom control rather than investigation, which is something that the primary care clinician felt they could have done themselves.[12]

1.8. Treating women with empathy and respect (n=10 studies)[8, 11, 12, 15, 19-24]

Primary care clinicians recognised the importance of empathising with how women feel, and discussing symptoms and conditions in an open manner which was not dismissive of women's ability to understand potential diagnoses and management. Clinicians believed that this built up a rapport with patients and incorporated the patients' perspective as an "expert on their own body" in collaborative decision making.[8]

1.9. Understanding psychosocial impacts of gynaecological conditions (n=13 studies)[8, 9, 11, 12, 14, 15, 19-25]

Clinicians recognised a need for an holistic approach to patient care, and showing an understanding of the psychological and social effects of a condition as well as the physiological effects.

1.10. Using women's subjective awareness of what is normal and abnormal to inform decision making (n=10 studies)[7, 8, 10, 11, 14, 18, 19, 22, 23, 26]

Primary care clinicians described how they take into account women's perceptions of what is normal or abnormal for them. In particular, this relates to understanding women's awareness of the difference between what they themselves consider normal physiological or psychological wellbeing and what they consider sufficiently abnormal to warrant seeking medical help. This could be characterised as enough difference to interfere with patients' daily living.[19]

1.11 Young women less likely to be considered for pathological condition (n=5 studies)[8, 12, 13, 18, 21]

Primary care clinicians were unlikely to consider a diagnosis of endometriosis or PCOS for adolescent women. Clinicians preferred to manage symptoms without applying the label of a chronic disease, as this was considered to be particularly unhelpful for young women, for example, a cause of anxiety. Clinicians noted that unless a condition was serious, there was no benefit in a diagnosis if the treatment for symptoms was the same irrespective of the diagnosis.

Individual clinician level subthemes identified in fewer than 4 studies

1.12. Clinician preference for women to come to clinics prepared (n=2 studies)[13, 28]

1.13. Importance of being able to motivate patients to make life style changes (n=2 studies)[16, 27]

1.14. Nurses refer back to GP if they do not have a solution (n=1 study)[22]

1.15. Option to refer patients to secondary care is sometimes used if primary care clinicians have exhausted all other courses of action, AKA "simple disposal" (n=2 studies)[22, 23]

1.16. Recognising the need to sensitively communicate about potential sequelae (n=2 studies)[9, 21]

1.17. Viewing women as 'good' or 'bad/challenging' according to whether they follow clinician advice (n=3 studies)[9, 10, 18]

1.18. Women who present with wide spectrum of complaints were more often considered as somatising and not referred (n=2 studies)[8, 13]

2. Structural and organisational factors

Structural and organisational themes describe factors which are largely outside of individual clinicians' control. The focus is on how the design and management of primary care settings affects the care that primary clinicians can provide and how wider issues in secondary care settings impact on primary care. There were seven subthemes within this theme including five which were mentioned in four or more studies. These are listed alphabetically, below.

2.1. Limited education for primary care clinical team (n=6 studies)[8, 12, 13, 15, 19, 22]

Primary care clinicians noted that they did not receive much training on women's health issues during their professional education or during ongoing training.

2.2. Long delays and limited access to secondary care (n=4 studies)[8, 12, 14, 27]

Clinicians perceived that there were delays and limited access to services in secondary care, and this impacted on primary care clinician decision making about referrals to secondary care.

2.3. Recognition of the importance of a multi-disciplinary approach (n=5 studies)[8, 11, 13, 19, 21]

Primary care clinicians considered that a collaborative approach to working with other clinical specialists could improve the level of care that a patient receives. This included working closely with gynaecologists to understand when it was appropriate for patients to be referred for investigation,[13] and working closely with dieticians, nurses, midwives, physiotherapists and counsellors to develop more holistic approaches to care.[11, 27]

2.4. Recognition that continuity of care is important and frustration that this is difficult to achieve (n=4 studies)[11, 12, 19, 28]

Primary care clinicians recognised that continuity of care was important in order to build a rapport with patients, and so that patients felt that they could trust them and have confidence in them. Where continuity of care was not achieved, clinicians felt that they could not provide the optimal level of care. Continuity required that care was provided by a sole clinician wherever possible, with an understanding of previous treatments, side effects and a patient's stage in life. Clinicians also made the specific point that continuity of care was important if they were trialling a course of treatment, in order to assess its effectiveness.[12]

2.5. Unmanageable GP workload (n=7 studies)[7, 9, 12, 15, 24, 27, 28]

Primary care clinicians perceived that high levels of GP workload sometimes prevented them from doing more than the minimum required for their patients. Short consultation times were often referred to in this context. This subtheme was identified in studies that contained GPs, and also nurse practitioners and pharmacists in primary care settings. As data was not disaggregated it is not clear if the subtheme relates solely to GPs or also to these other primary care practitioners.

Structural and organisational subthemes identified in fewer than 4 studies

2.6. Doctors don't always take full responsibility because they don't think women's health issues are their remit within their specialism (n=1 study)[25]

2.7. Pressure to reduce referrals (n=1 study)[12]

3. Community and external factors

Community and external factors themes describe how wider socio-cultural issues and beliefs affect interactions between primary care clinicians and women patients with gynaecological conditions or symptoms suggestive of gynaecological conditions. The focus is on how gynaecological conditions and symptoms are conceived in the wider society, and whether and how clinicians should take account of this when meeting with women patients. There were 7 subthemes within this group including 4 which were mentioned in 4 or more studies. These are listed alphabetically, below.

3.1. Normalisation of pain/symptoms in wider society and amongst clinicians (n=6 studies)[8, 10, 12, 14, 19, 28]

Primary care clinicians perceived that symptoms of gynaecological conditions, including pain and heavy menstrual bleeding, are not always recognised by patients as outside of the normal range. This was sometimes perceived as widely misunderstood amongst women,[10] but was also perceived to be a misunderstanding that is specific to minority groups with different cultural understandings of gynaecological issues.[14, 28] Some patients were thought not to consider heavy menstrual bleeding or menopause as medical conditions.[14, 28] One study also reported that clinicians were sometimes unsure of what constitutes 'normal' menstrual pain in young women who are experiencing this for the first time.[12]

3.2. Stigma or embarrassment of menstrual conditions and symptoms amongst patients (n=8 studies)[7, 8, 12-15, 25, 26]

Clinicians perceived that there is stigma and embarrassment about menstrual conditions and symptoms. This can include cultural stigma surrounding menstruation and embarrassment about visible signs of bleeding. Studies also described embarrassment about associated symptoms such as painful bowel movements, and pain with sexual intercourse. Clinicians were aware that some patients with a particularly strong sense of stigma or embarrassment would not present with heavy menstrual bleeding until it had severe other impacts, such as anaemia.[14]

3.3. Web-based sources of accurate information are needed to correct misinformation which is a cause of anxiety and mistaken beliefs amongst patients (n=6 studies) [8, 9, 11, 12, 17, 21]

Primary care clinicians noted that there was a preponderance of online misinformation about gynaecological conditions which was a cause of anxiety and mistaken beliefs that were hard to challenge.[9, 21] Clinicians said that they would find it helpful to be able to signpost patients to reliable sources of online information.[8, 12]

Community and external factors subthemes identified in fewer than 4 studies

3.4. Cultural beliefs of patients should be taken into account but stereotyping of minority groups by clinicians is unhelpful (n=2 studies)[14, 28]

Primary care clinicians described how an awareness of cultural beliefs of patients can improve the patient-clinician interaction. For example, it could help in the understanding of stigma or embarrassment that a patient might feel, and in particular could help in the understanding of when a patient might feel uncomfortable discussing an issue with a male clinician.[14] However, it was also noted that primary care clinicians should be careful not to rely on stereotypes of minority groups when gauging how to interact with patients.[28]

3.5. External factors which lead to faster referral (n=2 studies)[13, 14]

Primary care clinicians considered that there were factors that could lead to a faster referral, even if a patient's symptoms were similar to patients who were not referred or referred more slowly. These included where communication was difficult due to the patient having a limited understanding of the English language, and where a patient was unwilling to speak to male clinicians but could be referred to female clinicians in secondary care settings. Referral was also faster if fertility concerns were raised by the patient.

3.6. Women's health is underfunded and not seen as a priority for research (n=2 studies)[12, 25]

4. Factors related to multiple conditions

This set of subthemes relate to condition specific factors which are relevant across multiple conditions. There are six subthemes in this group including five which were mentioned in four or more studies.

4.1. Gynaecological conditions can be difficult to definitively diagnose (n=9 studies)[9, 11-13, 18, 21, 22, 25, 26]

Primary care clinicians reported that some gynaecological conditions are difficult to definitively diagnose. This sometimes means that patients are required to make multiple visits to see a clinician in order for the clinician to assess the patients' symptoms over time, and to consider whether symptoms can be managed without a referral or diagnosis. Definitive diagnosis may require a referral, potentially including an invasive procedure.

4.2. Lack of GP guidance (n=4 studies)[7, 13, 16, 18]

GPs considered that there is a lack of guidelines on diagnosing and managing gynaecological conditions and symptoms, and even where guidelines do exist, they still do not sufficiently help primary care clinicians with patient care.

4.3. Medicalisation of social phenomena/not believing there to be a physical issue (n=7 studies)[8-10, 20-22, 24]

Primary care clinicians considered that symptoms associated with gynaecological conditions could arise due to psychological issues rather than physical issues, in particular, symptoms of endometriosis and chronic pelvic pain.[9, 10, 22] Uncertainty was expressed regarding whether some gynaecological conditions should be classified as medical issues or societal problems or trends. For example, it was suggested that symptoms of PCOS could be caused by obesity,[21] and that PMS was a label that came in and out of "fashion".[20]

4.4. Need to follow a diagnostic hierarchy and exclude 'red flags' first (n= 8 studies)[8, 12, 13, 19, 21, 22, 24, 28]

Primary care clinicians sought to exclude the most serious and acute conditions before considering less serious or time sensitive conditions. This included excluding trauma and abuse, and cancer in older women. Once more serious conditions had been excluded, clinicians' sense of urgency for a diagnosis was reduced if the symptoms were not severe.

4.5. Trying but not succeeding to find solutions for patients who are dissatisfied with care (n=4 studies)[8, 10, 22, 24]

Primary care clinicians reported struggling to find solutions for patients who were dissatisfied with the level of care they had received for their condition or symptoms.

Multiple conditions subthemes identified in fewer than 4 studies

4.6. Risk of over diagnosis (n=3 studies)[17, 21, 22]

Stakeholder reflections

Both our stakeholder groups agreed that the Dixon et al.[12] framework covered relevant considerations in relation to managing patients with gynaecological conditions or symptoms suggestive of gynaecological condition, and the themes resonated with their experience. They also agreed that many elements of the framework were pertinent to other conditions, not just endometriosis. This provides reassurance for the appropriateness of our approach to analysis. However, one group suggested that the findings about endometriosis management were framed in a way that suggested onward referral was the desirable outcome. They felt that in many cases these patients were most appropriately managed in primary care, even without definitive diagnosis. The need to rule our serious conditions, such as ovarian cancer, as the cause of symptoms was seen as important, particularly in older women. It was felt that once this had been ruled out, then there may be less urgency to reach a diagnosis particularly as symptoms could be managed without it. In addition, reaching a diagnosis too early might lead to a condition being wrongly labelled and it was felt that it could be difficult to change this diagnostic label later on. Stakeholders suggested that expectations about the outcome of a primary care consultation varied, with some women expecting to be seen by a gynaecologist very quickly, and that this could lead to conflict between patient and clinician views.

Both groups noted that the experiences of male and female GPs were markedly different, with men rarely seeing patients presenting with gynaecological conditions or symptoms suggestive of a gynaecological condition, and that these numbers had decreased over time. In contrast, such patients were frequently seen by female GPs. It was suggested that male GPs were therefore less familiar with the issues when they did see such cases, and that it was difficult for them to get substantial experience with some techniques, such as speculum examinations. Further, it was perceived that male GPs might not update their knowledge with training about these topics, as it was seen as less relevant to their work. Management of these patients was acknowledged to be complex, with changes in approaches to treatment – in particular to more conservative treatments for conditions like menorrhagia - over time.

The male GPs noted that they needed to ask for a chaperone to be present when they did intimate examinations, and that this could negatively affect the dynamic with the patient. This was supported by the observation of the female GPs that women rarely accepted their offer of having someone else present for these examinations, preferring more privacy.

Both groups noted structural/organisational challenges in managing patients with gynaecological conditions or symptoms suggestive of gynaecological condition, particularly around short consultation times, and long waits for referral to a gynaecologist and for ultrasound or laparoscopy investigations (waits of months to a year were mentioned) which could make them reluctant to refer. Short appointment slots in primary care meant that it was not possible to both collect a detailed history and conduct a physical examination in the same appointment, leading to multiple visits being required.

Discussion

We found a relatively substantial qualitative research evidence base, with 23 papers from 18 unique studies seeking to understand primary care clinicians' perspectives on interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions. However, there were only a small number of subthemes directly about listening or communication. Despite this, several relevant factors were identified which may contribute to the challenges of diagnosing and managing these conditions and hence to the nature of consultations with women about them. These were found at four levels and related to:

- clinician experiences, knowledge and attitudes;
- structural and organisational issues;
- community and external issues;
- the complexities of diagnosing and managing specific conditions.

In this discussion, we interpret the identified themes and subthemes in the context of both the review question, and the Women's Health team's interest in improving communication with, and listening to, women in primary care. These interpretive themes are cross-referenced below to the descriptive subthemes in the Findings section, using subtheme numbers in brackets (with hyperlinks). Subthemes relating to specific conditions which are not listed in the Findings section are hyperlinked to the full list of themes and subthemes in Table 7 and Table 8 in Appendix E.

It is notable that identified subthemes supported by the most studies related to centring women's experiences and the importance of open dialogue between the patient and clinician (1.8; 1.9; 1.10). Clinicians recognised the need to treat women with empathy and respect (1.8), and to recognise the psychosocial, as well as physical, impacts of gynaecological conditions (1.9). This also meant using women's own perspectives of what was normal or abnormal in terms of symptoms to inform decision making (1.10).

However, given the findings of previous consultations and research among women, this does not seem to have translated into women feeling listened to, and respected, in these consultations.[1, 2, 6] It is possible that some of the other issues, related to the personal, structural and external contexts in which these consultations take place, combine to create a situation where women do not feel that their concerns are listened to. These include:

- Socio-cultural factors affecting the consultation experience;
- The need for further education, training or guidance for clinicians in managing these conditions;

- Factors affecting the decision to refer women, including obtaining a definitive diagnosis; and
- Factors related to service structure and organisation.

These are described below.

Socio-cultural factors affecting the consultation experience

A set of themes were identified that have the potential to contribute to poor patient experience. These related to both the broader socio-cultural landscape as well as the individual clinician's attitudes.

Primary care clinicians considered that there remains a sense of stigma and embarrassment about menstrual conditions and symptoms, particularly amongst some minority groups but also in the wider society (3.2). This was combined with the perception that some women felt that symptoms suggestive of gynaecological conditions were part of normal life, and that it was not necessary to seek medical help (3.1). Some clinicians suggested that symptoms (such as pain) might be psychological, rather than physical (4.3). These factors could lead to delays in women seeking appropriate care, or difficulties describing the experienced problem. For example, it was suggested that South Asian women would sometimes not present until they were anaemic from blood loss (3.2).[1] Symptoms of menopause and menstruation might not be considered by patients as medical conditions at all (3.1). Some clinicians unhelpfully expected patients to comply with, rather than engage with, care, viewing them as "good" or "bad" patients depending on how well they followed advice (1.17) and researchers suggested that clinicians might stereotype how ethnic minority groups view medical conditions rather than engage fully with individual patients (3.4).

Differences in how male and female GPs interact with women were apparent, including that some male GPs were sceptical of relying on women's reported subjective experiences of blood loss as a basis for diagnosis of menorrhagia (8.1). By contrast, it was also reported that some male GPs relied solely on patients' experience of blood loss, feeling ill-equipped to do anything else. Female GPs were described as more confident in combining in-depth exploration of patients' experiences with clinical judgement about the abnormality of the symptoms (8.1).

While some clinicians preferred patients who came to consultations prepared, with a clear idea of what they wanted (1.12), others thought that patients who had gleaned inaccurate information

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[1] Although note that this observation came from an older study (Chapple 1998) and it is not clear if such issues persist.

online might hold beliefs that they would find difficult to challenge (3.3). To address this problem, accurate sources of online information were considered necessary to help patients understand their symptoms and for clinicians to signpost patients (3.3).

Clinician expectations and preferences about patients, such as coming prepared to consultations (1.2) and following advice (1.17), including being responsive to lifestyle advice (such as weight loss for those with PCOS), suggest that some clinicians make judgements about who is a ‘deserving patient’ and who is not. This might influence the way in which women patients are treated. Similarly, clinicians may consider the wide of range of symptoms that some women present with as having psychological, rather than physical, origins (1.18). In some cases lifestyle and psychological factors, such as obesity, were considered as potential causes of physiological symptoms which needed to be addressed before the patient would see an improvement in health (4.3). However, clinicians felt that some patients were reluctant to accept that there were no easy solutions (6.1) and would disengage with primary care services (potentially opting for alternative medicines) if they felt that they were not receiving appropriate treatment (9.2).

Taken together, these factors suggest that symptoms related to gynaecological conditions remain contested, and that there is the potential for the needs of women not to be recognised within a primary care consultation. There is a need to challenge primary care clinicians’ assumptions on the best way of providing care, and for clinicians to better understand women patients’ perspectives on gynaecological conditions. It is also important to encourage patients to seek help without embarrassment.

Need for further education, training or guidance

A number of themes suggest that there is a need for further GP training, education and guidance on the diagnosis and management of gynaecological conditions. This was found across all conditions considered in this review. Clinicians considered that they sometimes lack sufficient knowledge or awareness of gynaecological conditions (1.4) due to limited education (2.1) and guidelines (4.2), or due to infrequent exposure to these conditions (1.3). Even if guidelines were available, lack of time in primary care may mean that clinicians were unable to read and understand them (6.2). Based on the observations of the stakeholder groups, it is possible that these factors apply more to male GPs than female GPs, as male GPs may see fewer patients with gynaecological conditions than female GPs, due to patient preference. Indeed, the stakeholder groups suggested male GPs may be less inclined to seek education and training due to infrequent exposure to gynaecological conditions, creating a vicious cycle.

Clinicians reported struggling to find solutions for patients that were dissatisfied with their care, particularly patients with long-term symptoms or conditions (4.5). This would sometimes include patients with symptoms for which no clear biomedical explanation could be identified, and GPs perceived that practice nurses also struggled to deal with such patients due to lack of training (9.4).

It is possible that such lack of knowledge and guidance may lead to women not being treated appropriately in primary care or to delays to getting a satisfactory treatment for their condition, which may mean women feel they are not being listened to because the primary care clinician team is ill-equipped to respond to their concerns. Further training for primary care clinicians on these issues is required to improve patient-clinician interaction, although by itself will not be enough to address the wider structural and socio-cultural factors.

Diagnosis and decisions to refer women

A number of themes related to diagnosis and referral decisions, which may lead to women feeling that GPs are gatekeeping further investigation. It was noted that many gynaecological conditions are difficult to definitively diagnose (4.1) and that some diagnoses require tests, such as scans, which can only be obtained through referral. However, referrals were not always made even if there were symptoms suggestive of a gynaecological condition. Reasons why included that clinicians reported following a diagnostic hierarchy which aims to exclude red flags (such as gynaecological cancer) first (4.4); once the most serious conditions had been excluded, clinicians had a reduced sense of urgency for diagnosis or referral to investigate other gynaecological conditions (4.4). Furthermore, clinicians were sometimes concerned about the potential adverse events of the necessary tests (in particular, laparoscopy) (1.2), which might also make them reluctant to refer. This reluctance might be exacerbated if clinicians thought that the results would not affect treatment (1.7). It was also noted that some clinicians felt pressured to reduce the numbers of referrals (2.7), and that delays in accessing secondary care may further reduce decisions to refer (2.2).

Not all gynaecological conditions require a referral for a diagnosis. However, there were additional reasons why these conditions might not be diagnosed. Some clinicians did not think that getting a diagnosis was necessary if the symptoms could anyway be adequately controlled in primary care (1.5). There was also a reluctance to give a patient a ‘label’ too early, particularly as this would not necessarily affect the treatment options, and could be a cause of anxiety for the patient (1.6). There was some concern about the risk of over- or misdiagnosis, which can lead to failure to treat the actual problem (4.6). However, it was also suggested in one study on chronic pelvic pain that, even if no pathological issues could be identified, a provisional diagnostic label helped to validate women’s symptoms (9.3).

It was suggested that some groups of women were more, or less likely to be offered referrals. GPs suggested that women who did not have English as a first language, those not wanting to be examined by a male clinician, or where infertility was a primary concern, might be more likely to be referred (all 3.5). More engaged and proactive women were also thought more likely to get referred (1.12). Younger women were seen as less likely to have serious pathology and so were less likely to be referred (1.11).

It is possible that the number of factors which influence the decision to refer or diagnose gynaecological conditions can lead to a mismatch of expectations and need between women and their clinicians, in terms of the outcome of a consultation, which may lead women to feel not listened to or not taken seriously. Primary care clinicians should explain to women patients why they think a referral is or is not advisable, including taking into account women's views about whether a diagnosis would be helpful or not.

Factors related to service structure and organisations

A number of themes identified challenges in the structure and organisation of health care services, in addition to those related to referral, which might lead to suboptimal experiences for women. This included high GP workload and limited consultation time, which was perceived by clinicians to have a detrimental effect on the quality of care that could be provided (2.5). This was perhaps not helped by the fact that primary care nurses sometimes struggled to deal with patients with challenging symptoms particularly, as noted above, patients with symptoms that had no clear biomedical explanation, and who would refer these patients back to see GPs (1.14; 9.4). A lack of continuity in Primary Care if multiple visits were required was also perceived by clinicians to be a challenge, especially when patients were unable to see the same clinician on successive visits (2.4).

These service level factors, which may lead to short consultations where a full history and examination cannot both be undertaken, and repeated appointments with different staff, may lead to poorer care and dissatisfaction among women seeking help. Addressing these organisational factors, such as by lengthening consultation times or guaranteeing continuity of care, would potentially improve patient-clinician interaction.

Strengths and limitations

This scoping review is based on extensive searches of several sources including bibliographic databases, search engines and websites, and makes use of forward citation searching and checking reference lists to identify additional studies. The searches identified a selection of studies which described clinicians' perspectives on interacting with women with gynaecological conditions or symptoms suggestive of such conditions, from a variety of conditions and symptoms. Of the 24 subthemes supported by four or more studies, only one was not supported by a UK-based study, which strengthens the relevance of these findings for the policy customer. The analysis has highlighted common themes and subthemes, and identified issues which might contribute to the known phenomenon of women not feeling listened to in primary care consultations. However, there were only a small number of identified subthemes which directly refer to the phenomenon of listening, which was the main area of interest in the topic brief. Instead, most of the identified themes and subthemes focus on the wider issue of interacting with women when considering diagnoses and management of gynaecological conditions and symptoms, from which reasons why women do not feel listened to must be inferred. There were also several older studies included in the analysis, and it is not clear how relevant the findings of these studies are for clinicians today. There were some gaps in the literature which require further evidence. We did not identify any studies that discussed disabled, LGBTQ+ or older women, and only a small number of studies discussed ethnic minority or younger women. Although we did identify some data within the included studies that addressed the issues of listening to and communicating with women, further studies which focus specifically on these issues would help to gain more understanding. We identified no studies which observed clinician-patient consultations, which would be another way of gaining understanding how clinicians and women interact in primary care settings. These could be analysed using conversation or discourse analysis to explore how women and their doctors interact and understand one another during these consultations. In particular, such studies might provide a fuller picture of the mismatch between women's perception of not being listened to, and the perception of clinicians' reported in our findings that it is important to listen sensitively to women when discussing gynaecological conditions and symptoms.

It would also be helpful for future studies to more explicitly report their theoretical perspectives, and in particular to explore clinician-patient interaction using feminist perspectives, as in Young et al.[10] This could be used to address apparent power imbalance in the patient-clinician relationship, in view of comments about expecting women to follow rather than challenge advice, and framing patients as 'good' or 'bad' depending on compliance. Studies also identified sexual and racial stereotyping which could harm patient care if this means that patient concerns are not properly addressed, and which might be usefully explored using more explicitly theory-based approaches such as feminist perspectives.

Finally, the majority of studies focused on the perspective of primary care doctors (including GPs and US-based family physicians and internists), with only a small number of studies considering the perspectives of other health care professionals, including nurses (n=3 studies), community gynaecologists (n=1 study), and community pharmacists (n=1 study). This focus on primary care doctors is inconsistent with the long-term vision for primary care as set out in the *Five Year Forward View*, which proposes to create new models of primary care in which other health care professionals take on more prominent roles alongside doctors.[41] Thus, future research should give more attention to the views of professionals such as nurses, physician associates, community gynaecologists and pharmacists.

Dissemination

The main intended audience of this review is the Women's Health Team at the Department of Health and Social Care. However, we also plan to share the findings of this review more widely by writing a paper for submission to a relevant health care journal and by producing a plain language 'briefing paper'. The former will be a detailed scientific report of the review aimed primarily at primary care clinicians. The latter will be tailored for a more general readership, including women patients, although we still aim to share this with primary care clinicians as an easily readable overview of the findings. The production of the briefing paper will involve our patient and public involvement team to ensure the presentation is suitable for the intended readership. We will also host the present report on the Exeter PRP Evidence Review Facility webpage and use our Twitter account to share news of the report's publication.

Conclusions

Primary care clinicians' perceive that attentive listening and open communication are important when discussing gynaecological conditions or symptoms with women patients in a consultation setting. They also consider it important to consider how women with gynaecological conditions and symptoms may be affected psychologically and socially, and try to take these factors into account when considering diagnosis and management. A collaborative patient-clinician approach is preferred wherever possible. However, primary care clinicians also appear to be impeded in realising these ideals by several different factors. These relate to their own limitations of knowledge and understanding, and also to the wider context of the structure and organisation of primary care settings (and relatedly, the secondary settings which can provide additional care), and the broader socio-cultural context. Gynaecological conditions and symptoms also pose challenges in terms of making a definitive diagnosis and management of symptoms. Although we were able to identify some data on listening to and communicating with women, most data related to wider issues which might affect the ability to listen to and communicate with women but do not directly address these issues. In order to gain more understanding of the perspectives of clinicians on interacting with women with gynaecological conditions or symptoms, specifically with respect to listening and communication, further primary research is required which explicitly addresses these issues.

Part 2: Methods, PRISMA flowchart summary, and study characteristics

Methods

Identification and selection of papers

As recommended for scoping reviews, our approach to study identification was as exhaustive as feasible in the timeframe and aimed to identify both published and unpublished (i.e. grey literature) evidence.[36] The bibliographic database search strategies were developed using MEDLINE (via Ovid) by SB in consultation with the review team and key stakeholders. The search terms were informed by our extensive background searches which were undertaken in order to inform the development of the research question and the overall approach to the review outlined in the protocol. The titles, abstracts and indexing terms of relevant studies identified during this process were inspected for appropriate search terms and supplemented with relevant synonyms. We also asked stakeholders with expertise on gynaecological conditions to suggest relevant search terms and consulted the search strategy developed by the Cochrane Gynaecology and Fertility Group to identify trials for their specialised register.[42] The final search strategy combined terms for relevant gynaecological conditions and common symptoms of gynaecological conditions, with terms for clinicians' perspectives (i.e. terms for doctors, nurses and health care professionals 'adjacent to' terms for perspectives, perceptions, views). A published qualitative study type filter was applied with adaptations to increase the sensitivity of the filter for the purposes of this review.[43] We used controlled headings wherever available (e.g. MeSH in MEDLINE) alongside free-text searching in the title and abstract fields of bibliographic records. The results of searches were limited to English language studies.

The final MEDLINE search strategy was translated for use in the below selection of health care bibliographic databases:

CINAHL (via EBSCO)
Embase (via Ovid)
HMIC (via Ovid)
MEDLINE ALL (via Ovid)
ASSIA (via ProQuest)

The results of the bibliographic database searches were exported to Endnote X8 (Clarivate Analytics, Philadelphia, PA, USA) and de-duplicated using the automated de-duplication feature and manual checking. The Ovid MEDLINE search strategy is reproduced in Appendix A. The search strategies for all bibliographic databases are available on request from the authors.

Forwards and backwards citation searches were conducted on all studies that met our inclusion criteria. Forwards citation searching was carried out via the Science Citation Index (Web of Science, Clarivate Analytics) and Google Scholar (https://scholar.google.co.uk/). Google Scholar and Google Search (UK) (www.google.co.uk) were searched using keywords to identify studies not indexed in bibliographic databases or missed by the bibliographic database search strategies. We also searched a selection of topically relevant websites including:

Primary care clinician college websites:

• Royal College of General Practitioners	https://www.rcgp.org.uk/
• Royal College of Nursing	https://www.rcn.org.uk/
• American Academy for Primary Physicians	https://www.aafp.org/home.html
• School for Primary Care Research	https://www.spcr.nihr.ac.uk/
• American Nurses Association	https://www.nursingworld.org/

Charities with an interest in gynaecological health:

• Wellbeing of Women	https://www.wellbeingofwomen.org.uk/
• Lady Garden Foundation	https://www.ladygardenfoundation.com/
• The Eve Appeal	https://eveappeal.org.uk/our-research/
• Endometriosis UK	https://www.endometriosis-uk.org/
• Primary Care Women's Health Forum	https://pcwhf.co.uk/
• Newson Health	https://www.newsonhealth.co.uk/

The *Google Scholar* and *Google Search* search strategies are reproduced in Appendix A. The search strategies for all websites searched are available on request from the author.

Inclusion criteria

The inclusion criteria and exclusion criteria applied to the studies identified through the search strategy are detailed below. We organised the criteria according to the PICo format (Population/problem, phenomenon of Interest, Context).

Population

Include:

- Primary care clinicians including:
    - General practitioners/family doctors
    - Nurse practitioners
    - Physician assistants
    - Any healthcare professionals based in primary care settings

AND

- Patients with gynaecological conditions, including, but not limited to:
    - Endometriosis
    - Menopause, including perimenopause, post-menopause and premature ovarian deficiency
    - Menstrual disorders, e.g. heavy menstrual bleeding, PMDD
    - Polycystic ovary syndrome
    - Reproductive morbidity limited to any condition of the reproductive tract (see also reproductive morbidity exclusion criteria, below)
    - Gynaecological cancers and fibroids
    - Patients with symptoms suggestive of gynaecological conditions of interest, e.g.
    - Feeling sick, constipation, diarrhoea, or blood in urine during period
    - Heavy menstrual bleeding
    - Pain after or during sexual intercourse
    - Pelvic pain
    - Severe period pain that stops normal activities

Exclude:

- Only secondary care clinicians as participants
- Male patients (unless study also reports disaggregated data on women patients)
- Reproductive morbidity which is a consequence of reproductive behaviour including pregnancy, abortion, childbirth or sexual behaviour

Phenomenon of interest

Include:

- Primary care clinicians' perspectives on interacting with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions.

- Challenges that affect primary clinicians’ ability to listen and communicate effectively with patients with gynaecological conditions or symptoms suggestive of gynaecological conditions.
- Primary care clinicians’ perspectives on how well equipped they feel to support women with gynaecological conditions, and being sensitive to experiences with women from specific population groups (e.g. ethnic minority women, LGBTQ+ etc.)

Exclude:

- Only patients’ perspectives on interacting with clinicians

Context

- Primary care settings including
    - General practice/family doctor settings
    - Family planning clinics

Additional inclusion/exclusion categories (study design, date limit, geographical location)

Study design:

Include:

- Recognised methods of qualitative data collection including, but not limited to:
    - Focus groups
    - Interviews
    - Ethnographies
- Recognised methods of qualitative data analysis including, but not limited to:
    - Thematic analysis
    - Interpretative phenomenology
    - Grounded theory

Exclude:

- Questionnaires
- Statistical/quantitative analysis of interview or observational (e.g. conversation analysis) data
- Surveys
- All non-qualitative study designs
- Mixed methods studies unless there is substantial qualitative analysis

Date limit:

- No date limit

Geographical limit:

- Restrict to the UK and World Bank high income countries

Language restriction:

- Studies published in English only

Publication type

- Theses were excluded

Study selection

As an initial exercise to calibrate inclusion judgments and verify the clarity of our inclusion criteria, all reviewers who contributed to screening (SB, GJMT, JTC and RG) applied inclusion and exclusion criteria to the same sample (n=100) of search results. Decisions were discussed in a group meeting to ensure consistent application of criteria. Where necessary, inclusion and exclusion criteria were revised to enable more consistent reviewer interpretation and judgement. The revised inclusion and exclusion criteria were then applied to the title and abstract of each identified citation independently by two reviewers, with disagreements resolved through discussion or referral to a third reviewer as required. For each record identified for possible inclusion at the title and abstract screening stage, the full text was obtained and assessed for inclusion in the same way.

Endnote X8 (Clarivate Analytics, Philadelphia, PA, USA) software was used to support study selection. A PRISMA flowchart is reported in the results section and reasons for exclusion of each record retrieved at full text in Appendix B.

Charting the data

Data extraction in a scoping review is described as charting the data and aims to capture the characteristics of the identified studies and information relevant to the review question.[37] A standardised data extraction form was developed in Microsoft Excel and piloted on a selection of included studies. This was used to collect the following information from each included full text paper (listed in order in which the data appears in the data extraction form):

- First author
- Date of publication
- Title of publication

- Related papers e.g. papers which are based on the same study data
- Country setting
- Conditions/symptoms of interest
- Other conditions discussed in the study
- Research questions and aim
- Results and conclusions
- Year of data collection
- Clinician sample size
- Type of clinicians in sample
- Gender of clinicians in sample
- Primary care clinician sample size
- Patient gender of interest
- Whether patients of interest include ethnic minority women/LBGT/disabled
- Whether patients are also included in the study
- Patient sample size
- Gender of patients in study
- Whether patients in study include ethnic minority women/LGBT/disabled
- Data collection methods (for clinicians and patients separately)
- Data analysis methods (for clinicians and patients separately)
- Patient demographics (including gender, ethnicity, sexuality, disability)
- Themes or ideas presented relevant to research question

Data extraction of study characteristics was carried out by one reviewer (SB) and checked by a second (BA, JTC, LS or RG).

Quality appraisal

Quality appraisal was carried out using an adapted version of the Wallace checklist.[29] The adaptation does not change the content, it just ensures that questions about reporting and conduct are answerable separately (for example, our questions 6 and 7 “was data collection adequately described” and “was data collection rigorously conducted to ensure confidence in the findings” are listed as a single question in the original). All assessments were performed by one reviewer (SB) and checked by a second reviewer (BA, JTC or RG), with disagreements settled by discussion or consultation with a third reviewer if necessary.

Protocol deviations

We made some minor changes to the registered protocol which are described.

- The protocol stated that we would exclude studies that included data from both primary and secondary care clinicians if the data was not disaggregated. However, due to finding only a small number of relevant studies in total including several studies that included aggregated data from primary and secondary care clinicians that was otherwise relevant to the research question, we have included these studies. Where data was presented separately for primary care clinicians, we only included this data in the analysis. For other papers, unless explicitly stated otherwise in the papers, we have assumed that themes were developed from the input of all clinicians, including those working in primary care, and coded all findings. Studies that match the original criteria are indicated in green in the study characteristics table (Table 2).
- The protocol stated that we would exclude studies that report patients’ perspectives on interacting with clinicians (unless a study also reports disaggregated data on clinicians’ perspectives on interacting with patients). However, we have included studies that have data on both clinician and patient perspectives even if they are not disaggregated in view of the low number of studies identified overall. Studies that do not match the original criteria are indicated in blue in the study characteristics table (Table 2).
- Theses were subsequently excluded due to being a prohibitive size for reading in full and coding within the limited time we had for completing this review.
- We did not extract data on how much text within each study is relevant to our research question or suggestions for further research.

Data analysis and presentation

As this is a scoping review, the data analysis aimed to identify and summarise key themes in the identified studies using a framework.[36] In order to summarise the themes in the included studies, we began by examining the papers on endometriosis since we identified more papers on this condition that other conditions. After reading these papers, we selected the recent paper by Dixon et al.[12] as an index paper to guide the analysis, as this paper had the most well developed set of themes and subthemes.[44] This paper aimed to explore GP perspectives about managing possible endometriosis. It contained subthemes relevant to the challenges of diagnosing endometriosis under four organising themes: *individual clinician level*; *structural and organisational primary care factors*, *factors specific to endometriosis, and community and external factors*.[12] These themes and associated subthemes were used as an organising framework against which the other papers' findings were compared, and their findings were translated into this framework. Where papers contained subthemes that did not fit within this framework, these were added to the coding framework within the existing subthemes wherever possible.

We translated all the papers on endometriosis into this framework first. Since many of the *clinician*, *structural and organisational*, and *community and external factors* were found to be similar across other conditions, we continued to use the framework to organise findings on other conditions. We added a new set of condition-specific themes inductively for each condition as the papers were analysed: PCOS, menopause, menorrhagia, chronic pelvic pain, and premenstrual syndrome. Despite the initial framework labelling a group of subthemes under the *factors specific to endometriosis* theme, some of these were also found to be present in accounts of other conditions. We therefore continued to code other papers' findings against this framework where relevant, and made a note to show to which condition the finding related. We also created a 'factors specific to multiple conditions' theme to capture subthemes which were relevant to multiple conditions. In addition, all subthemes under the three generically worded organising themes in the Dixon et al. paper (i.e. *individual clinician level*; *structural and organisational level*; *community and external factors*) were re-worded where appropriate to remove specific reference to endometriosis (typically replacing with the more generic descriptor, 'gynaecological condition') in order to keep these more generic labels open for coding for all types of gynaecological condition.[12] Otherwise, we used the wording from the original paper for the themes and subthemes. One subtheme in Dixon et al. was not used because it appeared not to be supported by the evidence within the findings (Falsely reassured by negative tests).[12] Because we added new subthemes which were not captured by the initial framework as we successively coded each included study, we made a second pass through all of the studies in order to check whether studies coded earlier in the process included subthemes which were identified at a later stage of the coding process. We then checked across all the themes and, where they covered similar concepts, these were merged and re named as appropriate. All coding was performed by one reviewer (SB) and checked by a second (JTC, BA or RG), with disagreements settled through discussion, referring to a third reviewer if necessary. [12]

As this is a scoping review, we did not undertake a full qualitative evidence synthesis.[36, 37] We narratively described the themes and subthemes we identified. Subthemes with fewer than four supporting studies were listed without narrative summary unless the subtheme is unclear without further explanation, in which case we have included a short summary. All themes and subthemes were also tabulated (see Table 7 and Table 8 in Appendix E). As none of the subthemes for specific conditions had four or more supporting studies these are presented in tabular format solely in Table 8 in Appendix E. Each condition in Table 8 was assigned a theme number sequentially following the four themes in the Dixon et al. index paper (5-10).[12]

Second stage of interpretive coding

A second stage of interpretative coding was then undertaken to see how the initial themes could an be understood in relation to the Women's Health team's specific focus on primary care clinician-patient interaction and women feeling as though they had not been listened to or dismissed. This was undertaken by one reviewer (RG) and checked by a second (SB). This is presented narratively in the Discussion section with cross references to the theme and subtheme numbers presented in the Findings section (themes 1-4) and in Table 8, which summarises subthemes specific to a single condition (themes 5-10).

Stakeholder involvement

We organised meetings with primary care clinicians to discuss their perspectives on interacting with women patients with gynaecological conditions or symptoms suggestive of gynaecological conditions. Participants were recruited by our PPI coordinator (Kristin Liabo) using existing networks of clinicians. We had positive responses from five GPs including 3 female GPs and 2 male GPs. In order to discuss issues which might be gender specific to GPs, we met with 2 female and 2 male GPs separately for one hour per meeting (1 female GP was unable to attend on the day). The meetings included a short presentation on the review by SB, discussion on clinicians perspectives led by RG and sense check of the index paper coding framework we used to code included studies.[12]

PRSMA flow chart summary

The bibliographic database searches identified 2682 study records (see Table 3 in Appendix A) and supplementary searches identified 289 study records, including 282 records from forwards citation searching, and 7 potentially relevant studies from backward citation searching and web searching. Following the removal of duplicates there were 1956 study records to screen. Of these, 62 were selected as potentially matching the eligibility criteria for our review. Full-text papers of 56 of the 62 potentially relevant study records were successfully obtained. The six records for which no full-text paper was obtained were conference abstracts, of which five had no associated full-text paper[45-49] and one[50] was associated with a full-text paper that was included in the 56 papers that we were able to obtain.[21] These are marked as 'Abstract' in the PRISMA diagram reasons for exclusion box in Figure 1.

Following full-text screening, a further 33 papers were excluded due to the following reasons: Not describing clinicians' perspective on gynaecological conditions or symptoms (n=2); not being set in primary care (n=5); not matching our phenomenon of interest (n=16) (typically these were studies which were not about gynaecological conditions); not being a qualitative study design (n=6); duplicate paper (identified by two separate search methods) (n=1); and due to being a PhD thesis (n=3). The full list of studies excluded at full-text screening with reasons for exclusion is presented in Table 4 in Appendix B.

Study characteristics

Description of included studies

The 23 included papers are based on data collected from 18 unique studies. Papers that are based on the same study data include: Chapple et al.[14] and Chapple et al.[7]; Bush et al.[16] and Nekhlyudov et al.[39]; Young et al.[9] and Young et al.[10] Furthermore, Bertero et al.[11] is a secondary analysis of data presented in Grundstrom et al.[19], and May et al.[23] includes a secondary analysis of data presented in Chapple et al.[40] All of the included papers were published in journal article format between the years 1998 and 2021. Papers were based on data collected from six countries including the UK (n=8), Australia (n=6), US (n=3), Netherlands (n=2), Sweden (n=2) Norway (n=1).

Conditions discussed in the included studies

The most frequently discussed condition in the included papers was endometriosis (n=8)[8-13, 19, 26] and smaller groups of papers discussed menopause (n=4),[15, 16, 28, 39] menorrhagia (n=3),[7, 14, 23] PCOS (n=3)[17, 21, 27] and chronic pelvic pain (n=2).[22, 24] Of these, one paper that discussed menorrhagia also reported data on chronic pelvic pain which is not relevant to this review as there was no discussion of gynaecology or women.[23] Infertility disease (which included consideration of patients with endometriosis, PCOS and vulvodynia),[25] menstrual disorders[18] and premenstrual symptoms[20] were each discussed in one paper.

Qualitative methods used by the included studies

Data collection in the majority of papers used a semi-structured interview format (n=19).[7-10, 12-23, 25-27, 39] There were two papers which collected data using focus groups,[24, 28] albeit the main component of one of these papers was a survey of gynaecologists for which a GP focus group was used to develop the survey questions.[24] A further two papers were secondary analyses of existing interview data.[11, 23] The mean sample size of clinicians who participated in the included studies was 28.7. Data analysis methods included thematic analysis (n=6), content analysis (n=4), framework analysis (n=3; inclusive of n=1 with a phenomenological approach), grounded theory (n=2), template analysis (n=1), constant comparative analysis (n=1), cumulative and condition comparative analysis (n=1) and systematic text condensation (n=1).

Participants in the included studies

Primary care clinicians who participated in the studies included GPs, nurse practitioners, internists/family practitioners, pharmacists, a community gynaecologist and an otherwise unspecified primary care physician. GPs were included in the majority of papers (n=20)[7-15, 17-27] including one paper which included a sub-sample of GPs in training.[13] Of these, two also included nurse practitioners[18, 22], one included pharmacists in community settings[15] and one included a single community gynaecologist.[18] Of the three remaining papers, all were based on data from the USA of which two included internist/family practitioners[16, 39] and one included nurse practitioners and an unspecified primary care physician.[28]

Primary care clinicians were the sole participants in 11 papers[7, 12-14, 18, 20, 22, 23, 26-28] and were analysed separately to secondary care clinicians in one paper.[24] These papers are highlighted green in Table 2 as providing the data that is unique to primary care clinicians. The remaining 11 papers included both primary and secondary care clinicians and reported aggregated data for these two sets of clinicians, all of which included gynaecologists.[8-11, 15-17, 19, 21, 25, 39] Of these, two papers included secondary clinicians from obstetrics and gynaecology settings,[16, 39] and two included endocrinologists[17, 21] The percentage of primary care clinicians within the overall sample of clinicians in papers which reported aggregated data on both primary and secondary care clinicians ranged from 24%[19] to 92%.[8]

There were typically more female clinician participants in the studies than male clinician participants, including one study with 100% female clinician participants.[26] Studies where this was not the case included one study with an equal number of female and male clinicians[15] and two papers (based on the same study data) with more male clinician participants than female clinician participants.[7, 14] The latter two were also the oldest papers in the review with data-collection carried out between 1995 and 1996.[7, 14] Four papers did not report the gender of clinicians in the sample.[8, 23, 24, 28]

Patients considered in the included studies

The majority of papers reported on the perspectives of primary care clinicians in relation to women patients only (n=21). There was one paper on chronic pelvic pain which reported data relating to both female and male patients (which included one paragraph on issues specific to women)[22] and one paper which did not report the gender of the patients of interest, but which, because the conditions discussed in the study are not limited to gynaecological conditions, is likely to include data on consultations with both female and male patients.[23] There were three papers which discussed issues specifically relating to BAME women patients, including two on women of South Asian descent in North West England[7, 14] and one on immigrant Spanish speaking Hispanic women in New York, USA.[28]

Almost one third of papers (n=7) included patient participants in the study sample alongside clinicians.[8, 11, 17, 24, 26, 28, 39] Of these, 4 reported wholly disaggregated data for clinicians and patients,[17, [24, 26, 28] one reported some disaggregated data for clinicians and patients[8] and two did not report disaggregated data for patients and clinicians.[11, 39]

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13. van der Zanden M, Teunissen DAM, van der Woord IW, Braat DDM, Nelen W, Nap AW. Barriers and facilitators to the timely diagnosis of endometriosis in primary care in the Netherlands. *Fam Pract* 2020;**37**:131-6. https://doi.org/10.1093/fampra/cmz041

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17. Copp T, Muscat DM, Hersch J, McCaffery KJ, Doust J, Dokras A*, et al.* The challenges with managing polycystic ovary syndrome: A qualitative study of women's and clinicians' experiences. *Patient Educ Couns* 2021; 10.1016/j.pec.2021.05.038. https://doi.org/10.1016/j.pec.2021.05.038

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30. National Institute for Health and Care Excellence. *Endometriosis: diagnosis and mangement [NG73]*. 2017. URL: https://www.nice.org.uk/guidance/ng73/ (accessed 20th October, 2021).

31. NHS. *Overview: Heavy periods*. 2021. URL: https://www.nhs.uk/conditions/heavy-periods/ (accessed 20th October, 2021).

32. National Institute for Health and Care Excellence. *Heavy menstrual bleeding: assessment and management [NG88]*. 2021. URL: https://www.nice.org.uk/guidance/ng88 (accessed 20th October, 2021).

33. Bitzer J, Serrani M, Lahav A. Women's attitudes towards heavy menstrual bleeding, and their impact on quality of life. *Open Access J Contracept* 2013;**4**:21-8. https://doi.org/https://doi.org/10.2147/OAJC.S38993

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48. Teede H. Is there a need to increase PCOS awareness? *Human Reproduction* 2017;**32**.

49. Wee LE, Lim LY, Koh GC-H. Two sides of the coin: A qualitative study of patient and provider perspectives on colorectal, breast and cervical cancer screening in a low-income Asian community. *Proceedings of Singapore Healthcare* 2015;**25**:80-91. https://doi.org/10.1177/2010105815616404

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Appendix A: Search report

Bibliographic databases

Database: MEDLINE ALL

Host: Ovid

Issue: 1946 to October 29, 2021

Date Searched: 1/11/2021

Searcher: SB

Hits: 775

Strategy:

1. endometrio*.tw.
2. Endometriosis/
3. adenomy*.tw.
4. adenomyosis/
5. ((menstrua* or period*) adj2 (heavy or pain*)).tw.
6. (menstrua* adj2 (disorder* or disturbance*)).tw.
7. exp Menstruation Disturbances/
8. dysmenorrh*.tw.
9. menorrhagi*.tw.
10. (oligomenorrh* or "oligo amenorrh*").tw.
11. amenorrh*.tw.
12. (premenstrua* or "pre menstrua*" or PMDD).tw.
13. ((gynaecolog* or gynecolog* or vagina*) adj3 (bleed* or condition* or discharg* or disease* or dryness or pain*)).tw.
14. Genital Diseases, Female/
15. (menopaus* or postmenopau* or perimenopaus* or "ovarian deficiency" or "ovarian insufficiency").tw.
16. exp Menopause/
17. (hot adj2 (flash* or flush*)).tw.

18. *Infertility, Female/
19. (polycystic adj3 ovar*).tw.
20. polycystic ovary syndrome/
21. or/1-20
22. (pain* adj3 (abdominal or back or intercourse or menstrua* or pee* or pelvi* or period* or sex* or stomach or tummy or urinat*)).tw.
23. (pelvic adj3 congestion).tw.
24. exp Pelvic Pain/
25. dyspareunia.tw.
26. dyspareunia/
27. (constipat* or diarrhea* or diarrhoea*).tw.
28. *constipation/
29. *diarrhea/
30. (blood* adj3 (excrement or faeces or feces or faecal or pee* or urinat* or urine)).tw.
31. (haematuria or hematuria).tw.
32. ((infertility or reproductive) adj2 (disease* or disorder* or infection* or morbidity)).tw.
33. *reproductive tract infections/
34. or/22-33
35. (women* or woman or female* or girl* or mother*).tw.
36. "women’s health".kw.
37. Women/
38. exp Women's Health/
39. Female/ not Male/
40. or/35-39
41. 34 and 40

42. ((endometr* or fibroid* or uter* or cervi* or ovar* or vagin* or fallopian* or vulva* or gynae* or gyne*) adj3 (cancer* or neoplas* or carcinom* or malignan* or tumor* or tumour*)).tw.
43. fibroids.tw.
44. exp Uterine Neoplasms/
45. exp Ovarian Neoplasms/
46. exp Fallopian Tube Neoplasms/
47. exp Vaginal Neoplasms/
48. exp Vulvar Neoplasms/
49. or/42-48
50. ("primary care*" or "general practice" or general practitioner* or GP* or "practice nurse*").tw.
51. exp Primary Health Care/
52. exp General Practice/
53. General Practitioners/
54. (primary adj1 ("health care" or healthcare)).tw.
55. (family adj1 (practi* or doctor* or physician*)).tw.
56. Family Planning Services/
57. or/50-56
58. 49 and 57
59. 21 or 41 or 58
60. ((clinician* or "care provider*" or doctor* or gp* or "general practitioner*" or "health professional*" or "health practitioner*" or "healthcare professional*" or "healthcare practitioner*" or nurs* or physician*) adj6 (attitude* or "discursive construction*" or experience* or perspective* or perception* or perceive* or view*)).tw.
61. *"Attitude of Health Personnel"/
62. ((clinician* or "care provider*" or doctor* or gp* or "general practitioner*" or "health professional*" or "health practitioner*" or "healthcare professional*" or "healthcare

practitioner*" or nurs* or physician*) adj3 (bias* or communicat* or discriminat* or disrespect* or interact* or listen* or prejudice* or stigma*)).tw.

63. Physician-Patient Relations/
64. Professional-Patient Relations/
65. or/60-64
66. (experience or experiences or perspective* or qualitative).tw.
67. ((conversation* or discourse) adj2 (analys* or analytic*)).tw.
68. (ethnograph* or "audio recording" or "video recording" or "audio video recording").tw.
69. "focus group*".tw.
70. exp Qualitative Research/
71. or/66-70
72. 59 and 65 and 71
73. limit 72 to english language

Table 3. Bibliographic database search results

Database	**Hits**
CINAHL	531
HMIC	35
Embase	1269
MEDLINE	775
ASSIA	72
Total records	**2682**
Duplicate records	**986**
Unique records	**1696**

Web searching

Search engine: Google Scholar

URL: https://scholar.google.com/

Date Searched: 8/11/2021

Searcher: SB

Search strategies:

(gynaecological OR gynecological) (views OR perspectives OR experiences) (“general practitioners” OR doctors OR clinicians OR nurses)	150 screened (sorted by relevance)
endometriosis (views OR perspectives OR experiences) ("general practitioners" OR doctors OR clinicians OR nurses)	200 screened (sorted by relevance)
menopause (views OR perspectives OR experiences) ("general practitioners" OR doctors OR clinicians OR nurses)	200 screened (sorted by relevance)
“menstrual disorders” (views OR perspectives OR experiences) ("general practitioners" OR doctors OR clinicians OR nurses)	150 screened (sorted by relevance)
polycystic (views OR perspectives OR experiences) ("general practitioners" OR doctors OR clinicians OR nurses)	150 screened (sorted by relevance)
("pelvic pain") (women or females) (views OR perspectives OR experiences) (“general practitioners” OR doctors OR clinicians OR nurses)	150 screened (sorted by relevance)

Search engine: Google Search

URL: www.google.co.uk

Date Searched: 3/11/2021

Searcher: SB

Search strategies:

(gynaecological OR gynecological) (views OR perspectives OR experiences) (“general practitioners” OR doctors OR clinicians OR nurses)	291 hits
endometriosis (views OR perspectives OR experiences) ("general practitioners" OR doctors OR clinicians OR nurses)	364 hits
menopause (views OR perspectives OR experiences) ("general practitioners" OR doctors OR clinicians OR nurses)	358 hits
“menstrual disorders” (views OR perspectives OR experiences) ("general practitioners" OR doctors OR clinicians OR nurses)	272 hits
polycystic (views OR perspectives OR experiences) ("general practitioners" OR doctors OR clinicians OR nurses)	331 hits
("pelvic pain") (women or females) (views OR perspectives OR experiences) (“general practitioners” OR doctors OR clinicians OR nurses)	325 hits

Appendix B: List of excluded studies

Table 4. Studies excluded at full-text with reasons for exclusion

Study	**Exclude reason**
Living with advanced breast cancer hormone treatment: the nurse's perspective. Eur J Cancer Care (Engl) 1998;7:113-9. https://doi.org/10.1046/j.1365-2354.1998.00076.x	Not primary care
Understanding menorrhagia: a physician's perspective. Surgical Technologist 2010;42:127-8.	Study design
Alami S, Hervouet L, Poiraudeau S, Briot K, Roux C. Barriers to Effective Postmenopausal Osteoporosis Treatment: A Qualitative Study of Patients' and Practitioners' Views. PLoS One 2016;11:e0158365. https://doi.org/10.1371/journal.pone.0158365	Phenomenon of interest
Allegretti A, Borkan J, Reis S, Griffiths F. Paired interviews of shared experiences around chronic low back pain: classic mismatch between patients and their doctors. Fam Pract 2010;27:676-83. https://doi.org/10.1093/fampra/cmq063	Phenomenon of interest
Ariss SM. Asymmetrical knowledge claims in general practice consultations with frequently attending patients: limitations and opportunities for patient participation. Soc Sci Med 2009;69:908-19. https://doi.org/10.1016/j.socscimed.2009.06.045	Phenomenon of interest
Arreskov AB, Lindell JF, Davidsen AS. General practitioner responses to concerns in chronic care consultations for patients with a history of cancer. J Health Psychol 2021; 10.1177/13591053211025593:13591053211025593. https://doi.org/10.1177/13591053211025593	Phenomenon of interest
Bekhuis E, Gol J, Burton C, Rosmalen J. Patients' descriptions of the relation between physical symptoms and negative emotions: a qualitative analysis of primary care consultations. Br J Gen Pract 2020;70:e78-e85. https://doi.org/10.3399/bjgp19X707369	Phenomenon of interest
Blakeman T, Macdonald W, Bower P, Gately C, Chew-Graham C. A qualitative study of GPs' attitudes to self-management of chronic disease. Br J Gen Pract 2006;56:407-14.	Phenomenon of interest
Chapple A. Menorrhagia: general practitioners’ and women’s perceptions of this condition and its treatment [PhD]. Manchester: University of Manchester; 1997.	Thesis
Copp T, Hersch J, McCaffery K, Jansen J, Doust J, Dokras A, et al. Challenges and uncertainties regarding polycystic ovary syndrome (PCOS) and the potential for	Abstract

overdiagnosis: Clinicians' views and experiences. BMJ Evidence-Based Medicine 2018;23:A45. https://doi.org/http://dx.doi.org/10.1136/bmjebm-2018-111070.95	
Crawford SL. What you don't know can hurt you: more information and communication are needed regarding menopausal therapies. Menopause 2017;24:1116-7. https://doi.org/10.1097/GME.0000000000000963	Study design
Cruickshank S, Hume A. The experience of providing support about menopausal symptoms to women with breast cancer. Eur J Oncol Nurs 2014;18:110-7. https://doi.org/10.1016/j.ejon.2013.08.001	Not primary care
Danielson EC, Mazurenko O, Andraka-Christou BT, DiIulio J, Downs SM, Hurley RW, et al. An Analysis of Primary Care Clinician Communication About Risk, Benefits, and Goals Related to Chronic Opioid Therapy. MDM Policy Pract 2019;4:2381468319892572. https://doi.org/10.1177/2381468319892572	Phenomenon of interest
Dhatt H, Horodniceanu EG, Bayliss M, Miller K, Stroupe A, Lasch K, et al. 23rd Annual Conference of the International Society for Quality of Life Research. Qual Life Res 2016;25:1-196. https://doi.org/10.1007/s11136-016-1390-7	Abstract
Fauconnier A, Staraci S, Huchon C, Roman H, Panel P, Descamps P. Comparison of patient- and physician-based descriptions of symptoms of endometriosis: a qualitative study. Hum Reprod 2013;28:2686-94. https://doi.org/10.1093/humrep/det310	Not primary care
Fredericks E. Short report: How family physicians can support discussions about menstrual issues. Canadian Family Physician 2014;60:e194-6.	Not clinician perspective
Grant C, Gallier L, Fahey T, Pearson N, Sarangi J. Management of menorrhagia in primary care-impact on referral and hysterectomy: data from the Somerset Morbidity Project. Journal of epidemiology and community health 2000;54:709-13. https://doi.org/10.1136/jech.54.9.709	Not clinician perspective
Hart A, Henwood F, Wyatt S. The role of the Internet in patient-practitioner relationships: findings from a qualitative research study. J Med Internet Res 2004;6:e36. https://doi.org/10.2196/jmir.6.3.e36	Phenomenon of interest
Hinton L, Kurinczuk JJ, Ziebland S. Reassured or fobbed off? Perspectives on infertility consultations in primary care: a qualitative study. Br J Gen Pract 2012;62:e438-45. https://doi.org/10.3399/bjgp12X649133	Phenomenon of interest
Houwen J, Lucassen P, Verwiel A, Stappers HW, Assendelft WJJ, Olde Hartman TC, et al. Which difficulties do GPs experience in consultations with patients with unexplained symptoms: a qualitative study. BMC Fam Pract 2019;20:180. https://doi.org/10.1186/s12875-019-1049-x	Phenomenon of interest

Johansen ML, Risor MB. What is the problem with medically unexplained symptoms for GPs? A meta-synthesis of qualitative studies. Patient Educ Couns 2017;100:647-54. https://doi.org/10.1016/j.pec.2016.11.015	Phenomenon of interest
Kitchen H, Aldhouse N, Haberland C, Schmitz H, Gater A, Gerlinger C, et al. A qualitative study of patient and clinician perspectives on item importance, scoring preferences, and clinically important differences for two patient-reported outcome measures: Endometriosis Symptom Diary (ESD) and Endometriosis Impact Scale (EIS). Qual Life Res 2018;27:1-190. https://doi.org/10.1007/s11136-018-1946-9	Not primary care
Kraft PA. Perimenopause: a phenomenological study of women and health care providers in rural areas: WEST VIRGINIA UNIVERSITY; 1997.	Thesis
Kristiansson MH, Brorsson A, Wachtler C, Troein M. Pain, power and patience--a narrative study of general practitioners' relations with chronic pain patients. BMC Fam Pract 2011;12:31. https://doi.org/10.1186/1471-2296-12-31	Phenomenon of interest
Liao K, Hunter MS, White P. Beliefs about menopause of general practitioners and mid-aged women. Family practice 1994;11:408-12.	Study design
May C, Allison G, Chapple A, Chew-Graham C, Dixon C, Gask L, et al. Framing the doctor-patient relationship in chronic illness: a comparative study of general practitioners' accounts. Sociol Health Illn 2004;26:135-58. https://doi.org/10.1111/j.1467-9566.2004.00384.x	Duplicate
Norton W, Mitchell H, Holloway D, Law C. The role of Endometriosis Clinical Nurse Specialists in British Society for Gynaecological Endoscopy registered centres: A UK survey of practice. Nurs Open 2020;7:1852-60. https://doi.org/10.1002/nop2.574	Study design
Olsson H. Nursing science in a Nordic perspective: under what conditions do the gynaecologist/women, midwife/women meet at a gynaecological examination? Scandinavian Journal of Caring Sciences 1990;4:13-5.	Study design
Ong BN, Hooper H. Comparing clinical and lay accounts of the diagnosis and treatment of back pain. Sociol Health Illn 2006;28:203-22. https://doi.org/10.1111/j.1467-9566.2006.00488.x	Phenomenon of interest
Rasmussen EB, Ro KI. How general practitioners understand and handle medically unexplained symptoms: a focus group study. BMC Fam Pract 2018;19:50. https://doi.org/10.1186/s12875-018-0745-2	Phenomenon of interest
Ryan GL, Lewis AM, Shinkunas LA, Lester WS, Stuart SP. “I was kind of taken aback because in my mind it had always been a personal and not a public health issue” –	Abstract

how physician experience and framing impacts advocacy for infertility care. Fertility and Sterility 2012;98:S96. https://doi.org/10.1016/j.fertnstert.2012.07.353	
Schall FM. Knowledge of menopause and attitude toward menopause in nurses and non-nurses [PhD]. Texas: Texas Woman's University; 1989.	Thesis
Stewart E, Fioratou E, Davey P, Szubert W, Neill C. Human factors approach to diagnostic and management processes of chronic pelvic pain. BJOG: An International Journal of Obstetrics and Gynaecology 2021;128:223. https://doi.org/http://dx.doi.org/10.1111/1471-0528.17-16715	Abstract
Stortenbeker I, Stommel W, Olde Hartman T, van Dulmen S, Das E. How General Practitioners Raise Psychosocial Concerns as a Potential Cause of Medically Unexplained Symptoms: A Conversation Analysis. Health Commun 2021; 10.1080/10410236.2020.1864888:1-12. https://doi.org/10.1080/10410236.2020.1864888	Phenomenon of interest
Teede H. Is there a need to increase PCOS awareness? Human Reproduction 2017;32.	Abstract
Toye F, Seers K, Barker KL. Meta-ethnography to understand healthcare professionals' experience of treating adults with chronic non-malignant pain. BMJ Open 2017;7:e018411. https://doi.org/10.1136/bmjopen-2017-018411	Phenomenon of interest
Twiddy H, Bradshaw A, Chawla R, Johnson S, Lane N. Female chronic pelvic pain: the journey to diagnosis and beyond. Pain Manag 2017;7:155-9. https://doi.org/10.2217/pmt-2016-0052	Study design
Wee LE, Lim LY, Koh GC-H. Two sides of the coin: A qualitative study of patient and provider perspectives on colorectal, breast and cervical cancer screening in a low-income Asian community. Proceedings of Singapore Healthcare 2015;25:80-91. https://doi.org/10.1177/2010105815616404	Abstract
Zale M, Lambert E, LaNoue MD, Leader AE. Shedding light on endometriosis: Patient and provider perspectives on a challenging disease. Journal of Endometriosis and Pelvic Pain Disorders 2020;12:69-76.	Not primary care

Appendix C: Study aims and results

Table 5. Aims and results of included studies

First Author	Title	Country setting	Condition/symptoms of interest	Research questions or aim	Results and conclusions from abstract
Arasu, 2019[27]	Barriers and facilitators to weight and lifestyle management in women with polycystic ovary syndrome: general practitioners' perspectives	Australia	PCOS	To understand the knowledge and practice of GPs on weight and lifestyle management in women with PCOS, specifically, barriers and facilitators for GPs in meeting the current recommendations for weight and lifestyle management.	We report that GPs unanimously acknowledge the importance of weight and lifestyle management in PCOS. Practice was influenced by both systems-related and individual-related facilitators and barriers. Individual-related barriers include perceived lack of patient motivation for weight loss, time pressures, lack of financial reimbursement, and weight management being professionally unrewarding. System-related barriers include costs of accessing allied health professionals and unavailability of allied health professionals in certain locations. Individual-related facilitators include motivated patient subgroups such as those trying to get pregnant and specific communication techniques such as motivational interviewing. System-related facilitators include the GP's role in chronic disease management. Conclusions: This study contributes to the understanding of barriers and facilitators that could be addressed to optimize weight and lifestyle management in women with PCOS in primary care.
Bertero, 2019[11]	Striving for a biopsychosocial approach: A secondary	Sweden	Endometriosis	The aim of this study was to identify and describe mutual components during healthcare encounters between women	Three themes were identified. (1) Continuity as a foundation for a biopsychosocial approach. The women

	analysis of mutual components during healthcare encounters between women with endometriosis and physicians			with endometriosis and physicians via a secondary analysis, in order to present a more comprehensive picture of these encounters.	and the physicians described the importance of continuity and both parties strived for a biopsychosocial approach whereby the female body was not treated as biomedical defect object, but as a part of the unity that constitutes a human being. (2) Listening sensitively. Women and physicians believed that listening sensitively involved more than just hearing the actual words – it required thoughtfulness, reflection and responsiveness. (3) Timing of diagnosis. The physicians tried to protect the women from worrying by treating the painful menstruations without mentioning endometriosis. However, the women regarded not mentioning endometriosis as a lack of competence on the part of the physicians. This study provides new insights into the need for further support in the provision of psychosocial care for women with endometriosis, in the striving towards a biopsychosocial approach.
Bullo, 2021[26]	Addressing challenges in endometriosis pain communication between patients and doctors: the role of language	UK	Endometriosis	[W]e aimed to examine what both patients and doctors consider effective and challenging in endometriosis pain communication. Additionally, we explored what common metaphors used by patients can be suggestive, or not, of endometriosis for doctors.	Both women and GPs reported the Numeric Rating Scale (NRS) to be insufficient as a standalone tool for communicating endometriosis related pain. Both also found descriptions of the quality, location, and impact on daily life of pain to more effective means of communicating pain symptoms. When presented with common metaphorical expressions surveyed women used to describe their pain, not all GPs recognized such metaphors as indicative of possible endometriosis. Further, some GPs

					reported some of the expressions to be indicative of other pathologies. Findings reveal the importance of language in pain communication and the need for additional tools to help women and doctors find the most effective way to communicate the experience and elicit appropriate investigative care. They also show the need for further investigation into how metaphor can be effectively used to improve patient-practitioner communication of endometriosis related pain.
Bush, 2007[16]	How the Women's Health Initiative (WHI) influenced physicians' practice and attitudes	US	Menopause	The goals of the present study were to obtain detailed qualitative information from physicians to (1) understand their perspectives on use of HT and the scientific evidence regarding the risks and benefits of HT; (2) understand the impact of the WHI on physicians' attitudes and clinical practice, including their practices and counselling strategies around HT discontinuation; and (3) inform development of a survey for a larger quantitative study.	Physicians were conflicted about the WHI results and its implications. Seven themes identified from in-depth interviews suggested that the WHI (1) was a ground-breaking study that changed clinical practice, including counseling; (2) was not applicable to the full range of patients seen in clinical practice; (3) raised concerns over the impact of publicized health information on women; (4) created uncertainty about the risks and benefits of HT; (5) called for the use of decision aids; (6) influenced discontinuation strategies; and (7) provided an opportunity to discuss healthy lifestyle options with patients. As a result of the WHI, physicians reported they no longer prescribe HT for prevention and were more likely to suggest discontinuation, although many felt women should be in charge of the HT decision. Physicians varied in their opinions of HT

					and the scientific evidence (positive and negative). Whereas the WHI delineated the risks and benefits of HT, physicians reported that decision aids are needed to guide discussions with women about menopause and HT. Better guidance at the time of WHI study publication might have been valuable to ensure best practices.
Chapple, 1998[14]	General practitioners' perceptions of the illness behaviour and health needs of South Asian women with Menorrhagia	UK	Menorrhagia	A study of general practitioners' (GPs) perceptions of the health needs of women of South Asian descent who suffer from menorrhagia.	This study suggests that some women of South Asian descent may not consult their GPs even though suffering severe menorrhagia. Moreover, some GPs perceive that women may suffer from anaemia as the result of such illness behaviour. One reason for this reluctance to consult for menorrhagia may be the fact that some women of South Asian descent prefer to be examined by female doctors, yet may attend practices that lack a female partner. The study also shows that South Asian women, who consult male GPs for menorrhagia, are sometimes referred to hospital outpatients without internal examinations, and that women may be reluctant to keep their hospital appointments because of the lack of female gynaecologists. The study also indicates that a shortage of female interpreters may make communication difficult between some health care professionals and their patients, particularly when a complex and sensitive subject such as menorrhagia needs to be discussed. Women of South Asian descent may suffer

					serious problems such as iron deficiency anaemia, partly due to untreated menorrhagia. Since this was a study of GPs' perceptions of the health needs of South Asian women, it is now important to interview women themselves, to learn more about their perceptions of menorrhagia, and their perceptions of any subsequent contact with health care professionals.
Chapple, 2001[7]	Is objective testing for menorrhagia in general practice practical? Results from a qualitative study	UK	Menorrhagia	The objective of the paper is to explore the interpretative character of medical knowledge and practice and the way that clinicians respond to the patient's assertion that her menstrual blood loss is excessive. In particular we are interested in the boundary between 'normal' and 'abnormal', because such boundaries are socially constructed. The paper also explores GPs' reactions to the suggestion that they might conduct objective tests for menorrhagia in their surgeries.	Two thirds of the respondents indicated that they seriously attempt an assessment of menstrual blood loss, while one third of the respondents appeared to pay more attention to the women's subjective assessment of unacceptable 'heavy' bleeding. Some general practitioners had a very negative attitude to menstrual blood. Very few would consider conducting objective tests for menstrual blood loss if such tests involved the collection of soiled pads and tampons. However, about half of the respondents thought that a pictorial chart might be useful when trying to estimate menstrual blood loss. Since general practitioners are not in agreement about the manner in which women's complaints of heavy bleeding should be assessed, evidence based clinical guidelines that deal with both 'subjective' and 'objective' menorrhagia are timely.
Copp, 2020[21]	Clinicians' perspectives on diagnosing polycystic ovary	Australia	PCOS	This study aimed to understand clinicians' views about the diagnosis of PCOS and explore how they manage any	Clinicians expressed a range of uncertainties and complexities regarding the diagnosis of PCOS, which were

	syndrome in Australia: a qualitative study			complexities and uncertainties in clinical practice.	organised into three areas: (i) establishing diagnosis (e.g. lack of standardisation regarding diagnostic cut-offs, risk of misdiagnosis), (ii) factors influencing the diagnostic process (e.g. awareness of limitations in evidence and consideration of the benefits and harms) and (iii) strategies for handling challenges and uncertainties (e.g. using caution and communication of uncertainties). Clinicians also varied in their concerns regarding under- and overdiagnosis. Overall, most felt the diagnosis was beneficial for women provided that it was the correct diagnosis and time was taken to assess patient expectations and dispel misconceptions, particularly concerning fertility. These findings underscore the vital need to first consider PCOS a diagnosis of exclusion and use caution before giving a diagnosis in order to reduce misdiagnosis, as suggested by clinicians in our study. Until there is greater standardisation of diagnostic criteria, more transparent conversations with women may help them understand the uncertainties surrounding the criteria and limitations in the evidence. Additionally, clinicians emphasised the importance of education and reassurance to minimise the potential harmful impact of the diagnosis and improve patient-centred outcomes.
Copp, 2021[17]	The challenges with managing polycystic	Australia	PCOS	This study aimed to explore the experience of managing PCOS for both	Findings across women with PCOS and clinician interviews were organised into

	ovary syndrome: a qualitative study of women's and clinician's experiences			clinicians and a community sample of women with PCOS across the spectrum of symptom severity.	three themes. Both women and clinicians experienced 1) challenges with managing PCOS, often stemming from the disparate and wide spectrum of presentations, issues with current treatment options (including limited evidence) and the long-term nature of management. Both spoke about 2) online information about PCOS and alternative treatments, including lack of relevant information and widespread misinformation. 3) Follow-up and continuity of care, where we found notable differences between women's and clinicians' expectations. This is the first study to explore both clinicians' and women's experiences with managing PCOS, illustrating several challenges in managing this heterogeneous condition. Practice implications: Clarifying and addressing patient expectations, providing personalised counselling and information according to PCOS phenotype and a multidisciplinary approach may reduce uncertainty and improve patient-centred care.
Davis, 2021[15]	Health-care providers' views of menopause and its management: a qualitative study	Australia	Menopause	The aim of the current study was to explore the understanding and views of Australian health-care providers, specifically general practitioners (GPs), gynecologists (GYs) and pharmacists (PHs), about menopause and its management. We were also interested in how confident health practitioners were in managing menopause with	There were equal numbers of GPs, GYs and PHs, and equal numbers of males and females in each group. All participants demonstrated sound understanding of menopause and its consequences. A strong theme was recognition of high usage of complementary and alternative medicines (CAMs) by women for menopausal symptoms. Most participants

				respect to immediate symptoms as well as their role in reducing the risks of osteoporosis and cardiovascular disease.	highlighted lack of efficacy evidence for most CAMs, but the majority of GPs and PHs considered CAMs to 'have a role'. Most supported menopausal hormone therapy (MHT) when symptoms impaired quality of life. Limitations to comprehensive care included knowledge gaps and lack of time. Australian health-care providers appeared knowledgeable about menopause, but uncertain about its management. MHT prescription appeared limited to women with severe symptoms despite lifestyle modification and a trial of CAMs. The upskilling of clinicians providing care for women at midlife, with respect to the indications for and prescribing of MHT, urgently needs to be addressed.
Dixon, 2021[12]	Navigating possible endometriosis in primary care: a qualitative study of GP perspectives	UK	Endometriosis	By developing an understanding of how GPs approach the management of women with symptoms suggesting possible endometriosis, this study aimed to identify ways to support these care journeys in primary care. These insights can support the development of resources and education tailored for primary care and evolve beyond a simple call for increased awareness.	Managing possible endometriosis in primary care brings challenges. While knowledge and awareness were prerequisites for considering endometriosis, other important considerations were raised. Symptoms suggestive of endometriosis are non-specific, making endometriosis one possible consideration of many. GPs move through a diagnostic hierarchy to exclude sinister causes and utilise trials of treatment as both therapeutic interventions and diagnostic tools; processes which take time. An endometriosis label or diagnosis has advantages and risks. GPs reported sharing decisions about investigation and

					referral while holding women's priorities as pivotal. These conversations were underpinned by their knowledge of uncertainties and unknowns, including the wide spectrum and unpredictability of endometriosis. GPs considerations are more complex than simply lacking awareness. The unknowns surrounding endometriosis matter to GPs. Further research and tailored resources for primary care, where women present with undifferentiated symptoms, are needed.
Esposito, 2005[28]	Agenda dissonance: immigrant Hispanic women's and providers' assumptions and expectations for menopause healthcare	US	Menopause	How different are immigrant women's expectations of care from the expectations of American healthcare providers? What are their assumptions about healthcare providers? How do these views compare with providers' expectations and experiences?	The women wanted provider-initiated, individualized anticipatory guidance about menopause, acknowledgement of their symptoms, and mainstream medical treatment for disruptive symptoms. Providers believed that menopause was an unimportant health issue for immigrant women and was overshadowed by concerns about high-risk medical problems, such as diabetes, heart disease and HIV prevention. The women expected a healthcare encounter to be patient centered, social, and complete in itself. Providers expected an encounter to be businesslike and one part of multiple visit care. Language and lack of time were barriers cited by all. Dissonance between patient-provider assumptions and expectations around issues of healthcare leads to missed opportunities for care.
Fernandes, 2020[25]	Clinicians' perceptions of Norwegian women's	Norway	Infertility diseases	To investigate how Gynecologists and General Practitioners (GP) in Norway	Clinical diseases (polycystic ovary syndrome, endometriosis and vulvodynia)

	experiences of infertility diseases			perceive: (i) female infertility diseases in their practice; (ii) how they deal with these diseases; (iii) how they explain the consequences of these diseases to their female patients.	and consequences of these diseases were the pinpointed themes. These led to a set of sub-themes: the main symptoms and the treatment of the diseases, from the perspective of both women and doctors (stigmatization, disturbances in women's daily life, diagnostic delay, and governmental support). The three most relevant disorders mentioned were polycystic ovary syndrome, endometriosis and vulvodynia. These diseases cause several impacts on the lives of women, because they feel stigmatized and limited in their daily life and sexuality, and the diagnosis of these diseases takes too much time. Governments should better redistribute the financing of women's health and allocate resources to specialized centers.
Grundstrom, 2016[19]	"A challenge" - healthcare professionals' experiences when meeting women with symptoms that might indicate endometriosis	Sweden	Endometriosis	To identify and describe HCPs' experiences when meeting women with symptoms that might indicate endometriosis.	Three clusters were identified: the corroborating encounter, the normal variation of menstruation cycles, and the suspicion of endometriosis. The healthcare professionals tried to make a corroborating encounter by acknowledging the woman, taking time to listen, and giving an explanation for the problems. Healthcare professionals had different ways to determine what was normal as regards menstrual pain, ovulation pain and dyspareunia. They also needed to have the competence to act and react when the symptoms indicated endometriosis. Meeting women with symptoms that

					might indicate endometriosis is challenging and demands a certain level of competence from healthcare professionals. Sometimes the symptoms are camouflaged as “normal” menstruation pain, making it hard to satisfy the needs of this patient group.
Labots-Vogelesang, 2021[20]	Views of Dutch general practitioners about premenstrual symptoms: A qualitative interview study	Netherlands	Premenstrual symptoms	We aimed to investigate the views of GPs about PMS, how GPs in daily practice diagnose complaints fitting PMS and how they prefer to address the problem.	Important themes emerged from the interviews: ‘no need for a symptom diary,’ ‘PMS defined as illness’ exclusively in case of disruption of normal functioning, and ‘symptomatic treatment’ as preferred approach. Most GPs considered PMS to be a physiological phenomenon, with taking history as an adequate diagnostic tool. Almost all GPs regarded a normal cyclical hormonal cycle as causal; many also mentioned the combination with personal sensitivity. Some pointed to a dividing line between physiological condition and illness if women could not function normally in daily life. Lastly, the approach GPs preferred was focussing on relieving symptoms of individual patients. In addition to explaining the hormonal cycle and lifestyle advice, all GPs advocated oral contraceptives, and if necessary psychological support. GPs expressed negative feelings about prescribing antidepressants. GPs considered physiological changes and personal sensitivity as aetiological factors. We recommend more training to improve GPs knowledge and more insight into the

					burden of women with PMS. A symptom diary is an essential diagnostic tool for GPs
May, 2004[23]	Framing the doctor-patient relationship in chronic illness: a comparative study of general practitioners' accounts	UK	Menorrhagia; Chronic pelvic pain	In this paper, we present the results of a re-analysis of qualitative data collected in a series of studies of British family doctors between 1995 and 2001, to explore the ways in which the legitimacy and authority of medical knowledge and practice are organised and worked out in relation to three kinds of chronic illness (menorrhagia; depression; and chronic low back pain/medically unexplained symptoms).	Our analysis defines some of the fundamental conditions through which general practitioners frame their relationships with patients presenting complex but sometimes diffuse combinations of ‘social’, ‘psychological’ and ‘medical’ symptoms. These are fundamental to, yet barely touched by, the increasingly voluminous literature on how doctors should interact with patients. Moving beyond the individual studies from which our data are drawn, we have outlined some of the highly complex and demanding features of what is often seen as routine and unrewarding medical work, and some of the key requirements for the local negotiation of patients’ problems and their meanings (for both patients and doctors) in everyday general practice.
McGowan, 2012[22]	Is chronic pelvic pain a comfortable diagnosis for primary care practitioners: a qualitative study	UK	Chronic pelvic pain	This study aimed to explore views of GPs and practices nurses on their experiences of consulting with women with CPP and understanding how they currently manage these patients.	Analysis suggests that women who present with CPP pose a challenge to GPs and practice nurses. CPP is not necessarily recognized as a diagnostic label and making the diagnosis was achieved only by exclusion. This contrasts with the relative acceptability of labels such as irritable bowel syndrome (IBS). GPs expressed elements of therapeutic nihilism about the condition. Despite practice nurses taking on increasing responsibilities for the management of patients with long term conditions, respondents did not feel that CPP was an area that they were comfortable in

					managing. The study demonstrates an educational/training need for both GPs and practice nurses. GPs described a number of skills and clinical competencies which could be harnessed to develop a more targeted management strategy. There is potential to develop facilitated self- management for use in this patient group, given that this approach has been successful in patients with similar conditions such as IBS.
Nekhlyudov, 2009[39]	Physicians' and women's views on hormone therapy and breast cancer risk after the WHI: a qualitative study	US	Menopause	The specific goal of this analysis was to explore the beliefs of physicians and women about HT and breast cancer risk and provide insights into the questions remaining after the WHI through expressive reflections of the study participants.	Concerns about breast cancer risk weighed into the decision-making process for physicians and women in initiating and continuing hormone therapy. For women, control of menopausal symptoms was important and possibly outweighed their concerns about the potential risks of breast cancer. Though concerned about its association with increasing breast cancer risk, physicians were willing to consider hormone therapy to manage women's menopausal symptoms but were frustrated about the lack of available non-hormone therapy alternatives. Most physicians and some women were aware of the Women's Health Initiative, and its findings appeared to influence their beliefs about hormone therapy and breast cancer risk, though doubts remained among both groups about the study findings and implications. Our qualitative study suggests that after

					the Women's Health Initiative, concerns about breast cancer risk weighed into decisions to initiate and continue hormone therapy for both physicians and women, but menopausal symptoms often directed use.
O'Flynn, 2004[18]	Diagnosing menstrual disorders: a qualitative study of the approach of primary care professionals	UK	Menstrual disorders	The aim of the study was to uncover the models of menstrual disorders used by primary care practitioners in everyday practice.	Medical practitioners were critical of the guidance provided by gynaecological definitions and texts. Practitioners put more emphasis on defining normality than on defining disorder. Practitioners used a wide range of criteria to judge their patients' complaints and decide on a course of action. Female practitioners had access to personal and professional experience and used this to develop an understanding of women's complaints. Male practitioners in particular were limited by problems in discussing menstruation in detail. Because of the difficulties in assessing patient history, other non-gynaecological factors such as patient age and consulting behaviour informed practitioners' judgements. This study draws attention to practitioners' problems in using current definitions of menstrual disorders. The combination of unhelpful medical definitions, lack of standards of normality and difficulties in discussing menstruation resulted in individual practitioners making judgements in idiosyncratic ways. In the absence of a useful gynaecological model, practitioners develop individual, often

					subjective and gendered models to use in practice.
Rowe, 2021[8]	Improving clinical care for women with endometriosis: qualitative analysis of women's and health professionals' views	Australia	Endometriosis	The aim was to compare women's and healthcare providers' accounts of health care, identify commonalities and differences, and seek solutions that could enhance the care experience for both groups.	Endometriosis can have debilitating consequences. However, women reported that healthcare providers may dismiss symptoms, lack essential knowledge and provide inconsistent advice; treatments are seldom successful or without adverse side-effects. Health professionals acknowledged limitations in expertise, persistent myths, and challenges in achieving best practice. Enhancing collaborative care skills, individualized treatment plans, and local referral pathways to multi-disciplinary care may improve satisfaction with endometriosis care-giving and receiving. This is the first comparison of patient and practitioner perceptions of endometriosis in primary healthcare. Models of multi-disciplinary, collaborative care need to be developed and evaluated against consumer-informed measures of women's wellbeing, quality of life and satisfaction with symptom management and health care.
Selfe, 1998[24]	Chronic gynaecological pain: an exploration of medical attitudes	UK	Chronic pelvic pain	We aimed to explore attitudinal constructs about pelvic pain in women, and to test for possible relationships between such variables as respondent sex, ethnicity, age and years from postgraduate training.	Principal components analysis identified five factors accounting for 32.4% of the variance, labelled 'efficiency', 'complexity', 'socio-cultural liberalism', 'pathology' and 'communication'. Scores for 'socio-cultural liberalism' were higher among gynaecologists in the younger age groups, women, and those giving their ethnic origin as Caucasian. Scores for 'pathology'

					were lower among younger gynaecologists. A sex difference just failed to reach statistical significance. Multiple linear regression confirmed significant independent relationships with scores for 'socio-cultural liberalism' and respondent sex, ethnicity and age group under 38 years.
van der Zanden, 2020[13]	Barriers and facilitators to the timely diagnosis of endometriosis in primary care in the Netherlands	Netherlands	Endometriosis	The aim of this study was to explore the barriers and facilitators influencing time to diagnosis of endometriosis from the GPs' perspective.	Analysis of the transcripts revealed relevant determinants of practice in four main themes: professionals' experience and competence, patient characteristics, guideline factors and professional collaboration. A lack of knowledge and awareness appeared to result in a low priority for establishing the diagnosis of endometriosis, especially in young women. Infertility, patient engagement and a recent serious case or training facilitated referral. Several factors in daily primary health care contribute to the diagnostic delay in endometriosis. Future interventions to reduce this delay may be aimed at increasing awareness by means of education, incorporating the subject into national clinical guidelines and improvements in interdisciplinary collaboration.
Young, 2017[9]	Clinicians' perceptions of women's experiences of endometriosis and of psychosocial care for endometriosis	Australia	Endometriosis	To describe clinicians' perceptions of women's experiences of living with endometriosis and of the provision of psychosocial care for endometriosis.	Clinicians' perceptions of women's experiences of endometriosis were consistent with those reported by women, particularly when discussing potential infertility. However, less comprehensive descriptions of the effects of

					endometriosis on women’s work and social life and intimate relationships were observed. Some clinicians asserted that endometriosis is caused by poor mental health. General practitioners positioned themselves as best placed to provide psychosocial care to women with endometriosis; gynaecologists suggested various potential providers but rarely themselves. Most clinicians assessed themselves as not being adequately trained to understand and provide care for the psychosocial aspects of endometriosis; half of the gynaecologists did not believe it was necessary for them to do so. The findings of this research demonstrate clinicians’ need for further support in the provision of psychosocial care for women with endometriosis, potentially through expanded clinical guidelines and professional development opportunities
Young, 2019[10]	"Do made people get endo or does make you mad?’’: Clinicians’ discursive constructions of Medicine and women with endometriosis	Australia	Endometriosis	To examine the language clinicians use to construct Medicine and women with endometriosis and to identify whether these constructions endorsed or challenged historical discourses, and any implications for women with endometriosis.	Clinicians endorsed Medicine as the authoritative knowledge on women and their bodies, and constructed Medicine as being about providing answers on, and doing things to, the body. Women with endometriosis were constructed as reproductive bodies with hysterical tendencies. The historical hysteria discourse was most often endorsed when discussing ‘‘difficult’’ women, referring to those for whom treatment was not helpful or who held a perception of their disease alternative to their clinician. The findings of our study are consistent with

					previous social analyses of medical literature on endometriosis and with women’s reported experiences, suggesting these discourses to be prevalent in contemporary healthcare for endometriosis. Medical education needs to address the historical androcentric bias of medical knowledge and equip clinicians with the skills to address women’s diverse needs.

Appendix D: Quality appraisal

Table 6. Quality appraisal using adapted version of Wallace checklist

First author date	1. Is the research question clear?	2. Is the theoretical or ideological perspective of the author (or funder) explicit?	2b. Has this influenced the study design, methods or research findings?	3. Is the study design appropriate to answer the question?	4. Is the context or setting adequately described?	5. Is the sample adequate to explore the range of subjects and settings, and has it been drawn from an appropriate population?	6. Was the data collection adequately described?	7. Was data collection rigorously conducted to ensure confidence in the findings?	8. Was there evidence that the data analysis was rigorously conducted to ensure confidence in the findings?	9. Are the findings substantiated by the data?	10. Has consideration been given to any limitations of the methods or data that may have affected the results?	11. Do any claims to generalisability follow logically and theoretically from the data?	12. Have ethical issues been addressed and confidentiality respected?
Arasu 2019[27]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bertero 2019[11]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	N	N	Y
Bullo 2021[26]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bush 2007[16]	Y	N	CT	Y	Y	CT	Y	Y	Y	Y	Y	CT	Y
Chapple 1998[14]	Y	N	CT	Y	Y	Y	Y	Y	N	Y	N	Y	N
Chapple 2001[7]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	N	Y	N
Copp 2020[21]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Copp 2021[17]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Davis 2021[15]	Y	N	CT	Y	Y	Y	Y	Y	Y	N	N	N	Y
Dixon 2021[12]	Y	N	CT	Y	Y	Y	Y	Y	CT	Y	Y	Y	Y
Esposito 2004[28]	Y	N	CT	Y	Y	N	Y	Y	Y	Y	N	Y	Y
Fernandes 2020[25]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
Grundstrom 2016[19]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
Labots-Vogelesang 2021[20]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

First author date	1. Is the research question clear?	2. Is the theoretical or ideological perspective of the author (or funder) explicit?	2b. Has this influenced the study design, methods or research findings?	3. Is the study design appropriate to answer the question?	4. Is the context or setting adequately described?	5. Is the sample adequate to explore the range of subjects and settings, and has it been drawn from an appropriate population?	6. Was the data collection adequately described?	7. Was data collection rigorously conducted to ensure confidence in the findings?	8. Was there evidence that the data analysis was rigorously conducted to ensure confidence in the findings?	9. Are the findings substantiated by the data?	10. Has consideration been given to any limitations of the methods or data that may have affected the results?	11. Do any claims to generalisability follow logically and theoretically from the data?	12. Have ethical issues been addressed and confidentiality respected?
May 2004[23]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	CT
McGowan 2010[22]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nekhlyudov 2009[39]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
O'Flynn 2004[18]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Rowe 2021[8]	Y	N	CT	Y	Y	Y	Y	Y	CT	Y	N	Y	Y
Selfe 1998[24]	Y	N	CT	Y	Y	N	Y	Y	CT	Y	N	Y	Y
van der Zanden 2020[13]	Y	N	CT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Young 2017[9]	Y	N	CT	Y	Y	Y	Y	Y	Y	CT	N	N	Y
Young 2019[10]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y

Key: Y= Yes; N= No; CT = Can’t tell

Notes: Quality appraisal questions adapted from the Wallace checklist[29]

Appendix E: Themes, subthemes and supporting studies

Table 7. Themes 1-4, subthemes, supporting studies, conditions discussed, and clinicians in study samples

	Themes and subthemes	Studies, n	Supporting studies	Conditions discussed	Clinicians in study sample		Country settings
					Primary care	Secondary care	
1.	**Individual clinician level**						
	Identified by at least 4 studies						
1.1.	Clinician's role in validating there is an issue and being the provider of a solution or signposting to other services	4	Chapple 2001[7]; Rowe 2021[8]; Young 2017[9]; Young 2019[10]	Endometriosis (n=3),[8-10] menorrhagia (n=1)[7]	GPs	Gynaecologists	UK, Australia
1.2.	Concern about investigations required for diagnosis	4	Bertero 2019[11]; Dixon 2021[12]; Rowe 2021[8]; van der Zanden 2020[13]	Endometriosis (n=4)[8, 11-13]	GPs	Gynaecologists	UK, Australia, Netherlands, Sweden
1.3.	Infrequent clinical exposure to menstrual problems or gynaecology	4	Chapple 1998[14]; Davis 2021[15]; Dixon 2021[12]; van der Zandern 2020[13]	Endometriosis (n=2);[12, 13] menopause (n=1)[15] menorrhagia (n=1)[14]	GPs, pharmacists	Gynaecologists	UK, Australia, Netherlands

1.4.	Lacking knowledge or awareness of gynaecological conditions and secondary care options	7	Bush 2007[16]; Copp 2021[17]; Dixon 2021[12]; O'Flynn 2004[18]; Rowe 2021[8]; van der Zandern 2020[13]; Young 2017[9]	Endometriosis (n=4),[8, 9, 12, 13] menopause (n=1),[16] menorrhagia (n=1),[17] menstrual disorders (n=1)[18]	Family practice, internal medicine (USA), GPs, nurse practitioners	Endocrinologists, gynaecologists, obstetricians	UK, Australia, Netherlands, USA
1.5.	May not feel diagnosis needed if adequate symptom control achieved	4	Dixon 2021[12]; Grundstrom 2016[19]; Labots-Vogelesang 2021[20]; Rowe 2021[8]	Endometriosis (n-3),[8, 12, 19] PMS [20]	GPs	Gynaecologists, midwives	UK, Australia, Netherlands, Sweden
1.6.	Not wanting to give patients a 'label' too early	5	Bertero 2019[11]; Copp 2020[21]; Dixon 2021[12]; van der Zander[13]; Young 2019[10]	Endometriosis (n=4),[10-13] Copp 2020 (n=1)[21]	GPs	Endocrinologists, gynaecologists	UK, Australia, Netherlands, Sweden
1.7.	Reluctance for referral because lack of gain perceived	5	Copp 2021[17]; Copp 2020[21]; Dixon 2021[12]; McGowan 2010[22]; van der Zanden 2020[13]	Chronic pelvic pain (n=1),[22] endometriosis (n=2),[12, 13] PCOS (n=2)[17, 21]	GPs, practice nurses,	Endocrinologists, gynaecologists	UK, Australia, Netherlands
1.8.	Treating women with empathy and respect	10	Bertero 2019[11]; Copp 2020[21]; Davis 2021[15]; Dixon 2021[12]; Grundstrom 2016[19]; Labots-Vogelesang	Chronic pelvic pain (n=2),[22, 24] endometriosis (n=4),[8, 11, 12, 19] menopause (n=1),[15] menorrhagia	GPs, nurse practitioners, pharmacists	Endocrinologists, gynaecologists, midwives	UK, Australia, Netherlands, Sweden

			2021[20]; May 2004[23]; McGowan 2010[22]; Rowe 2021[8]; Sefle 1998[24]	(n=1),[23] PCOS (n=1)[21] and PMS (n=1).[20]			
1.9.	Understanding the psychosocial impacts of gynaecological conditions	13	Bertero 2019[11]; Chapple 1998[14]; Copp 2020[21]; Davis 2021[15]; Dixon 2021[12]; Fernandes 2020[25]; Grundstrom 2016[19]; Labots-Vogelesang 2021[20]; May 2004[23]; McGowan 2010[22]; Rowe 2021[8]; Selfe 1998[24]; Young 2017[9]	Chronic pelvic pain (n=2),[22, 24] endometriosis (n=5),[8, 9, 11, 12, 19] infertility disease (n=1),[25] menopause (1),[15] menorrhagia (n=2),[14, 23] PCOS (1),[21] PMS (n=1)[20]	GPs, pharmacists, practice nurses	Endocrinologists, gynaecologists, midwives	UK, Australia, Netherlands, Norway, Sweden
1.10.	Using women's subjective awareness of what is normal or abnormal to inform decision making	10	Bertero 2019[11]; Bullo 2021[26]; Chapple 1998[14]; Chapple 2001[7]; Grundstrom 2016[19]; May 2004[23]; McGowan 2010[22]; O'Flynn 2004[18]; Rowe 2021[8]; Young 2019[10]	Chronic pelvic pain (n=1),[22] endometriosis (n=5),[8, 10, 11, 19, 26] menorrhagia (n=3),[7, 14, 23] menstrual disorders (n=1)[18]	Community gynaecologist, GPs, nurse practitioners	Gynaecologists, midwives	UK, Australia, Sweden

1.11.	Young women less likely considered for pathological condition	4	Copp 2020[21]; Dixon 2021[12]; O'Flynn 2004[18]; Rowe 2021[8]; van der Zanden 2020[13]	Endometriosis (n=3),[8, 12, 13] menstrual disorders (n=1)[18] PCOS (n=1)[21]	Community gynaecologist, GPs, nurses	Endocrinologists, gynaecologists	UK, Australia, Netherlands
	Identified by fewer than 4 studies						
1.12.	Clinician preference for women to come to clinics prepared	2	Esposito 2005[28]; van der Zanden 2020[13]	Endometriosis (n=1),[13] menopause (n=1)[28]	Nurse practitioners, unspecified physician, GPs	None	Netherlands, USA
1.13.	Importance of being able to motivate patients to make life style changes	2	Arasu 2019[27]; Bush 2007[16]	Menopause (n=1),[16] PCOS (n=1)[27]	Family practice, internal medicine (USA), GPs	Gynaecologists, obstetricians	Australia, USA
1.14.	Nurses refer back to GP if they do not have a solution	1	McGowan 2010[22]	Chronic pelvic pain (n=1)[22]	GPs, practice nurses	None	UK
1.15.	Option to refer patients to secondary care is sometimes used if primary care clinicians have exhausted all other courses of action, AKA "simple disposal"	2	May 2004[23]; McGowan 2010[22]	Chronic pelvic pain (n=1),[22] menorrhagia (n=1)[23]	GPs, practice nurses	None	UK

1.16.	Recognising the need to sensitively communicate about potential sequelae	2	Copp 2020[21]; Young 2017[9]	Endometriosis (n=1),[9] PCOS (n=1)[21]	GPs	Endocrinologists, gynaecologists	Australia
1.17.	Viewing women as 'good' or 'bad/challenging' according to whether they follow clinician advice	3	O'Flynn 2004[18]; Young 2017[9]; Young 2019[10]	Endometriosis (n=2),[9, 10] menstrual disorders (n=1)[18]	Community gynaecologist, GPs, nurses	Gynaecologists	Australia, UK
1.18.	Women who present with wide spectrum of complaints were more often considered as somatising and not referred	2	Rowe 2021[8]; van der Zanden 2020[13]	Endometriosis (n=2)[8, 13]	GPs	Gynaecologists	Australia, Netherlands
2.	**Structural and organisational factors**						
	Identified by at least 4 studies						
2.1.	Limited education for primary care clinical team	6	Davis 2021[15]; Dixon 2021[12]; Grundstrom 2016[19]; McGowan 2010[22]; Rowe 2021[8]; van der Zanden 2020[13]	Chronic pelvic pain (n=1),[22] endometriosis (n=4),[8, 12, 13, 19] menopause (n=1)[15]	GPs, pharmacists	Gynaecologists, midwives	UK, Australia, Netherlands, Sweden

2.2.	Long delays and limited access to secondary care	4	Arasu 2019[27]; Chapple 1998[14]; Dixon 2021[12]; Rowe 2021[8]	Endometriosis (n=2),[8, 12] menorrhagia (n=1),[14] PCOS (n=1)[27]	GPs	Gynaecologists	UK, Australia
2.3.	Recognition of the importance of a multi-disciplinary approach	5	Bertero 2019[11]; Copp 2020[21]; Grundstrom 2016[19]; Rowe 2021[8]; van der Zanden 2020[13]	Endometriosis (n=4),[8, 11, 13, 19] PCOS (n=1)[21]	GPs	Gynaecologists, midwives	Australia, Netherlands, Sweden
2.4.	Recognition that continuity of care is important and frustration that this is difficult to achieve	4	Bertero 2019[11] Dixon 2021[12]; Esposito 2005[28]; Grundstrom 2016[19]	Endometriosis (n-3),[11, 12, 19] menopause (n=1)[28]	GPs, nurse practitioners, unspecified physician	Gynaecologists, midwives	UK, Sweden, USA
2.5.	Unmanageable GP workload	7	Arasu 2019[27]; Chapple 2001[7]; Davis 2021[15]; Dixon 2021[12]; Esposito 2005[28]; Selfe 1998[24]; Young 2017[9]	Chronic pelvic pain (n=1),[24] endometriosis (n=2),[9, 12] menopause (n=2),[15, 28] menorrhagia (n=1),[7] PCOS (n=1)[27]	GPs, nurse practitioners, pharmacists, unspecified physician	Gynaecologists	UK, Australia, USA
	Identified by fewer than 4 studies						
2.6.	Doctors don't always take full responsibility because they	1	Fernandes 2020[25]	Infertility disease (n=1)[25]	GPs	Gynaecologists	Norway

	don't think WH issues are their remit within their specialism						
2.7.	Pressure to reduce referrals	1	Dixon 2021Dixon 2021[12]	Endometriosis (n=1)[12]	GPs	None	UK
3.	**Community and external factors**						
	Identified by at least 4 studies						
3.1.	Normalisation of pain/symptoms in wider society and amongst clinicians	6	Chapple 1998[14]; Dixon 2021[12]; Esposito 2005[28]; Grundstrom 2016[19]; Rowe 2021[8]; Young 2019[10]	Endometriosis (n=4),[8, 10, 12, 19] menopause (n=1),[28] menorrhagia (n=1)[14]	GPs, nurse practitioners, unspecified physician	Gynaecologists, midwives,	UK, Australia, Sweden, USA
3.2.	Stigma or embarrassment of menstrual conditions and symptoms amongst patients	8	Bullo 2021[26]; Chapple 1998[14]; Chapple 2001[7]; Davis 2021[15]; Dixon 2021[8, 12, 13, 25]	Endometriosis (n=4),[8, 12, 13, 26] infertility disease (n=1),[25] menopause (n=1),[15] menorrhagia (n=2)[7, 14]	GPs, pharmacists	Gynaecologists	UK, Australia
3.3.	Web-based sources of accurate information are needed to correct misinformation which is a cause of anxiety and	6	Bertero 2019[11]; Copp 2021[17]; Copp 2020[21]; Dixon 2021[12]; Rowe 2021[8] Young 2017[9]	Endometriosis (n=4),[8, 9, 11, 12] PCOS (n=2)[17, 21]	GPs	Endocrinologists, gynaecologists	UK, Australia, Sweden

	mistaken beliefs amongst patients						
	Identified by fewer than 4 studies						
3.4.	Cultural beliefs of patients should be taken into account but stereotyping of minority groups by clinicians is unhelpful	2	Chapple 1998[14]; Esposito 2005[28]	Menopause (n=1),[28] menorrhagia (n=1)[14]	GPs, nurse practitioners, unspecified physician	None	UK, USA
3.5.	External factors which lead to a faster referral	2	Chapple 1998[14]; van der Zanden 2020[13]	Endometriosis (n=1),[13] menorrhagia (n=1)[14]	GPs	None	UK, Netherlands
3.6.	Women's health is underfunded and not seen as a priority for research	2	Dixon 2021[12]; Fernandes 2020[25]	Endometriosis (n=1),[12] infertility disease (n=1)[25]	GPs	Gynaecologists	UK, Norway
4.	**Multiple conditions**						
	Identified by at least 4 studies						
4.1.	Gynaecological conditions can be difficult to definitively diagnose	9	Bertero 2019[11]; Bullo 2021[26]; Copp 2020[21]; Dixon 2021[12]; Fernandes 2020[25]; McGowan 2010[22]; O'Flynn 2004[18]; van	Chronic pelvic pain (n=1),[22] endometriosis (n=5),[9, 11-13, 26] infertility disease (n=1) menstrual disorders (n=1),[18] PCOS (n=1)[21]	Community gynaecologist, GPs, nurses, practice nurses	Endocrinologists, gynaecologists	UK, Australia, Netherlands, Norway, Sweden

			der Zanden 2020[13]; Young 2017[9]				
4.2.	Lack of GP guideline	4	Bush 2007[16]; Chapple 2001[7]; O'Flynn 2004[18] van der Zanden 2010[13]	Endometriosis (n=1),[13] menopause (n=1),[16] menorrhagia (n=1),[7] menstrual disorders (n=1)[18]	Community gynaecologist, GPs, nurse practitioners, pharmacists	Gynaecologists	UK, Netherlands, USA
4.3.	Medicalisation of social phenomenon / Not believing there to be a physical issue	7	Copp 2020[21]; Labots-Vogelesang 2021[20]; McGowan 2010[22]; Rowe 2021[8]; Selfe 1998[24]; Young 2017[9]; Young 2019[10]	Chronic pelvic pain (n=2),[22, 24] endometriosis (n=3),[8-10] PCOS (n=1),[21] PMS (n=1),[20]	GPs, practice nurses	Endocrinologists, gynaecologists	UK, Australia, Netherlands
4.4.	Need to follow a diagnostic hierarchy and exclude 'red flags' first	8	Copp 2020[21]; Dixon 2021[12]; Esposito 2005[28]; Grundstrom 2016[19]; McGowan 2010[22]; Rowe 2021[8]; Selfe 1998[24]; van der Zanden 2020[13]	Chronic pelvic pain (n=2),[22, 24] endometriosis (n=3),[8, 12, 13, 19] menopause (n=1),[28] PCOS (n=1)[21]	GPs, nurse practitioners, unspecified physician	Endocrinologists, gynaecologists, midwives	UK, Australia, Netherlands, Sweden, USA

4.5.	Trying but not succeeding to find solutions for patients who are dissatisfied with care	4	McGowan 2010[22]; Rowe 2021[8]; Selfe 1998[24]; Young 2016[10]	Chronic pelvic pain (n=2),[22, 24] endometriosis (n=2)[8, 10]	GPs, practice nurses	Gynaecologists,	UK, Australia
	Identified by fewer than 4 studies						
4.6.	Risk of over diagnosis	3	Copp 2021[17]; Copp 2020[21]; McGowan 2010[22]	Chronic pelvic pain (=1),[22] PCOS (n=2)[17, 21]	GPs, practice nurses	Endocrinologists, gynaecologists	UK, Australia

Table 8. Subthemes identified for specific gynaecological conditions, supporting studies, and clinicians in study samples

	Themes and subthemes	**Studies, n**	**Supporting studies**	**Clinicians in study sample**		**Country setting**
				Primary care	**Secondary care**	
5.	**Endometriosis**					
5.1.	Disease impacts can be variable and unpredictable and across multiple systems	2	Dixon 2021[12]; Young 2017[9]	GP	Gynaecologists	UK, Australia
6.	**PCOS**					
6.1.	Patients reluctant to accept that there is no quick fix	2	Arasu 2019[27]; Copp 2021[17]	GP	None	Australia

6.2.	Too much guidance	1	Arasu 2019[27]	GP	None	Australia
6.3.	Unrewarding for GPs to prescribe lifestyle treatment option because patients do not engage	1	Arasu 2019[27]	GP	None	Australia
7.	**Menopause**					
7.1.	Concerns about long term HRT use and lack of alternative treatments	2	Bush 2007[16]; Nekhlyudov 2009[39]	Family practice, internal medicine (USA)	Gynaecologists, obstetricians	USA
8.	**Menorrhagia**					
8.1	Differences in how male and female GPs interact with patients	2	Chapple 2001[7]; O'Flynn, 2004[18]	Community gynaecologist, GPs, nurses	None	UK
9.	**Chronic pelvic pain**					
9.1.	CPP is a new label for pre-existing conditions	1	McGowan 2010[22]	GPs, practice nurses	None	UK
9.2.	Disengagement of dissatisfied patients	1	McGowan 2010[22]	GPs, practice nurses	None	UK
9.3.	Provisional diagnostic label keeps patients happy by validating their symptoms	1	Selfe 1998[24]	GPs	Gynaecologists	UK

9.4.	Uncomfortable talking about symptoms that can not be explained in biomedical terms (nurses) / Perception of doctors that nurses to do not know how to deal with patients with somatisation	1	McGowan 2010[22]	GPs, practice nurses	None	UK
10.	**PMS**					
10.1.	Only an illness when it affects daily lifestyle	1	Labots-Vogelsang 2021[20]	GPs	None	Netherlands