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Evidence Check

General practitioners raising and discussing sensitive health issues with patients

An Evidence Check rapid review brokered by the Sax Institute
for the NSW Ministry of Health — June 2023

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This report was prepared by: Peter Bragge, Veronica Delafosse, Ngo Cong-Lem, Diki Tsering and Breanna Wright from the Monash Sustainable Development Institute Evidence Review Service at BehaviourWorks Australia.
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Executive Summary

Background

A range of preventive health issues can be challenging for general practitioners (GPs) to raise and discuss with patients during consultations. GPs can feel ill-prepared to explore these issues in limited consultation time, while patients often experience embarrassment, shame and/or the effects of stigma. Both GPs and patients can also perceive that the responsibility of initiating conversations of this nature rests with the other party in the conversation, rather than themselves.

If sensitive health issues are not initiated and discussed with patients in a way that facilitates engagement with care, opportunities for prevention and early intervention that optimise patient outcomes and promote overall health and wellbeing can be missed.

This Evidence Check was commissioned by the Centre for Population Health, NSW Ministry of Health, as part of a project to improve how preventive, sensitive health issues are raised in NSW general practice.

Review questions

The Evidence Check covered three research questions:

1. **From adult patients' perspectives, what is known about raising and discussing sensitive preventive health issues with a general practitioner?**
2. **What are general practitioners' perspectives on raising and discussing sensitive health issues with patients?**
3. **What approaches or factors have been shown to be effective when general practitioners raise sensitive preventive health issues with adult patients?**

Summary of methods

The review team carried out a systematic search of Ovid MEDLINE, Ovid Cochrane and six grey literature databases. Two reviewers independently screened and selected studies, and appraised them for quality. All included studies were independently assessed for methodological quality by two researchers.

Key findings

Results of searching and study characteristics

Searching identified 28 studies overall, comprising 23 studies relevant to observational questions (1 and 2); four studies pertaining to interventions (question 3); and one study relevant to all questions.

Overall study quality was moderate to high, meaning reasonable confidence can be placed in findings. Weight management (two reviews, eight primary studies) and sexual health (one review, six primary studies) were the most frequent sensitive health issues, representing more than half of all included studies in the Evidence Check. Most of the 24 relevant primary studies were based in Australia (n = 9) and the UK (n = 7).

Question 1: From adult patients' perspectives, what is known about raising and discussing sensitive preventive health issues with a general practitioner?

Key themes reported in studies involving both GPs and patients were:

- Lack of time in a consultation to raise and discuss sensitive health issues (12 studies): Given the numerous pressures on GPs including and beyond addressing sensitive health issues, this is an unsurprising finding.
- Gender differences between GPs and patients (five studies, all in sexual health): patients across included studies indicated a clear preference to be seen by a GP of the same gender.

Key themes reported in studies involving patients were:

- Perceived GP attitude (six studies): Where patients felt they would be judged by GPs they were less likely to raise sensitive issues. Where patients felt their GP was professional and had a long-term relationship with them, they felt more comfortable raising sensitive issues.
- Embarrassment / privacy (five studies): Studies reported that patients were reluctant to raise sexual health concerns because of embarrassment. Relating to this is a perception that the information discussed in a GP consultation may not remain private; for example, that the reception staff will know about such discussions.
- Cultural / societal values (five studies): Patients felt raising issues pertaining to weight management, sexual health and smoking would result in negative judgements and / or discrimination based on societal attitudes and norms regarding those issues.
- Perception that raising sensitive issues was exclusively the role of the GP (five studies).

Question 2: What are general practitioners' perspectives on raising and discussing sensitive health issues with patients?

Key themes reported in studies involving GPs were:

- Knowledge / skills (10 studies): GPs encounter a broad array of conditions in everyday practice. They have a relatively higher degree of confidence in their knowledge and skills for some conditions compared with others. Studies reported that confidence in knowledge and skills for weight management and sexual health were relatively low. Furthermore, the GPs had low confidence in the additional skill of being able to raise and discuss sensitive issues.

- Unsure of / beliefs about role (nine studies): GPs recognise the importance of sensitive health issues but feel addressing such issues is beyond their professional role. For example, they may feel weight management is a public health responsibility and that sexual health management is the domain of specialists in this field.
- Sensitive issues are usually not considered to be the primary focus / priority of the consultation (nine studies): GPs find appropriately discussing and addressing sensitive health issues can conflict with more immediate health needs that may be the primary focus of a GP appointment.

Question 3: What approaches or factors have been shown to be effective when general practitioners raise sensitive preventive health issues with adult patients?

Only five out of the 31 studies in this Evidence Check described or evaluated interventions that made conversations about sensitive issues easier for GPs and / or patients. A consistent theme across these studies was the use of structured approaches to sensitive health issues:

- Use of a screening tool to guide weight-related discussions made these easier for patients and GPs. The EOSS-2 risk tool focuses on nine risk factors associated with overweight and obesity including age, self-reported quality of life, disability, bodily pain and depression, and family history of diabetes, hypertension or high blood sugar.[1]
- Similarly, the structured 5AsT approach to weight management explored by Luig et al.[2] focused on health rather than weight loss and functional goals aligned with patient value and quality of life.
- The validated eCHAT tool starts the conversation outside of the GP setting by screening electronically for mental health and lifestyle issues across nine domains—problematic smoking, drinking, recreational drug use, gambling, depression, anxiety, exposure to abuse, difficulty with anger control and physical inactivity. This includes practical steps to address identified issues either independently or with support of health services.[3]
- Question prompt lists are another intervention that can assist GPs to raise sensitive preventive health issues with patients, for example:
  - AskShareKnow, which focuses on three questions applicable to multiple health issues: (1) What are my options? (including wait and watch); (2) What are the possible benefits and harms of those options? and (3) How likely are each of the benefits and harms to happen to me?
  - Question Builder (QB) tailors a set of questions applicable to most health issues to five different appointment types including three types of GP appointment—routine check-up, new symptoms and follow-up.[4]

Gaps in the evidence

This Evidence Check found two gaps in research:

1. The evidence base is predominantly observational. This means the key issues that hamper and help foster conversations about sensitive health issues are relatively well understood in comparison with what works to foster these conversations. More research examining the effectiveness of promising approaches is therefore needed.

2. The evidence base is predominantly in the areas of weight management (10 studies, including two reviews) and sexual health (seven studies, including one review). More primary and review studies are needed focusing on other important sensitive health issues such as mental health, domestic violence, hepatitis, smoking and alcohol and/or other drug use.

Discussion and conclusion

This rapid Evidence Check used a comprehensive search approach and best-practice principles of dual, independent study selection and appraisal. The identified evidence was generally of moderate to high methodological quality, meaning confidence can be placed in the review findings. However, because of time limitations we included only studies from 2018 onwards in the review. This limitation was offset by placing no year limitations on Q3 (intervention studies) and in the Google Scholar search (sorted by relevance).

Interventions to support and promote the raising of sensitive issues were identified both through this Evidence Check and with reference to established applied behaviour change approaches in other fields. General behaviour change approaches that are applicable to this challenge include creating non-judgemental environments that normalise sensitive health issues; simulation training; and public campaigns that reduce stigma and challenge unhelpful cultural norms.

Addressing lack of time in consultations is a challenging issue across all areas of GP practice. Significant system-level change would be required to extend standard consultation times; focusing on optimising workflows may therefore be more feasible. Addressing GP patient–gender mismatch through diverse GP representation may also be feasible in larger practices.

The key theme of the few intervention studies identified in this Evidence Check was the use of prompting, screening or other structured tools by GPs. Collectively, these approaches have two main features. First, they are a way of approaching sensitive health conversations less directly, for example by focusing on underlying risk factors for sensitive health conditions such as obesity and mental illness rather than addressing the issues directly. Second, through either risk-factor or more general question prompts, these approaches take the onus away from GPs and patients to come up with a way of asking the question using their own words.

Table 1—Summary of themes by condition across all included studies for Q1 (patient perspectives) and Q2 (GP perspectives)

		GP themes													Shared			Patient themes										
Clinical focus	Citation Study type (R = review; P = primary study)	Knowledge / skills	Unsure of / beliefs	Not focus of consultation / priority	Beliefs about condition / consequences	Expectation of intervention	Fear of offending	Negative emotions	Assumptions	Perception of GP / patient relationship	Risk assessment	Advance knowledge / awareness	Communication / language	Confidentiality / privacy	Lack of time	Gender mismatch	Age mismatch	Perceived GP attitude	Cultural / societal values	Embarrassment / privacy / confidentiality	Feels GP role to raise / address condition	Confidence in GP / talking about	Stigma	Acceptance / attitudes	Information needs	Experience / relationship with GP	Fear
Weight management	Ananthakumar 2020, R								■													■	■					
	Auckburally 2021, R	■	■				■						■						■									
	Blackburn 2015, P	■	■	■	■	■		■							■													
	Blackburn 2019, P	■					■		■																			
	Coffey 2018, P			■											■													
	McHale 2019, P														■													
	McHale 2020, P		■	■											■									■	■			
	Norman 2022, P		■	■	■		■			■					■													
	Spooner 2018, P	■																					■					
	Thille 2019, P								■														■					
Sexual health	Ezhova 2020, R	■													■			■	■	■			■		■	■		
	Collyer 2018, P	■	■								■	■			■	■												
	Dyer 2019, P			■												■												
	Ejegi-Memeh 2020, P															■		■		■	■			■				
	Leusink 2018, P	■	■	■		■		■						■		■												
	Malta 2018, P		■	■					■						■	■	■											
	Malta 2020, P				■	■												■	■	■	■				■	■		■
Other / mixed	Osborne 2023, R (mental health)		■	■	■	■		■					■	■	■			■		■	■	■						■
	Gravely 2019, P (smoking)										■								■					■				
	Jovicic 2020, P (loneliness)		■		■		■	■							■													
	Aira 2003, P (alcohol)	■		■		■					■	■			■													
	Mousaco 2019, P (domestic violence)	■	■		■		■			■																		
	Hodyl 2020, P (mixed)														■			■	■	■	■	■						
	Song 2020, P (mixed)	■								■								■			■	■						
	TOTAL n themes	10	9	9	6	5	5	4	4	3	3	2	2	2	12	5	1	6	5	5	5	4	4	3	3	2	2

Background

Initiating discussions of sensitive preventive health issues with patients can be challenging for general practitioners (GPs). This may be due to a range of factors including lack of time, uncertainty on the GP's part about their role and lack of confidence to broker these conversations. Given this is important for timely identification of such conditions, it is important to identify and implement interventions that can support GPs to raise sensitive health issues.

The Centre for Population Health (CPH), NSW Ministry of Health, has established a project to develop understanding of this area of practice with a focus on the challenges experienced by GPs and patients, their root causes and evidence-based opportunities and approaches to support GPs to initiate preventive health conversations.

In 2020, the CPH commissioned qualitative market research to understand the barriers to raising sensitive health issues with patients. The market research found:

- GPs often don't see the identified health issues as sensitive, even though patients may feel they are sensitive
- GPs are more likely to raise the issue if they have strong knowledge and confidence and/or there is a clear treatment or referral pathway
- Lack of time to discuss or manage the issue is a significant barrier, as is the lack of appropriate reimbursement.

Anecdotal evidence suggests some GPs themselves find certain health issues embarrassing or taboo and will actively avoid initiating conversations about these with their patients; and that patients can have negative care experiences when sensitive health issues are raised in a suboptimal way, including:

- Patients feeling embarrassed, judged, targeted, stigmatised and fearful of discrimination if certain health issues are disclosed
- If the health issue is not discussed in a sensitive/appropriate way the patient may choose not to engage in available care
- Patients not feeling comfortable initiating or discussing some health issues with GPs as the health issue is viewed as taboo, e.g. discussing certain risk behaviours (sexual practices, illicit/illegal drug use).

The CPH is seeking to develop recommendations for interventions, activities and support mechanisms to improve how preventive, sensitive health issues are raised and managed in NSW general practice, with the overall aim of improving:

- Patient access to high-quality, appropriate and timely care
- Improved patient care experience
- Improved access to preventive healthcare in the primary care setting.

This project supports the NSW Government's Future Health Strategy 2022–2032 outcomes:

- Outcome One—Patients and carers have positive experiences and outcomes that matter
- Outcome Three—People are healthy and well.

Review questions

Question 1: From adult patients' perspectives, what is known about raising and discussing sensitive preventive health issues with a general practitioner, including:

a) What preventive health issues are considered sensitive by patients?
b) What are the reasons that patients consider some preventive health issues to be sensitive?

Scope

- 'Sensitive health issues' refers to those health issues where patients may be hesitant or reluctant to raise or discuss these with a GP. The review team will need to develop search terms for sensitive health issues, as this is not a commonly used term.
- The CPH has a focus on prevention. Of most relevance for this Evidence Check are the CPH's strategic priorities, including sexually transmissible infections (STIs), HIV, viral hepatitis B and C, adults living with overweight and obesity, and smoking and vaping cessation. Other Ministry of Health priorities within scope are domestic violence, alcohol and other drugs (AOD), and mental health (including self-harm and suicide).
- The Evidence Check team will:
  - Identify health issues that adult patients (18 years and over) consider to be sensitive
  - Summarise the reasons why adult patients may consider some preventive health issues sensitive, for example embarrassment, stigma, discrimination, judgement, confidentiality
  - Summarise the evidence across health issues, for example "embarrassment was found to be a common issue identified by patients…".

Out of scope for this Evidence Check are:

- Studies that relate to specific techniques/methods of improving communication between patient and GP.

Question 2: What are general practitioners' perspectives on raising and discussing sensitive health issues with patients, with regard to:

a) Their role in raising sensitive health issues as part of the consultation
b) Their understanding of patient perspectives about sensitive health issues
c) Barriers to raising and discussing sensitive health issues
d) Enablers that support raising and discussing sensitive health issues.

Question 3: What approaches or factors have been shown to be effective when general practitioners raise sensitive preventive health issues with adult patients?

- 'Effective' refers to those approaches that have improved GPs' ability to raise sensitive health issues

- ‘Approaches’ may include those at the level of the individual GP, the practice or the practice group or system. For example:
  - GP—established relationship with patient, strong communication skills, culturally appropriate communication, shared decision making, identification of people who may be in higher risk groups for particular health issues
  - Practice—GPs of different sexes and cultural background, culturally appropriate reception and waiting areas, resources that provide information for the patient, communication via digital technologies, information about what to expect during the consultation, follow-up arrangements
  - System—funding models, access to telehealth, mass media campaigns, training for undergraduates and as part of continuing education, availability of resources and tools, use of translators
- The evidence for each approach or factor should be clearly described.

Out of scope for this Evidence Check are:

- Studies that relate to specific techniques/methods of improving communication between patient and GP.

Key definitions

Sensitive preventive health issues: Health issues where patients may be hesitant or reluctant to raise or discuss these with a GP. Of most relevance for the CPH are those within its remit, including those relating to **STIs, HIV, viral hepatitis, adults living with overweight and obesity, smoking/vaping cessation, domestic violence, alcohol and other drugs (AOD), and mental health (including self-harm and suicide).**

Methods

Search strategy, approach and rationale

Table 2 - Eligibility criteria with reference to the three review questions

	Include	Exclude
Study type	Reviews Primary studies	Theses Book chapters
Population	*Q1: Patients presenting to general practice / primary healthcare settings *Q2 & 3: general practitioners (GPs)	Health professionals other than general practitioners, including specialists (where the context for raising sensitive issues is pre-determined) Majority patient population under 18 years of age
Study setting	Q1–3: General practice / primary healthcare in Australia, UK and comparable jurisdictions such as New Zealand and Canada Articles that are relevant with respect to sensitive issues and population but outside of settings comparable to Australia will be tagged as 'secondary interest' (i.e. will be clearly identified in a separate table if tabulated and / or used to inform the interpretation of included articles)	Tertiary settings, e.g. hospital Specialist consultations, e.g. surgeon
Study focus	Q1 & 2: Primary aim of study is description of issues associated with initiating conversation between GPs and patients regarding preventive, sensitive health issues, including (but not limited to) STIs; HIV; hepatitis; overweight and obesity; domestic violence; alcohol and	Communication research or best practice standards (e.g. RACGP 'green' book) that are not specifically related to the topic of raising and discussing sensitive health issues

	Include	Exclude
	other drugs (AOD); mental health, self-harm and suicide; smoking/vaping cessation* Q3: Primary aim of study is description or evaluation of strategies designed to address barriers to initiation of a conversation regarding preventive, sensitive health issues as described above	
Outcome	Q1 & 2: n/a Q3: Any measure of behavioural intention, confidence or actual behaviours pertaining to GPs initiating discussion of sensitive health issues	
Publication status	Peer-reviewed journals Grey literature: Preprint articles, reports Year range calibrated to yield and timelines	Theses Book chapters

*__Q1: Patients' perspectives__ on what sensitive health issues are and why; __Q2: GP perspectives__ on their role in raising and discussing sensitive health issues; barriers and facilitators to doing so; and perception of patients' views about sensitive health issues; __Q3: Effectiveness of interventions__ to aid GPs in raising sensitive health issues.

Type and method of review

This is an Evidence Check, defined by the Sax Institute as "a rapid review of existing evidence tailored to the individual needs of an agency".

Data extraction (selection and coding)

We exported search results into Covidence (Cochrane technology platform), removing duplicates from the total number of identified records. Two reviewers Independently screened titles/abstracts (depending on resource capacity relative to yield) for eligibility, applying a priori inclusion and exclusion criteria. Following title/abstract screening, two reviewers independently applied the inclusion

and exclusion criteria to the remaining full-text records. Any conflicts for any step were resolved by a consensus discussion between the two reviewers or involvement of a third reviewer.

Data extraction focused on the following data items: authors; publication date; research design; primary aim; study population; barriers and facilitators to initiation of discussion of sensitive issues from the perspective of GPs and patients; interventions addressing barriers and facilitators (proposed or tested).

Risk of bias (quality) assessment

All included studies were independently appraised for methodological quality by two researchers (CL, DT), who used the following quality appraisal tools:

- Systematic reviews: The AMSTAR II tool[5]
- Narrative reviews: The SANRA tool[6]
- Qualitative studies: CASP Qualitative Studies Checklist[7]
- Mixed methods studies: Mixed Methods Assessment Tool (MMAT).[8]

Search databases

Refer to Appendix 1 for search strategies.

- Ovid MEDLINE
- Ovid Cochrane
- Grey literature databases:
  - Google Scholar
  - Canadian Agency for Drugs and Technologies in Health (CADTH)
  - Dimensions
  - MedNar
  - MedlinePlus
  - World Health Organization.

Results

Search and selection

Appendix 2 contains a summary of search and selection processes. After removal of duplicates, two independent reviewers screened 1878 studies in the Covidence platform; 65 full-text studies were then assessed for eligibility and, following this, 28 studies were included in the Evidence Check. These comprised:

- **Four reviews and 20 primary studies relevant to Q1** (patients' perspectives on what sensitive health issues are and why) and **Q2** (GP perspectives on their role in raising and discussing sensitive health issues; barriers and facilitators to doing so; and perception of patients' views about sensitive health issues)
- **One review (also relevant to Q1 and Q2) and four primary studies relevant to Q3** (effectiveness of interventions to aid GPs in raising sensitive health issues).

We also identified a further 19 studies of secondary interest that were conducted in settings not deemed to be comparable to Australia. Of these, 16 were relevant to Questions 1 and 2, and three were relevant to Question 3. We extracted basic study information for these studies (Appendix 3), but they were not subject to further analysis or synthesis.

Study quality

Appendix 4 presents the results of quality appraisal undertaken by two independent reviewers. In summary:

- Two systematic reviews evaluated with the AMSTAR II were of moderate to high quality (Ananthakumar 2020 = 11/13, Osborne 2023 9/13)
- Two narrative / scoping reviews evaluated with SANRA were also moderate to high quality (Auckburally 2021 = 7/12, Ezhova 2020)
- Fifteen qualitative studies evaluated using the CASP had scores ranging from 7/10 to 10/10, indicating these studies were generally high quality
- Nine studies evaluated using the MMAT had scores of 2/5 to 4/5 with most being 3/5 (n = 4) or 4/5 (n = 4) indicating these studies were generally high quality.

Collectively, the quality appraisal findings indicate moderate confidence can be placed in review findings and high confidence can be placed in the findings of the 24 primary studies.

Study characteristics

Reviews relevant to Questions 1 and 2 (observational, n = 4): Table 3a

The four reviews focused on weight management (n = 2), sexual health (n = 1) and mental health (n = 1). Three of the four reviews encompassed both GP and patient populations, with one review (Ananthakumar 2020 focusing only on patients.

Primary studies relevant to Questions 1 and 2 (observational, n = 20): Table 3b

The clinical focus of these 20 primary studies was weight management (n = 8); sexual health (n = 6); mixed clinical issues (n = 2); loneliness (n = 1); alcohol use (n = 1); smoking / tobacco (n = 1); and domestic violence (n = 1). Nine studies focused only on GPs, seven recruited only patients and the remaining five were mixed GP / patient populations. These studies were conducted in the following countries:

- UK = 7
- Australia = 7
- Finland = 1
- Ireland = 1
- Canada = 1
- New Zealand = 1
- The Netherlands = 1
- Multiple countries (US, UK, Australia, Canada) = 1.

Reviews relevant to Question 3 (interventional, n = 1): Table 3c

One review relevant to Questions 1 and 2[9] also contained a subset of studies focusing on interventions.

Primary studies relevant to Question 3 (interventional, n = 4): Table 3d

Interventional studies examined weight management (n = 2); mixed clinical issues (n = 1) and health information-seeking (n = 1). Two intervention studies recruited patients and two had mixed patient / GP populations. Two studies were conducted in Australia and one each in Canada and New Zealand.

Findings

Questions 1 & 2

From adult patients' perspectives, what is known about raising and discussing sensitive preventive health issues with a general practitioner? What are general practitioners' perspectives on raising and discussing sensitive health issues with patients?

Table 1 presents a summary of key themes by condition across all included observational studies (n = 24). Themes were identified pertaining to GPs' perspectives (n = 13 themes); patient perspectives (n = 10); and GP & patient (i.e. shared) perspectives (n=3).

The following section describes the most frequently identified themes by count (including ties) in each category. These are the themes for which there is a relatively larger volume of supporting studies and therefore more confidence can be placed in these for informing interventions.

Themes reported in studies involving patients

Most frequent patient theme (six studies):

- Perceived GP attitude

Second-most frequent patient theme (five studies each):

- Embarrassment / privacy
- GPs' role to raise / address sensitive issues
- Cultural / societal views.

Perceived GP attitude was identified in relation to sexual health (three studies), mixed clinical areas (two) and mental health (one). When patients feel their GP has a negative or biased attitude towards the topics, they are less likely to raise them for discussion.10 This issue also relates to the quality of the GP–patient relationships. Studies identified a number of interventions to address this issue, for example, by creating an environment that is perceived as non-judgemental to the patient. This can be achieved through posters in the waiting room and consulting rooms that promote positive messages encouraging and normalising discussion of sensitive topics. The included studies reflected that the influence of perceived GP attitude can play both a barrier and facilitator role; when GPs raise topics in a neutral and non-judgemental tone, this may also signal to patients that the GP does not have a negative attitude.11 Interventions that target 'bedside manner' or empathy in GPs may also affect patient perceptions. Where GPs were perceived as professional, and long-term therapeutic relationships existed, patients were more likely to feel comfortable raising sensitive issues.

There are some complexities to note when considering interventions addressing this theme. First, patient perceptions of GP attitudes are difficult to test and may not reflect actual GP attitudes.

Second, intervening to create the conditions of a trusted long-term GP–patient relationship is potentially difficult because of the varying turnover of, and access to, specific GPs in different regions.

Embarrassment / privacy was a theme in five studies, four of which focused on sexual health. Studies reported that patients are reluctant to raise sexual health concerns because of embarrassment. Relating to this is a perception that the information discussed in a GP consultation may not remain private, for example that the reception staff will know about such discussions. There are interventions that can successfully address this barrier. These include stigma reduction campaigns (including targeting attitudes and social norms) and normalisation of uncomfortable conversations. An important component of interventions such as these are the attitudes and behaviours of GPs, which relates to the above theme of perceived GP attitude. If patients perceive that a GP is uncomfortable or embarrassed to discuss a topic that will reinforce that it is an uncomfortable topic to talk about. Therefore, normalising and reducing stigma attached to sensitive topics is an important aspect of successful interventions.

Cultural / societal views were identified as a theme in two studies focusing on sexual health; in one study on weight management; one on smoking and one study with a mixed clinical focus. For example, cultural framing of sex as unnatural in old age is a barrier to older people seeking sexual health advice.[10, 12] In the area of weight management, patients prefer neutral terms such as 'weight' to 'obese', which can have negative connotations because of societal views across various cultures.[9] This again presents a potential barrier to patients raising discussion of weight in a GP consultation. Intervening to shift community perceptions about these conditions would require broad population-wide campaigns as well as campaigns targeted at healthcare workers.

The remaining prominent patient theme, the **perception that it is a GP's role to raise / address sensitive issues,** was described in five articles—two with a mixed clinical focus, two in sexual health and one in mental health. This theme intersects with the prominent GP theme of being unsure of / or beliefs about their role. This is described in the GP theme section below.

Themes reported in studies involving GPs

Most frequent GP theme (10 studies):

- Knowledge / skills

Second-most frequent GP theme (nine studies each):

- Unsure of / beliefs about role
- Not focus of consultation.

Three out of the five dominant themes fell under GP themes. These were: knowledge / skills; unsure of / beliefs about role; and not focus of consultation / not a priority. These themes were particularly prevalent across the topics of weight management and sexual health; however, this is driven by the number of articles represented by these two topics.

The GP theme of **knowledge / skills** was identified in 10 studies, particularly across the topic areas of weight management and sexual health but also in alcohol use and domestic violence. A number of factors contribute to this:

- Being generalists, feeling they have adequate knowledge across a diverse range of topics and populations may feel like a challenge for many GPs
- Knowledge and skills relate to having adequate knowledge of the sensitive topic itself as well as the skills that enable GPs to raise and navigate conversations. This may also include knowing the right terminology to use that patients find respectful, which may differ across age and population groups.

Literature from behavioural sciences supports several interventions that aim to increase knowledge and skills, including in the health sector. These include providing instructions about how to perform the behaviour (in this case how and when to raise a sensitive topic); breaking tasks down into easy and simple to perform steps; providing information about the consequences and/or benefits of performing the behaviour; and behavioural practice or rehearsal (e.g. simulation training).

The theme **unsure of / beliefs about role** was described in nine studies, particularly in the topics of weight management (four studies) and sexual health (three studies). For example, in the case of weight management, GPs were conflicted about how their role and responsibility intersected with that of other relevant actors, such as the public health sector. Providing clarity about GPs' role in raising and managing different sensitive health topics with patients could assist GPs in feeling confident in their role. Furthermore, addressing GP attitudes towards their role so that it is seen as their responsibility could also be effective.

Not the focus of the consultation / priority, described in nine studies, reflected challenges for GPs when a sensitive issue arises in the context of a consultation for a different, often unrelated topic. This intersects with lack of time and limited consultations in that GPs may not have the time to adequately raise or discuss an additional topic even when they feel it is warranted or necessary. There may also be an additional difficulty in navigating how much time in a given consultation should be dedicated to a topic that was not the reason for the patient attending the practice. In addition to time constraints, there is likely an awkwardness about raising an unrelated topic, especially one of a sensitive nature. Behavioural interventions that may assist in addressing these barriers include targeting GP attitudes to sensitive topics so that they are seen as a priority to raise and simulation training to practise conversations, especially raising additional topics with patients in limited time windows.

Themes reported in studies involving both GPs and patients

Most frequent shared theme (12 studies):

- Lack of time

Second-most frequent shared theme (five studies):

- Gender discordance.

Lack of time to raise these issues in the consultation was the most frequent theme, identified in nearly half of these 25 studies. This theme was identified across all clinical focus areas except domestic violence (one study). Given the numerous pressures on GPs described across multiple domains both within and beyond the context of sensitive health issues, this is a somewhat unsurprising finding.

Lack of time is an area in which interventions—specifically to alter the structure and funding of GP appointments—could be challenging or even impossible without significant system reforms.

Interventions that seek to improve and streamline general practice workflows, systems and processes to save GPs time may be more feasible.

GP / patient gender preference was identified in five studies, all in the clinical area of sexual health. This is also a predictable result, with patients across the included studies indicating a clear preference to be seen by a GP of the same gender.

While the ability to match genders to patients seeking sexual health-focused consultations will be dependent on the size and composition of individual general practices, the recommendation stemming from this finding is relatively simple and low-cost. In many cases, GP practices may already be recommending that patients in this category consult the GP they are most comfortable dealing with, and there are specialists in men's and women's health also. Equally and where possible, patients can self-select a GP of their own gender.

Question 3

What approaches or factors have been shown to be effective when GPs raise sensitive preventive health issues with adult patients?

This Evidence Check found relatively little empirical evidence for interventions, identifying only one review and four relevant primary studies. Therefore, clear opportunities exist for the Centre for Population Health (CPH) to build the evidence base through well-designed research studies.

There is evidence from one medium quality review that training can develop GP skills, knowledge and confidence in having conversations about weight management, and that objective communication tools such as growth charts for children are a useful visual non-judgemental support to these.[9]

Although paediatric care is beyond the scope of this Evidence Check, the principle of using objective measures to support these conversations may be applicable to adult patients. This is supported by the 2021 Australian primary study of Atlantis et al.[1], which showed use of a screening tool increased the likelihood of GPs identifying or recording obesity. Patients also reported they were more comfortable having weight-related discussions when this screening tool was used. The tool gave GPs and patients a shared, appropriate language for the discussion and enabled a focus on medical goals.

Similarly, the structured '5AsT' approach to weight management published by Luis et al.[2] involved a structured approach based on established principles of healthy weight management, such as recognition of obesity as a multifaceted chronic disease; a focus on health rather than weight loss; and functional goals aligned with patient value and quality of life. Based on the perspectives of 20 patients, this approach was found to foster genuine interest and compassion, enable patients to identify root causes of obesity and facilitate a strength-based rather than deficit-focused approach.

Shah et al.'s 2019 New Zealand study of the AsiaCHAT screening tool[3] was also found to foster identification of issues that may otherwise be missed; assist patients in describing their mental health more effectively; and combat shyness in patients with an Asian cultural background. However, time and resource cost were identified as barriers to implementation of this approach.

Finally, the Australian study of health information-seeking by Tracey et al.[4] examined question prompt lists in a sample of 31 patients. They were perceived as effective in making it easier for patients to ask

questions without feeling they were wasting consultation time; normalising the process of asking questions; and giving patients a sense of control in health decisions. While some questions needed refining, the authors recommended that question prompt lists could be incorporated into an appointment app or booking system.

Collectively, the key theme of the intervention studies was the use of prompting, screening or other structured tools. These were found to be effective in initiating and discussing sensitive health issues across a range of clinical domains. In combination with training to build GP knowledge, skills and confidence, it appears that use the use of such tools enables both GPs and patients to shift their focus away from each other by creating a focus on the use and findings of such tools and frameworks. Such tools present a shared, non-judgemental terminology that both parties are comfortable using.

Although it has a small evidence base, this does present some empirical support for the development of targeted behaviour change strategies addressing key barriers identified in the literature. Furthermore, with several studies led by Australian researchers[1, 4] or in New Zealand[3] there are opportunities to build on this research in NSW.

Table 3a – Reviews relevant to Q1: Patients' perspectives on what are sensitive health issues and why; and Q2: GP perspectives on their role in raising and discussing sensitive health issues, barriers and facilitators to doing so, and perception of patients' views about sensitive health issues [n = 4]

Citation, year, N studies Review type; quality score (tool)	Aim of review	Population	Clinical focus	Key findings including barriers and facilitators
Ananthakumar, Jones[13] 2020 21 studies Systematic review 11/13 (AMSTAR II)	Assess patient reactions to consultations in which excess weight could have been or was discussed.	Patients	Weight management	• Doctors offered banal advice based on negative assumptions about patient health behaviours. • Doctors assumed patient symptoms stemmed from being overweight. • Patients responded positively to offers of support for weight loss and active monitoring of weight. • Patients who are living with overweight and obesity internalise weight stigma, fuelling beliefs that clinicians are judging them negatively.

Citation, year, N studies Review type; quality score (tool)	Aim of review	Population	Clinical focus	Key findings including barriers and facilitators
Auckburally, Davies[9] 2021 Not stated Narrative review 7/12 (SANRA)	Summarise perceived barriers to optimal discussion about weight status and preferred weight-based terminology.	GPs and patients	Weight management	• The terms ‘weight’ and ‘BMI’ for adults and ‘weight, weight problem and plus size’ for adolescents and ‘gaining too much weight’ for children were found to be the preferred and least offensive terms, while ‘fatness’ was reported to be the least desirable word of those offered. • Other terms such as ‘obese’, ‘large size’ and ‘excess fat’ were also rated as undesirable, with ‘morbidly obese’, ‘fat’ and ‘obese’ viewed as the most stigmatising and blameful words. • GPs were unsure of their responsibility; there was some mention of prevention of obesity at a public health level, but the management for current obesity was seen as less important unless there were comorbidities. They were worried about offending patients. • Training directed at developing skills, knowledge and confidence in having conversations about weight would allow for healthcare professionals to more easily raise the topic with patients and families.
Ezhova, Savidge[12] 2020 Not stated Scoping review 11/12 (SANRA)	Identify the barriers that stop older people seeking sexual health advice and treatment.	GPs and patients	Sexual health	• Barriers for patients included: cultural and societal views and beliefs about sexual health, stigma, embarrassment and discrimination, quality of relationship between patient and doctor. • Barriers for doctors included lack of education and training and a lack of information.

Citation, year, N studies Review type; quality score (tool)	Aim of review	Population	Clinical focus	Key findings including barriers and facilitators
Osborne, De Boer[14] 2023 9 studies Systematic review 9/13 (AMSTAR II)	Explore the barriers and facilitators to young people having conversations with their GPs about suicide risk, including thoughts and behaviours.	GPs and patients	Suicide / suicide ideation	• GP attitudes and beliefs impede inquiry because it can be uncomfortable, awkward and uncertain. • GPs found appointments with young people uniquely difficult and couldn't differentiate suicidal concerns from teenage angst. • GPs had insufficient time for these conversations and had concerns about managing confidentiality. • GPs lacked the knowledge and skills to navigate these conversations. • For young people, a perceived indifferent or impersonal attitude by the GP discouraged disclosure, along with a lack of time and fears about consequences. • Young people are not confident that GPs have the skills to manage these conversations, yet they felt it was the GP's responsibility to raise them.

Table 3b – Primary studies relevant to Q1: Patients' (PTs) perspectives on what are sensitive health issues and why; and Q2: GP perspectives on their role in raising and discussing sensitive health issues, barriers and facilitators to doing so, and perception of patients' views about sensitive health issues [n = 20]

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Aira, Kauhanen[15] 2003 Finland Qualitative 7/10 (CASP)	Explore factors influencing health practitioners inquiring about patients' alcohol consumption.	36 GPs 0 PTs	Alcohol use	Barriers: • Sensitive nature of the topic—seen as more sensitive than smoking, overeating or lack of exercise • Poor availability or knowledge of intervention tools • Low expectation that intervention will be helpful • Lack of time. Facilitators: • Awareness of issue in advance of the consultation, e.g. from spouse • Signals that prompt suspicion of alcohol misuse, e.g. appearance, age, sex, profession.
Blackburn, Stathi[16] 2015 UK Qualitative 8/10 (CASP)	Explore general GPs perceived barriers to raising the topic of weight in general practice.	17 GPs 0 PTs	Weight management	Barriers: • Limited understanding about obesity care. • Concern about negative consequences such as alienating or offending the patient. • Lack of time and resources to deal with a sensitive issue.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Blackburn and Stathi[17] 2019 UK Qualitative 9/10 (CASP)	Examined the discursive power relations that shape how GPs understand and talk about obesity.	20 GPs 0 PTs	Weight management / obesity	• GPs draw on discourse that constructs obesity as primarily caused by individual behaviour while simultaneously drawing on discourse that positions patients as powerless to lose weight and subject to judgement and blame by wider society. • While framing obesity as an important health problem that should be addressed rather than ignored, GPs simultaneously describe body weight as central to one's sense of self and a personal attribute, which they feel reluctant to criticise. • Uncertainty about how and when to raise the topic of weight, and the threat of alienating and/or upsetting patients, are contributing to an unease and lack of motivation by healthcare professionals to identify weight as an issue.
Coffey, Curran[18] 2018 Ireland Quantitative cross-sectional survey 3/5 (MMAT)	Assess patients' attitudes towards weight loss management.	0 GPs 167 PTs	Weight management	• The majority of PTs (87%) did not discuss with their GPs before taking actions to manage their weight and 60% reported their GPs had never discussed the topic with them. • GPs tended to discuss weight topics with patients living with obesity more than patients living with overweight (42% vs. 16%, respectively). • Two main reasons for GPs' lack of weight topic discussion: GPs' focusing on the presenting health issue and time constraint.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Collyer, Bourke[19] 2018 Australia Qualitative 7/10 (CASP)	Explore the perspectives of Victorian GPs on promoting sexual health to young men aged 16–25 years.	17 GPs 0 PTs	Sexual health	• GPs perceived young men as a difficult group to discuss sexual health with; their lack of knowledge and finding an entry point for the discussion was challenging, compared with female patients. • Conducting a risk assessment made it easier to discuss sexual health. • GPs identified several barriers limiting their promotion of sexual health to young men: • young men's reluctance to seek care • time constraints • gender mismatch. • GPs with a special interest in sexual health suggested the need to develop rapport before beginning a sexual health discussion; the use of posters in the waiting room also helped. • GPs had mixed perceptions about whose responsibility it was to initiate a conversation.
Dyer, Kirby[20] 2019 UK Quantitative 4/5 (MMAT)	Explore GP and PT perspectives on erectile dysfunction management after prostate cancer treatment.	167 GPs 546 PTs	Erectile dysfunction (ED)	• PTs were generally unsatisfied with ED management; 12% of PTs were not told ED was a potential side effect of their prostate cancer treatment. • 67% GPs reported they 'never/rarely' initiated ED discussion with their patients. • Female GPs were less likely to initiate a conversation about ED compared with male GPs—44% and 20%, respectively. • Communication barriers: GPs' gender and perception of PT age; PTs' reluctance to raise the topic because of embarrassment.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Ejegi-Memeh, Hinchliff[21] 2020 UK Qualitative 10/10 (CASP)	Explore barriers and facilitators to discussions of sexual health in primary care for females with type 2 diabetes.	0 GPs 10 PTs	Sexual health and wellbeing (SHW)	• How professionals had listened to participants in the past, often about health issues unrelated to SHW, was a deciding factor in whether to bring up SHW. • The participants expressed a desire for healthcare professionals to 'ask more questions', suggesting that if more questions were asked, they would be more willing to discuss sexual health and wellbeing issues that they did not feel able to bring up themselves. • The sample of female participants preferred discussing these matters with a female practitioner. • Acceptance, lack of rapport and embarrassment were barriers to discussions.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Gravely, Thrasher[22] 2019 US, UK, Australia, Canada Quantitative 4/5 (MMAT)	Assess health professionals' advice on quitting smoking using nicotine vaping products.	0 GPs 4150 PTs	Smoking / vaping	• 6.8% reported discussing nicotine vaping products (NVPs) with a health professional. • 2.1% of smokers reported that an HP recommended that they use an NVP. • Among those who discussed NVPs with their HP, 54.0% of smokers reported that they brought up the topic and 45.0% reported that their HP did (1.0% did not know/remember). • Overall, discussions and NVP recommendations were more common among smokers who were: from the US, Canada or England; younger; more highly educated; more frequent NVP users; and more positive about NVPs. • Both discussions about and recommendations to use NVPs were significantly associated with having received advice by a health professional in the past year to quit smoking, and with smokers who believed that the public approved of NVPs/vaping.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Hodyl, Hogg[23] 2020 Australia Mixed methods 3/5 (MMAT)	Identify the preferred communication channels to support men's health information access.	0 GPs 461 PTs	Varied (not limited to sensitive issues)	Barriers from survey: • Health issues were perceived to be a private matter (59%) • PTs wanted more time (16%), felt embarrassed (12%), felt uncomfortable (12%), and not confident talking to anyone (9%). Barriers from group focus interview: • The social construct of masculinity led PTs to feel the need to be 'tough' and talking about health was a sign of weakness • PTs felt discomfort (private or sensitive information) and would not discuss a topic unless asked • Quality of GP–PT relationship and PT's perception of whether their health information was accepted were also barriers.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Jovicic and McPherson[24] 2020 UK Qualitative 7/10 (CASP)	Explore GPs' views and experiences of loneliness within their older adult patients, and their related agency.	19 GPs 0 PTs	Loneliness	GPs' perception: • PTs should be largely responsible for managing their loneliness • GP services should primarily be used for medical needs rather than providing emotional support to PTs • The role of GPs is to support PTs with loneliness, but not to cure it • Families and communities are more appropriate contexts for addressing loneliness in PTs. Barriers: • Time constraint for GPs (7 minutes per PT in the UK) • GPs may worry about the conversation becoming uncontrollable in terms of time management once initiated • Some PTs may perceive loneliness as a social stigma and may be upset if asked about it.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Leusink, Teunissen[25] 2018 The Netherlands Qualitative 8/10 (CASP)	Identify barriers and facilitators in the diagnostic process of women with recurrent vulvovaginal complaints in primary care.	17 GPs 0 PTs	Vulvodynia	Barriers: • Difficulties inquiring about sexual behaviours • Reluctance to discuss sexual topics if they are not relevant to a sexually transmitted disease (STD) • Gender mismatch, uncertainty, and lack of education • (Male) GPs worrying they may be seen as interfering with their PTs' privacy • GP perception that PTs' emotions may be potentially 'contagious', worsening stress / burnout, therefore maintaining an emotional distance. Facilitators: • GP perception that patients may benefit from discussing sexual issues.
Malta, Hocking[26] 2018 Australia Qualitative 7/10 (CASP)	Explore GPs' knowledge of and attitudes towards sexual health among older patients.	15 GPs 0 PTs	Sexual health	Barriers: • GPs' attribution of responsibility to PTs for initiating discussion on the sensitive topic • Mismatch in age and gender between GPs and PTs • Time constraint—GPs prioritising discussing more urgent/complex heath issues • Quality of GP–PT relationship • Judgement as to whether it is related to the presenting health issue.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Malta, Temple-Smith[10] 2020 Australia Qualitative 8/10 (CASP)	Investigate sexual health discussion between GPs and older patients.	0 GPs 21 PTs	Sexual health	Barriers: • GPs waiting for their PTs to bring up discussions about sexual health • GPs' negative ageist attitude towards the topic • PTs' fear of being judged by their GPs. Facilitators: • Support tools (e.g. sexual health forms, website) to initiate discussion about sensitive topics • Confidentiality; trusting relationship between GPs and PTs.
McHale, Cecil[27] 2019 UK Quantitative 3/5 (MMAT)	Analyse weight-related communication processes between GPs and PTs.	14 PCPs 218 PTs	Overweight	• A low rate of weight-related discussions occurring between GPs and PTs (25%) • Extended conversations resulting from PTs initiating discussions with their GPs.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
McHale, Laidlaw[28] 2020 UK Mixed methods 3/5 (MMAT)	Understand beliefs of GPs and PTs regarding obesity and weight management.	14 GPs 305 PTs	Overweight	Barriers: • PTs living with overweight not duly aware of this and its associated health risks • GPs viewing their role as being mainly to raise PTs' awareness but not to monitor or treat their PTs' overweight. • GPs' perception as to whether or not there was a clear link between PTs living with overweight and the presenting health issue, lack of referral pathways, time constraints, and the view that the sensitive health issue was not a management priority • PTs' lack of motivation, not seeing themselves as living with overweight.
Mousaco, Tarzia[29] 2019 Australia Qualitative 8/10 (CASP)	Explore GPs' experiences of carrying out early interventions for male patients perpetrating intimate partner violence (IPV).	21 GPs 0 PTs	Intimate partner violence	GPs' experiences of dealing with intimate partner violence: • Feeling unprepared to identify and respond to male PTs with IPV. • Worrying about adversely affecting their therapeutic relationships with the PTs. • Facing the dilemma of being non-judgemental: naming the violence and supporting their PTs (the perpetrators) at the same time. Facilitators of IPV-related conversation: • Quality of GP–PT relationships • Strategies—Using indirect questions (e.g. about mental health, relationship) to engage in the topic without confronting their PTs. GPs expressed a need for more education and training in this area.

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Norman, Chepulis[30] 2022 New Zealand Mixed methods 2/5 (MMAT)	Explore GPs' perspectives on obesity management.	29 GPs 0 PTs	Obesity	Barriers: • GP worries about potentially offending PTs if they raise the issue • Time constraints • Their relationship with PTs • Perceived relevance to the presenting health issue • GP beliefs that it is not their responsibility to manage the obesity epidemic and that the general care setting is not an appropriate place for obesity treatment.
Song, Dennis[11] 2020 Australia Qualitative 8/10 (CASP)	Identify major expectations of PTs in consultations with their GPs.	10 GPs 18 PTs	General	Facilitators: • PTs favouring having a long-term therapeutic relationship with GPs, which makes it easier for them to discuss a chronic/rare/unknown health condition • GPs' friendliness, informal conversation and professionalism • GPs' respect for PTs' (health-related) background, experience, confidence in managing their conditions, and autonomy of PTs in their health decisions • Whole-person care (e.g. GPs discussing mental health issues).

Citation; country Study type; quality score (tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including barriers and facilitators
Spooner, Jayasinghe[31] 2018 Australia Mixed methods 4/5 (MMAT)	Test whether perceived weight stigma among PTs was associated with level of obesity.	0 GPs 120 PTs	Obesity	GPs were considered one of PTs' weight stigma sources. PTs' barriers: • Non-English-speaking background • Being unemployed • Low health literacy. Interventions are needed to improve GPs' awareness, communication (e.g. their use of potentially offensive words) and ability to show empathy for PTs.
Thille[32] 2019 Canada Qualitative 8/10 (CASP)	Identify weight stigma discourses in GP setting.	3 GPs 29 PTs	Weight management	Barriers: • PTs associated their weight status (increase, reduction or stability) with some forms of behavioural failure • GPs tended to agree with PTs' self-criticism and behavioural accounts as an appropriate response to their weight change. Facilitators: • GPs reviewing health-related behaviours before discussing bodily measures • GPs and PTs co-building an ongoing plan with participants, focusing on goals and challenges.

Table 3c - Reviews identified relevant to Q3: Effectiveness of interventions to aid GPs in raising sensitive health issues [n = 1]

Citation, year, N studies Review type; quality score (tool)	Aim of review	Population of interest	Clinical focus	Key findings including facilitators relating to interventions
Auckburally, Davies[9] 2021 Not stated Narrative review 7/12 (SANRA)	Summarise the perceived barriers to optimal discussion about weight status and preferred weight-based terminology for adults, adolescents and parents of younger children.	GPs and patients	Weight management	Facilitators: • Training directed at developing skills, knowledge and confidence in having conversations about weight would allow for healthcare professionals to more easily raise the topic with patients and families • Objective communication tools, such as growth charts, may help in presenting the child's weight status in a visual, non-judgemental manner to aid discussion.

Table 3d - Primary studies identified relevant to Q3: Effectiveness of interventions to aid GPs in raising sensitive health issues [n = 4]

Citation; country Study type; quality score (appraisal tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including facilitators relating to interventions
Atlantis, John[1] 2021 Australia Qualitative 8/10 (CASP)	Assess the clinical usefulness of a new screening tool based on the EOSS for activating weight management discussions in general practice.	5 GPs 25 PTs	Weight management	• GPs are more likely to identify or record obesity in patients with a weight-related health chronic condition than in those without. All GPs agreed the EOSS-2 Risk Tool was applicable to a range of patients, including young adults, for early detection and prevention of developing weight-related complications • The GP participants highlighted the tool's usefulness in initiating discussions about weight-related health issues with their patients in a comfortable and non-judgemental way. Similarly, patient participants described how the tool made them feel more comfortable discussing their weight with their GPs. It helped GPs focus on medical goals instead of their patients' behaviour and clearly removed uncertainty about using appropriate language and concern about bringing up their weight, which is commonly expressed by healthcare professionals globally.

Citation; country Study type; quality score (appraisal tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including facilitators relating to interventions
Luig, Anderson[2] 2018 Canada Qualitative 7/10 (CASP)	Examine interactional processes in clinical consultations, impacts on and outcomes for PTs as facilitated by 5AsT, a personalised care plan approach.	0 GPs 20 PTs	Weight management / obesity	Effectiveness: • 5AsT framework generated positive cognitive and emotional shifts in PTs. Facilitators: • GPs listened to PTs with genuine interest and compassion • GPs allowed PTs to tell the stories that could help identify the root cause of their obesity (e.g. crisis events leading to severe stress) • GPs identified PTs' strengths and provided functional and realistic advice and an action plan for change • GPs incorporated reflective tools (e.g. journal entries) for PTs to reflect on their daily activities and effectiveness of different weight-management approaches.

Citation; country Study type; quality score (appraisal tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including facilitators relating to interventions
Shah, Corter[3] 2019 New Zealand Mixed methods 4/5 (MMAT)	Explore PTs' and GPs' perspectives on a translated version of AsiaCHAT, a health screening tool.	244 GPs and PTs	Mixed health issues	Effectiveness: • The AsiaCHAT screening tool was positively perceived by GPs and PTs as a useful tool for facilitating discussion of sensitive health topics. GPs found it to be particularly useful: • For the Asian population whom they considered shy and not ready to disclose underlying health issues • To identify a range of issues that otherwise might be missed • To assist PTs in describing their mental health issues more effectively. Barriers: • Extended consultation time • Fees incurred for PTs. • Time constraint because of the number of PTs.

Citation; country Study type; quality score (appraisal tool)	Aim	N [GPs] N [PTs]	Clinical focus	Key findings including facilitators relating to interventions
Tracy, Ayre[4] 2022 Australia Qualitative 9/10 (CASP)	Understand PTs' attitude to and experience of using two generic question prompt lists (QPLs).	0 GPs 31 PTs	Heath information-seeking	Effectiveness: • Made it easier for PTs to ask questions without feeling they were wasting their GP's time • Normalised the process of asking questions about health information • Gave PTs choices and a sense of control in health decisions • Prepared them for asking effective questions. Barriers: • Some question instructions in the QPLs were unclear • QPLs were not readily accessible to PTs. QPLs should be made more accessible, for example, by incorporating it into an appointment app or a booking system.

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Appendices

Appendix 1 - Search strategy

Database: Ovid MEDLINE(R) <1946 to February 24, 2023>

Search strategy: highlighted rows represent optimal yields within the time frame and scope.

Yield:

Q1 (2018–2023, no country limits) = 1170

Q2 (2018–2023, no country limits) = 293

Q3 (no year restriction, no country limits) = 104

#	Query	Yield
1	((sensitiv* or difficult* or awkward or challeng* or humiliat* or shameful or upset* or delicate or unpleasant) adj5 health). ti,ab.	45,078
2	personal health. ti,ab.	4,729
3	Sexual Health/	2,341
4	(sexual adj1 (health or dysfunction* or education or activit*)). ti,ab.	33,145
5	exp Sexually Transmitted Diseases/	403,954
6	((sexual* or venereal*) adj2 (disease* or infection*)). ti,ab.	36,046
7	(STD or STDs or STI or STIs). ti,ab.	24,192
8	exp HIV/	106,865
9	((HIV or human immunodeficiency or AIDS or acquired immun* deficienc*) adj1 virus*). ti,ab.	89,635
10	exp Hepatitis/	181,535
11	hepatitis. ti,ab.	215,157
12	Overweight/	32,429

#	Query	Yield
13	overweight. ti,ab.	73,997
14	exp Obesity/	255,576
15	(obese or obesity). ti,ab.	315,941
16	exp Domestic Violence/	49,557
17	((domestic or family or child) adj1 (violen* or abuse*)). ti,ab.	17,351
18	alcohol-related disorders/ or alcohol-induced disorders/ or fetal alcohol spectrum disorders/ or psychoses, alcoholic/ or alcoholic intoxication/ or alcoholism/ or binge drinking/ or amphetamine-related disorders/ or cocaine-related disorders/ or drug overdose/ or opiate overdose/ or inhalant abuse/ or marijuana abuse/ or opioid-related disorders/ or heroin dependence/ or morphine dependence/ or opium dependence/ or substance abuse, intravenous/ or substance abuse, oral/ or substance withdrawal syndrome/ or alcohol withdrawal delirium/ or alcohol withdrawal seizures/ or “tobacco use disorder”/	201,284
19	Smoking Cessation/	32,390
20	“alcohol and other drugs”. ti,ab.	1348
21	(AOD adj3 (alcohol or drugs)). ti,ab.	109
22	smoking/ or pipe smoking/ or smoking reduction/ or cocaine smoking/ or marijuana smoking/ or tobacco smoking/ or cigar smoking/ or cigarette smoking/ or vaping/	159,763
23	((smoking or vap*) adj1 (cessation or ceas* or quit* or giving up)). ti,ab.	29,562
24	Pharmaceutical Preparations/ad [Administration & Dosage]	10,471
25	nonprescription drugs/ or behind-the-counter drugs/	6637
26	(drug* or pharmaceutical*). ti,ab.	1,741,780
27	mental health/ or exp mental disorders/	1,455,289
28	(mental* adj1 (health or hygiene or disorder*)). ti,ab.	198,407
29	self-injurious behavior/ or self-mutilation/ or exp suicide/	82,341
30	((self adj1 (harm or injur* or destructive)) or suicide). ti,ab.	71,489
31	(behavio* adj3 concern). ti,ab.	572
32	or/1-31 [String 1 Sensitive health issues]	4,313,873

#	Query	Yield
33	General Practice/	15,269
34	Family Practice/	66,891
35	(GP or GPs). ti,ab.	59,052
36	((general or family or health*) adj1 (practi* or provider* or professional* or personnel)). ti,ab.	226,168
37	General Practitioners/	10,346
38	Physicians, Family/	17,150
39	((family or practice) adj1 (physician* or doctor* or clinician*)). ti,ab.	23,219
40	Primary Health Care/	90,522
41	Access to Primary Care/ [2023 - formerly Primary Health Care term]	8
42	(primary adj3 care). ti,ab.	147,288
43	or/33-42 [GP or Primary Care terms]	452,630
44	((initiati* or raising or raise* or quer* or question or questioning or enquir* or inquir* or activat* or broach* or "bring up" or introduce* or steer* or propound* or propose* or "physician led" or "patient led" or voluntar*) adj5 (sensitiv* or difficult* or awkward or challeng* or humiliat* or upset* or delicate or unpleasant or tactful* or perspective* or attitude* or perception* or definition* or view* or concern* or issue* or discuss* or convers* or barrier* or facilitator* or enabler* or stigma* or opinion* or understand* or s#eptic* or deferen* or empower* or reluct* or embarrass* or shame* or uneas* or discomfort* or uncomfortable or unpleasant or disturb* or disconcert* or confus* or tactful)).ti,ab,kf.	164,576
45	((patient* or client* or consumer*) adj4 (perspective* or attitude* or perception* or definition* or view* or concern* or issue* or barrier* or facilitator* or enabler* or stigma* or opinion* or understand* or s#eptic* or deferen* or empower* or reluct* or embarrass* or shame or uneas* or discomfort* or uncomfortable or unpleasant or disturb* or disconcert* or confus* or tactful)).ti,ab,kf,sh.	228,018
46	32 and 43 and 45 [Q1 Sensitive and GP PHC and PTs perspectives]	8465
47	limit 46 to (english language and “all adult (19 plus years)” and yr=“2018 - 2023”) [Q1]	1170
48	32 and 43 and 44 [Q2 Sensitive and GP PHC’s perspectives]	2,202
49	limit 48 to (english language and “all adult (19 plus years)” and yr=“2018 - 2023”) [Q2]	293

#	Query	Yield
50	((effect* or success* or worthwhile or functional or helpful) adj4 (intervention* or implement*)). ti,ab.	151,484
51	32 and 43 and 44 and 50 [Q3 Sensitive and GP PHC's effectiveness of interventions]	104
52	limit 51 to (english language and "all adult (19 plus years)") [Q3 - no year limit]	40
53	exp canada/ or exp united kingdom/ or exp australia/ or new zealand/	760,896
54	47 and 53 [Q1 and countries]	170
55	49 and 53 [Q2 and countries]	45
56	52 and 53 [Q3 and countries]	9

Database:
EBM Reviews—Cochrane Central Register of Controlled Trials <February 2023>
EBM Reviews—Cochrane Database of Systematic Reviews <2005 to February 28, 2023>

Yield:

Q1 (2018–2023, no country limits) = 382

Q2 (2018–2023, no country limits) = 125

Q3 (no year restriction, no country limits) = 63

#	Query	Yield
1	((sensitiv* or difficult* or awkward or challeng* or humiliat* or shameful or upset* or delicate or unpleasant) adj5 health). ti,ab.	2696
2	personal health. ti,ab.	534
3	Sexual Health/	124
4	(sexual adj1 (health or dysfunction* or education or activit*)). ti,ab.	4790
5	exp Sexually Transmitted Diseases/	17,470
6	((sexual* or venereal*) adj2 (disease* or infection*)). ti,ab.	2361
7	(STD or STDs or STI or STIs). ti,ab.	2863
8	exp HIV/	3703

#	Query	Yield
9	((HIV or human immunodeficiency or AIDS or acquired immun* deficienc*) adj1 virus*). ti,ab.	4789
10	exp Hepatitis/	7447
11	hepatitis. ti,ab.	20,039
12	Overweight/	6564
13	overweight. ti,ab.	18,977
14	exp Obesity/	18,139
15	(obese or obesity). ti,ab.	44,807
16	exp Domestic Violence/	1076
17	((domestic or family or child) adj1 (violen* or abuse*)). ti,ab.	849
18	alcohol-related disorders/ or alcohol-induced disorders/ or fetal alcohol spectrum disorders/ or psychoses, alcoholic/ or alcoholic intoxication/ or alcoholism/ or binge drinking/ or amphetamine-related disorders/ or cocaine-related disorders/ or drug overdose/ or opiate overdose/ or inhalant abuse/ or marijuana abuse/ or opioid-related disorders/ or heroin dependence/ or morphine dependence/ or opium dependence/ or substance abuse, intravenous/ or substance abuse, oral/ or substance withdrawal syndrome/ or alcohol withdrawal delirium/ or alcohol withdrawal seizures/ or “tobacco use disorder”/	13,924
19	Smoking Cessation/	5119
20	“alcohol and other drugs”. ti,ab.	155
21	(AOD adj3 (alcohol or drugs)). ti,ab.	21
22	smoking/ or pipe smoking/ or smoking reduction/ or cocaine smoking/ or marijuana smoking/ or tobacco smoking/ or cigar smoking/ or cigarette smoking/ or vaping/	7508
23	((smoking or vap*) adj1 (cessation or ceas* or quit* or giving up)). ti,ab.	10,210
24	Pharmaceutical Preparations/ad [Administration & Dosage]	0
25	nonprescription drugs/ or behind-the-counter drugs/	237
26	(drug* or pharmaceutical*). ti,ab.	261,896
27	mental health/ or exp mental disorders/	93,908

#	Query	Yield
28	(mental* adj1 (health or hygiene or disorder*)). ti,ab.	28,134
29	self-injurious behavior/ or self-mutilation/ or exp suicide/	1965
30	((self adj1 (harm or injur* or destructive)) or suicide). ti,ab.	5030
31	(behavio* adj3 concern). ti,ab.	59
32	or/1-31 [String 1 Sensitive health issues]	453,146
33	General Practice/	649
34	Family Practice/	2230
35	(GP or GPs). ti,ab.	8022
36	((general or family or health*) adj1 (practi* or provider* or professional* or personnel)). ti,ab.	22,957
37	General Practitioners/	477
38	Physicians, Family/	510
39	((family or practice) adj1 (physician* or doctor* or clinician*)). ti,ab.	1876
40	Primary Health Care/	5576
41	Access to Primary Care/ [2023 - formerly Primary Health Care term]	0
42	(primary adj3 care). ti,ab.	26,342
43	or/33-42 [GP or Primary Care terms]	50,032
44	((initiati* or raising or raise* or quer* or question or questioning or enquir* or inquir* or activat* or broach* or "bring up" or introduce* or steer* or propound* or propose* or "physician led" or "patient led" or voluntar*) adj5 (sensitiv* or difficult* or awkward or challeng* or humiliat* or upset* or delicate or unpleasant or tactful* or perspective* or attitude* or perception* or definition* or view* or concern* or issue* or discuss* or convers* or barrier* or facilitator* or enabler* or stigma* or opinion* or understand* or s#eptic* or deferen* or empower* or reluct* or embarrass* or shame* or uneas* or discomfort* or uncomfortable or unpleasant or disturb* or disconcert* or confus* or tactful)).ti,ab,kf.	7948
45	((patient* or client* or consumer*) adj4 (perspective* or attitude* or perception* or definition* or view* or concern* or issue* or barrier* or facilitator* or enabler* or stigma* or opinion* or understand* or s#eptic* or deferen* or empower* or reluct* or embarrass* or shame or uneas* or discomfort* or uncomfortable or unpleasant or disturb* or disconcert* or confus* or tactful)).ti,ab,kf,sh.	29,031

#	Query	Yield
46	32 and 43 and 45 [Q1 Sensitive and GP PHC and PTs perspectives]	1032
47	limit 46 to (english language and “all adult (19 plus years)” and yr=“2018 - 2023”) [Q1]	382
48	32 and 43 and 44 [Q2 Sensitive and GP PHC’s perspectives]	279
49	limit 48 to (english language and “all adult (19 plus years)” and yr=“2018 - 2023”) [Q2]	125
50	((effect* or success* or worthwhile or functional or helpful) adj4 (intervention* or implement*)). ti,ab.	58,192
51	32 and 43 and 44 and 50 [Q3 Sensitive and GP PHC’s effectiveness of interventions]	63
52	limit 51 to (english language and “all adult (19 plus years)”) [Q3 - no year limit]	63
53	exp canada/ or exp united kingdom/ or exp australia/ or new zealand/	19,690
54	47 and 53 [Q1 and countries]	17
55	49 and 53 [Q2 and countries]	5
56	52 and 53 [Q3 and countries]	2

Grey literature searches

- **Canadian Agency for Drugs and Technologies in Health (CADTH)**—didn’t find anything suitable
- **Dimensions**—a database similar to Scopus—yield 9, but not grey literature
- **MedNar**—didn’t find anything suitable
- **Open Grey**—ceased in 2018
- **MedlinePlus**—health topics “Personal Health Issues”, “Talking with your doctor”—nothing suitable
- **World Health Organization**—World Health Organization Alma-Ata Declaration on Primary Healthcare, and the more recent Astana Declaration from the Global Conference on Primary Healthcare—nothing suitable
- **HSRProj (Health Services Research Projects in Progress)**—discontinued September 2021.

Google Scholar

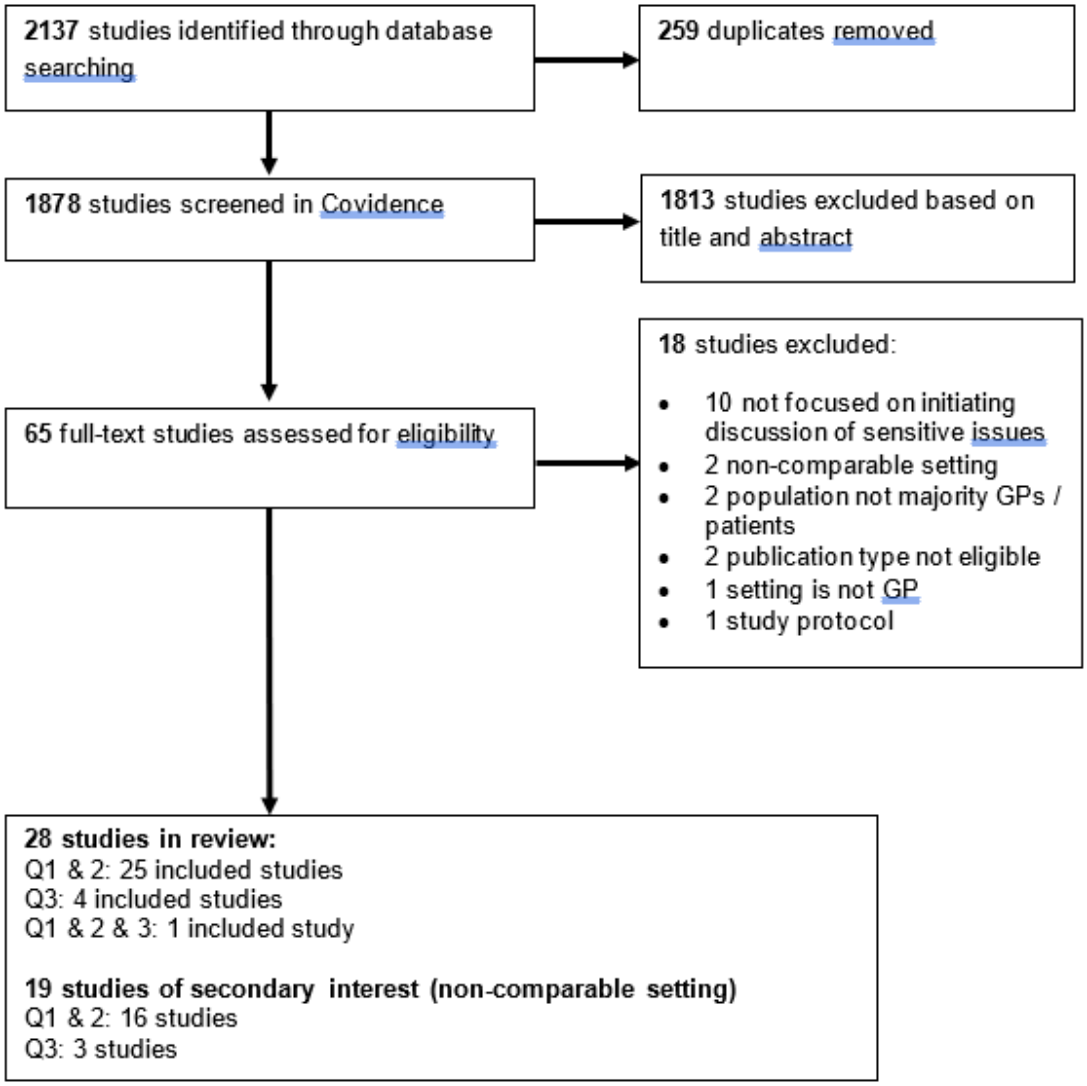
Search string

initiating|raising|difficult|awkward|challenging|humiliating|shameful|upsetting|delicate|unpleasant|stigma|reluctance “primary*care”|“general practitioner” -nursing -treatment

First 100 results by relevance screened by a single screener (PB) on April 4, 2023; no relevant studies found.

Appendix 2 - PRISMA diagram

Figure 1—Study selection



Appendix 3 - Studies in non-comparable settings

Appendix 3a - Studies in non-comparable settings identified relevant to Q1 & Q2 [n = 16]

Citation, year Country	Clinical focus	Key findings from abstract
Caterson, Alfadda[33] 2019 Australia, Chile, Israel, Italy, Japan, Mexico, Saudi Arabia, South Korea, Spain, the UAE and the UK	Weight management / obesity	• A total of 14,502 PwO [people living with obesity] and 2785 HCPs [healthcare professionals] completed the survey • There was a median of three (mean, six) years between the time PwO began struggling with excess weight or obesity and when they first discussed their weight with an HCP • Most PwO (68%) would like their HCP to initiate a conversation about weight and only 3% were offended by such a conversation • Among HCPs, belief that patients have little interest in or motivation for weight management may constitute a barrier for weight management conversations • Realisation that PwO are motivated to lose weight offers an opportunity for HCPs to initiate earlier weight management conversations.

Citation, year Country	Clinical focus	Key findings from abstract
Hernandez and Petronio[34] 2020 US	Sexual behaviour	• Many young people, and in particular young women, are reticent to talk to their physicians about sexual behaviour because they typically consider the information to be private • Many physicians are also uncomfortable discussing sexual topics with their patients • Qualitative analysis of semi-structured interviews with female college students was used to explain their perceptions of disclosure of sexual behaviours to their physician. Specifically, the participants' perceptions of physicians' communication competence informed privacy management rules • The results of this study show there are many avoidable physician communication behaviours that create a thick privacy boundary between physician and patient.
Holmes, Yamin[35] 2021 US	Sexual thoughts / behaviour	• A sample of 134 Arab American women, ages 18–35 years (M=20.6), completed self-report measures of sexual health and attitudes and psychological symptoms, and then were randomised to an interview or control (waitlist) condition • The 60-min disclosure interview inquired about sexual attitudes, experiences and conflicts. Five weeks later, all participants completed follow-up measures • Analyses of covariance (controlling for baseline levels of the outcome measure) indicated that the interview led to significantly greater sexual satisfaction and less discomfort with sexual self-disclosure at five-week follow-up, compared with controls • These experimental findings suggest the value, rather than the risk, of clinicians encouraging Arab American women to openly disclose and discuss their sexual experiences and attitudes in a confidential, empathic setting.

Citation, year Country	Clinical focus	Key findings from abstract
Kaitz, Ray[36] 2020 US	Body image and eating issues	• A total sample of 102 female college students (aged 18–35 years) in the Boston area completed self-report questionnaires online (February 2015 to January 2016) • Themes in both communication and relationship domains emerged. Communication themes for participants included: health information, prompting by the PCP, and other barriers. • Relationship themes included: patient and provider characteristics, negative and positive emotions, and trust • According to these participants, many women experience negative interactions with their providers when discussing these sensitive topics.
Koball, Mueller[37] 2018 US	Weight management / obesity	• 1000 patients who recently saw their provider for non-weight-specific appointments were mailed measures of demographics, self-reported height and weight, activity level, adherence, perceptions of and recommendations for weight-related discussions, and internalised weight bias—242 patients responded (24% response rate) • 47% of patients living with overweight and 71% of patients living with obesity recalled that their provider discussed weight • Most patients (75%) would like their provider to be ‘‘very direct/straightforward’’ when discussing weight, and 52% would be ‘‘not at all offended’’ if they were diagnosed as ‘‘overweight/obese’’ • Most patients (63%) reported being ‘‘extremely comfortable’’ discussing weight with providers • Patients with higher BMI had higher levels of internalised weight bias ($p<.001$) and wanted their provider to ‘‘discuss weight sensitively’’ ($p<.05$).

Citation, year Country	Clinical focus	Key findings from abstract
Lopez, Helm[38] 2020 US	Weight management / obesity Bariatric surgery	• A 39-question electronic survey was emailed to PCPs [primary care providers] at a single academic institution with community physicians; 121 surveys were distributed and a 33.9% response rate (n = 41) was achieved • PCPs indicated initiating weight loss management conversations <50% of the time with 48.8% of patients • Provider-identified barriers to discussing weight loss surgery included being unsure if a patient's insurance would cover the procedure or if patients would qualify (24.4% vs. 19.5%) • In addition, 43.9% of providers felt the risks of bariatric surgery outweighed the benefits.
Pretorius, Couper[39] 2022 South Africa	Sexual history	• 155 consultation recordings were qualitatively analysed in this grounded theory research • 21 doctors participated in video-recorded routine consultations with 151 adult patients living with hypertension and diabetes, who were at risk of sexual dysfunction • No history taking for sexual dysfunction occurred • Consultations were characterised by poor communication skills and a lack of holistic practice • Patients identified rude doctors, shyness and lack of privacy as barriers to sexual history taking, while doctors thought they had more important things to do with their limited consultation time • Consultations were doctor-centred and sexual dysfunction in patients was entirely overlooked, which could have a negative effect on biopsychosocial wellbeing and potentially led to poor patient care.

Citation, year Country	Clinical focus	Key findings from abstract
Pretorius, Mlambo[40] 2022 South Africa	Sexual history	• This was part of grounded theory research, involving 151 adult patients living with hypertension and diabetes and 21 doctors they consulted • There was a disconnect between patients and doctors regarding their expectations about initiating the discussion on sexual challenges and relational and clinical priorities in the consultation • Patients wanted a doctor who listened. Doctors wanted patients to tell them about sexual dysfunction. Other minor barriers included gender, age and cultural differences and time constraints • A disconnect between patients and doctors caused by the doctors' perceived clinical priorities and screening expectations inhibited sexual history taking in a routine consultation in primary care.
Prevatt and Desmarais[41] 2018 US	Postpartum mood disorder (PPMD)	• A sample of predominantly white, middle class, partnered adult women from an urban area in the southeast US (n = 211) within three years postpartum participated in an online survey • More than half the sample reported PPMD symptoms, but one in five did not disclose to a healthcare provider • Approximately half women reported at least one barrier that made help-seeking "extremely difficult" or "impossible" • More than one-third indicated they had less than adequate social support • Social support and stress, but not barriers, were associated with disclosure in multivariable models • Many women experiencing clinically significant levels of distress did not disclose their symptoms of PPMD. Beyond universal screening, efforts to promote PPMD disclosure and help-seeking should target mothers' social support networks.

Citation, year Country	Clinical focus	Key findings from abstract
Pujalte, Effiong[42] 2020 US	Sexual health	• Family physicians at “our institution” were given written surveys with 22 questions to answer and rank in order of their best practice • All the participants identified time constraints and the presence of a patient’s spouse, parents or siblings as the most common barriers • Other barriers included fear of embarrassing patients and feeling inadequately knowledgeable about the sexual practices of lesbian, bisexual, gay and transgender patients • All the participants reported that patients rarely object to discussing sexual behaviours • To prevent new cases of STIs, it is important to work around these barriers to improve physician–patient communication. This can be further improved by providing continuous learning opportunities for medical students, residents and board-certified family physicians on ways to appropriately counsel patients on safe sexual practices.

Citation, year Country	Clinical focus	Key findings from abstract
Shaheen, Ashkar[43] 2020 Palestine	Domestic violence	• In-depth interviews were carried out with 20 women who had experienced DV • Women encountered barriers at individual, healthcare service and societal levels • Lack of knowledge of available services, concern about the healthcare primary focus on physical issues, lack of privacy in health consultations, lack of trust in confidentiality, fear of being labelled 'mentally ill' and losing access to their children were all highlighted • Women wished for health professionals to take the initiative in enquiring about DV • Wider issues concerned women's social and economic dependency on their husbands, which led to fears about transgressing social and cultural norms by speaking out • Women feared being blamed and ostracised by family members and others or experiencing an escalation of violence • The findings can inform training of health professionals in Palestine to address these barriers, to increase awareness of the link between DV and many common presentations such as depression, to ask sensitively about DV in private, to reassure women about confidentiality, and to increase awareness among women of the role that health services can play in DV.
Shields, Fuzzell[44] 2019 US	Chronic non-cancer pain / opioid management	• We conducted an observational study using audio-recorded primary care appointments (up to 3/patient) and self-reported assessments of primary care providers (PCPs) and patients. Eight PCPs and 30 patients had complete data for 78 clinic visits • PCPs and patients engaged in more opioid and pain management talk when patients reported greater pain catastrophising and PCPs reported higher psychosocial orientation • PCPs and patients engaged in talk about mental health and opioid safety when patients reported greater anxiety, higher working alliance with their PCP, and when PCPs reported higher burnout • PCPs' negative attitudes about opioids were associated with fewer discussions about mental health and opioid safety.

Citation, year Country	Clinical focus	Key findings from abstract
Vannoy, Park[45] 2018 US	Suicide / suicide ideation	• Thematic analysis of interviews focused on depression and suicide with 77 depressed, low-socioeconomic status older men of Mexican origin, or US-born non-Hispanic whites recruited from primary care • Several themes inhibiting suicide emerged: it is a problematic solution because of religious prohibition, conflicts with self-image, the impact on others; and lack of means/capacity • Three approaches to preventing suicide emerged: talking with patients about depression, talking about the impact of their suicide on others, and encouraging them to be active • The vast majority, 98%, were open to such conversations • Suicide is rarely discussed in primary care encounters in the context of depression treatment • Our study suggests older men are likely to be open to discussing suicide with their PCP.
Zimmaro, Lepore[46] 2020 US	Sexual health / breast cancer (BC)	• BC outpatients (N = 144; M age = 56, 67% white) in a sexual health communication intervention study provided baseline data • Two factors emerged: patients' own beliefs about or perceived inability to discuss sexual health ("self-centred barriers"), and patients' perceptions of providers' reactions to discussing sexual health ("provider-centred barriers") • Women endorsing more barriers reported lower sexual communication self-efficacy, outcome expectancies and general clinical self-efficacy (p's≤.001); no differences in sexual concerns, emotional distress or discussing sexual health were found • When grouped according to these barriers, women differed in their confidence and expectations for sexual health communication, regardless of the degree of sexual or emotional distress.

Citation, year Country	Clinical focus	Key findings from abstract
Jerden, Dalton[47] 2018 US and Sweden	Weight, alcohol	• The study compared patients' perspectives in the US and Sweden on primary care providers' counselling on four lifestyle habits: weight, eating habits, physical activity and smoking • The study used a telephone interview with 629 patients from both countries who had visited a physician in primary care and asked them about their perception of the importance of healthy lifestyle habits, their need to change, their desire to receive support from primary care, and the support they had actually received • The study found more US patients than Swedish patients reported a need to change their lifestyle habits, except for alcohol consumption. The majority of patients in both countries who stated a need to change wanted to have support from primary care. However, more US patients than Swedish patients reported that their primary care provider had initiated a discussion about lifestyle modification • The study concluded that there were high and similar patient expectations for lifestyle counselling in both countries, but more frequent initiation of discussions of lifestyle issues in US primary care. The study suggested further studies to better understand the reasons for the differences.
Traumer, Jacobsen[48] 2019 Denmark	Sexual health	• The study explored how patients with cancer or chronic disease and sexual dysfunction experience sexuality as a taboo subject in the healthcare system • The study used semi-structured interviews with 10 women recruited from a sexological centre and performed a qualitative thematic analysis • The study found sexuality is a sensitive and taboo subject in the Danish healthcare system, as patients or healthcare professionals avoid or dismiss conversations about it • The study concluded communication about sexuality is essential for improving patients' wellbeing, and healthcare professionals should routinely address it with patients.

Appendix 3b - Studies in non-comparable settings identified relevant to Q3: Effectiveness of interventions to aid GPs in raising sensitive health issues [n = 3]

Citation, year Country	Clinical focus	Key findings from abstract
Albright, Bryan[49] 2018 US	Substance use / mental health	• Online simulation where users practise role-playing with emotionally responsive virtual patients to learn motivational interviewing strategies to better manage screening, brief interventions and referral conversations • Results showed significant increases in knowledge/skill to identify and engage in collaborative decision making with patients • Results strongly suggest role-play simulation experiences can be an effective means of teaching screening and brief intervention. • **NOTE:** 180 / 227 participants were nurses or nurse practitioners.
Khalid, Tong[50] 2022 Malaysia	Sexual dysfunction	• This study determined the effectiveness of a prompt sheet in initiating a discussion of sexual dysfunction in a primary care setting • In the intervention group [those who received a prompt sheet allowing participants to indicate their decision, prior to the consultation, as to whether to discuss erectile dysfunction], only 59% of participants opted to discuss their sexual problems; 80.5% of these had those discussions during the consultation • Thus, in the intervention group, 47.8% of total participants discussed erectile dysfunction (ED) compared with 4.6% in the control group (odds ratio (OR) 18.4, 95% confidence interval (CI): 5.4–66.2, $p < 0.001$) • Sub-analysis did not reveal any relationship between either ethnicity or the severity of the ED and the participant's option to discuss ED • A prompt sheet is a simple and inexpensive tool to cue a discussion of erectile dysfunction during consultation. More importantly, prompt sheets provide patients with an opportunity to indicate their interest in discussing ED, helping bridge the communication gap between men and their doctors.

Citation, year Country	Clinical focus	Key findings from abstract
Leblanc, Albuja[51] 2018 US	HIV	• Qualitative study that described current health providers' approaches to engage patients into the HIV care continuum (HCC) • Health providers (N = 22) used various approaches to engage patients/clients into HIV screening and subsequent HIV care • Approaches were represented by an interpersonal process and a thematic analysis revealed the nuances in the approaches that manifested in the following themes: uses of self, normalising disease and engaging couples • This study demonstrated the importance for health providers to be aware of the specific context of patient's vulnerability to HIV infection and barriers to care • Self-awareness and the capability to self-reflect on one's personal practice also helped to ensure engagement of those vulnerable to infection or infected with HIV into the HCC.

Appendix 4 - Summary of results of quality appraisal

Appendix 4a - Review studies relevant to Q1 & Q2

Citation	Study design	Appraisal tool	Appraisal score
Ananthakumar 2020	Systematic review	AMSTAR II	11/13
Auckburally 2021 (also relevant to Q3)	Narrative review	SANRA	7/12
Ezhova 2020	Scoping review	SANRA	11/12
Osborne 2023	Systematic review	AMSTAR II	9/13

Appendix 4b - Primary studies relevant to Q1 & Q2

Citation	Study design	Appraisal tool	Appraisal score
Aira, 2020	Qualitative	CASP-Qualitative	7/10
Blackburn 2015	Qualitative	CASP-Qualitative	8/10
Blackburn 2019	Qualitative	CASP-Qualitative	9/10
Coffey 2018	Quant-descriptive survey	MMAT-Mixed	3/5
Collyer 2018	Qualitative	CASP-Qualitative	7/10
Dyer 2019	Quant-descriptive survey	MMAT-Mixed	4/5
Ejegi-Memeh 2020	Qualitative	CASP-Qualitative	10/10
Gravely 2019	Quant-descriptive survey	MMAT-Mixed	4/5
Hodyl 2020	Mixed methods	MMAT-Mixed	3/5
Jovicic 2020	Qualitative	CASP-Qualitative	7/10

Citation	Study design	Appraisal tool	Appraisal score
Leusink 2018	Qualitative	CASP-Qualitative	8/10
Malta 2018	Qualitative	CASP-Qualitative	7/10
Malta 2020	Qualitative	CASP-Qualitative	8/10
McHale 2019	Quant-analytic survey	MMAT-Mixed	3/5
McHale 2020	Mixed methods	MMAT-Mixed	3/5
Mousaco 2019	Qualitative	CASP-Qualitative	8/10
Norman 2022	Quant-descriptive survey	MMAT-Mixed	2/5
Song 2020	Qualitative	CASP-Qualitative	8/10
Spooner 2018	Quant-analytic survey	MMAT-Mixed	4/5
Thille 2019	Qualitative	CASP-Qualitative	8/10

Appendix 4c - Primary studies relevant to Q3

Citation	Study design	Appraisal tool	Appraisal score
Atlantis 2021	Qualitative	CASP-Qualitative	8/10
Luig 2018	Qualitative	CASP-Qualitative	7/10
Shah 2019	Mixed methods	MMAT-Mixed	4/5
Tracy 2022	Qualitative	CASP-Qualitative	9/10