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Patients' and Primary Care Practitioners' Perspectives of Primary Care Consultations Relating to Menstrual Problems: A Meta-Ethnography

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ABSTRACT

Past research indicates suboptimal primary care communication surrounding menstrual problems. This meta-ethnography synthesized qualitative research on patient and primary care practitioner perspectives to advance understanding of consultation dynamics. Menstrual problems included menorrhagia, dysmenorrhea, or gynecological conditions (e.g., endometriosis). Searches (MEDLINE, EMBASE, CINAHL, PsycINFO, citation, website) yielded 30 included articles. Synthesized findings revealed complex shared concepts between patients' and practitioners' perspectives: varying attitudes toward and discussions about menstrual problems and patients, alongside tensions in expectations, roles and knowledge sharing. Empowering patients and practitioners to improve communication in these areas could enable more effective primary care menstrual problem consultations.

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Primary health care; communication; women's health; menstruation disturbances; systematic review

Introduction

From menarche to menopause, women and people who menstruate can encounter menstrual problems including severe pain and heavy menstrual bleeding (Attia et al., 2023; Chakrabarty et al., 2024). Prevalence of severe pain and heavy menstrual bleeding globally is thought to range between 25%–94% and 4%–63%, respectively (Armour et al., 2019b; Harlow & Campbell, 2004; Pouraliroudbaneh et al., 2024; Sinharoy et al., 2023). Previous systematic reviews highlight people's attempts to alleviate severe pain or heavy menstrual bleeding through medication use (e.g., nonsteroidal anti-inflammatories or contraceptives) or "home remedies" (e.g., rest, heat, herbal medicine, and exercise) (Armour et al., 2019a; Pouraliroudbaneh et al., 2024). While some individuals seek health-care support as an extension of self-management, patterns of help-seeking behavior vary across different contexts (Armour et al., 2019a; Pouraliroudbaneh et al., 2024). In many countries, including the UK (NHS, n.d.), national health systems advise individuals to seek initial support from primary care practitioners if menstrual problems significantly impact their quality of life.

Patient-practitioner communication is key to effective medical care and the patient-practitioner relationship. Practitioners who express positive messaging within a warm, caring relationship can enhance positive health outcomes (Di Blasi et al., 2001; Howick et al., 2018). However, some patients experience negative health-care interactions and suboptimal patient-practitioner communication (Barrington et al., 2021; Harris et al., 2026; Henry et al., 2020a; Moreno Gómez et al., 2023; Peel et al., 2025; Robstad et al., 2025; Young et al., 2015). Some patients are apprehensive about consulting due to taboo or embarrassment surrounding menstruation (Barrington et al., 2021; Harris et al., 2026; Henry et al., 2020a; Moreno Gómez et al., 2023), some feel dismissed by practitioners who normalize

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their menstrual problems (Barrington et al., 2021; Harris et al., 2026; Henry et al., 2020a; Moreno Gómez et al., 2023; Peel et al., 2025; Robstad et al., 2025; Young et al., 2015), and some perceive a need to "fight" for care (Harris et al., 2026; Henry et al., 2020a; Moreno Gómez et al., 2023; Peel et al., 2025; Young et al., 2015). Some patients question practitioners' knowledge of menstrual problems (Harris et al., 2026; Peel et al., 2025) but feel effective, empathetic communication could help mitigate this (Young et al., 2015). According to a recent review, primary care practitioners recognize the importance of empathetic, respectful, and attentive communication in consultations for menstrual and gynecological conditions (Briscoe et al., 2024). However, sociocultural factors such as patient embarrassment, primary care practitioner gender, patients' preconceived ideas prior to consulting, and structural and organizational factors such as practitioner workload, lack of continuity of care, and limited consultation durations can impede communication in clinical practice (Briscoe et al., 2024). Some primary care practitioners felt they required further education, training, and guidance on gynecological conditions (Briscoe et al., 2024).

Reviews on menstrual problems have historically focused separately on patient (Garside et al., 2008; Henry et al., 2020a; Young et al., 2015) and primary care practitioner (Briscoe et al., 2024) perceptions. In comparison, this review interprets and integrates these perspectives to identify shared concepts and points of divergence. This approach offers a more nuanced understanding of how primary care consultations for menstrual problems are experienced and understood—insights that may not emerge from separate syntheses and that could suggest potential starting points for improving communication in primary care.

Aim

Utilizing meta-ethnography, we aimed to create a new interpretation of perspectives of primary care consultations for menstrual problems by bringing together qualitative research with both primary care practitioners and patients to identify shared concepts and points of divergence.

Methods

Approach to the Review

This review focuses on the lived experiences, perceptions, and social contexts surrounding primary care consultations for menstrual problems, dimensions best explored through qualitative research. Our review followed Noblit and Hare's (1988) seven steps of meta-ethnography. KR (PhD candidate), led and received guidance from the team (psychologists and an academic general practitioner [GP] with extensive combined qualitative research experience). SH (PhD candidate researching endometriosis in primary care) screened articles. The review protocol was prospectively registered (PROSPERO Registration No. CRD42023490880). This meta-ethnography was conducted according to the eMERGe Guidelines (France et al., 2019).

Stages of Meta-Ethnography

Getting Started

Meta-ethnography enables accounts—such as patient and practitioner—to be "put together" where mere integration would not be appropriate (Barnett-Page & Thomas, 2009). In contrast to some synthesis methods (e.g., textual narrative, framework, "best fit") which seek to describe and summarize, meta-ethnography (amongst others: thematic, critical interpretative synthesis) creates a fresh interpretation of the reviewed data (Barnett-Page & Thomas, 2009). Recent reviews related to menstrual problems and health care have followed more descriptive approaches (Briscoe et al., 2024; Moreno Gómez et al., 2023) and have not followed a formal approach to synthesis (Young et al., 2015) or have conducted a meta-ethnography that lacks coherence or does not follow established reporting guidance (Henry et al., 2020a), making this review's meta-ethnographic approach novel.

Deciding What Is Relevant

Our search strategy was adapted from the SPIDER tool (Cooke et al., 2012), with piloting and consultation with an information specialist. In December 2023, KR systematically searched four electronic databases (MEDLINE, EMBASE, CINAHL, and PsycINFO) from inception to the present, without date, language, or country restrictions. KR also undertook keyword searching in Google Scholar (January 2024), forward and backward citation searching using Web of Science and Google Scholar (July 2024) and searching of primary care clinician college and gynecological health charities' websites (August 2024). These databases and websites were selected for their relevance to the review topic and because they have been used in similar reviews (Briscoe et al., 2024). Inclusion and exclusion criteria are presented in Table 1. The full search strategy is available in the supplementary file.

Primary qualitative and mixed-methods studies (providing the qualitative findings were substantial and distinguishable) were included. We expected that qualitative data collected via survey or questionnaire would provide insufficiently rich data for meta-ethnography (Noblit & Hare, 1988).

The overarching focus was "menstrual problems," defined as menorrhagia or dysmenorrhea specifically, or gynecological conditions where these menstrual problems are a key presentation (i.e., endometriosis, fibroids). This definition was revised after screening. Conditions related to menstrual problems such as menopause, premenstrual syndrome (PMS), and polycystic ovary syndrome (PCOS) were originally included because communication "problems" during the primary care encounter do not appear to be specific to one type of menstrual problem or condition. Literature on interactions in primary care in these contexts, however, appeared to focus more on symptoms other than menstruation and management related to these, such as focusing on mood in PMS (Labots-Vogelesang et al., 2021), weight management for PCOS (Ismayilova & Yaya, 2023; Jones et al., 2011), and management of vasomotor symptoms for menopause (Barber & Charles, 2023; MacLellan et al., 2023). Menopause, PMS, and PCOS were therefore excluded from this review. This decision aligned with suggestions that meta-ethnography's scope should be restricted to avoid gross generalizations (Noblit & Hare, 1988). The decision was also suitable considering the review's focus on menstrual problems and symptoms, particularly menorrhagia or dysmenorrhea.

This review focuses exclusively on primary care consultations; therefore, only studies involving primary care practitioners were included. This included GPs, nurses, and allied health professionals working in the primary care settings defined within each study's country. Studies about specialist consultations, (e.g., gynecologists, other secondary care practitioners) were excluded. Studies with mixed populations (e.g., primary and secondary care practitioners) were included if findings from different settings were distinguishable.

Screening was recorded using Rayyan (Ouzzani et al., 2016). KR screened all titles/abstracts and SH independently double-screened 20% of them early in the screening process. Full texts were obtained and evaluated for inclusion by KR (100%) and SH (10%). Discrepancies or uncertainties were resolved through discussion (RDH, HE, LM, FB).

Table 1. Summary of inclusion and exclusion criteria.

SPIDER	Inclusion	Exclusion
Phenomenon of Interest, Design, Research type	Primary qualitative and mixed-methods studies with qualitative/narrative outcomes from primary or secondary qualitative studies and mixed methods studies associated with the consultation, interaction or communication between primary care practitioners and patients primarily about menstrual problems. Can include secondary analysis of primary qualitative data.	Qualitative studies using only questionnaire or survey methods. Reviews of any kind. Protocols. Qualitative results as part of a scale development article. Book chapters.
Sample	Patients (adults and adolescents) who have presented to primary care with menstrual problems. Studies with a mixed group of patients will be evaluated individually for relevance.	Patients with women's health problems that are not considered menstrual problems. Patients with a reproductive morbidity which is a consequence of reproductive behavior including pregnancy, abortion, childbirth, or sexual behavior.
Sample	Primary care practitioners (e.g., GPs, practice nurses, family practitioners, community gynecologists, and pharmacists) who undertake consultations or interactions with patients about menstrual problems.	secondary care practitioners only (i.e., gynecologists) or those where findings are unable to be deciphered between primary care practitioners and secondary care clinicians.
Phenomenon of Interest	Studies set in primary care and community settings.	Studies set solely in secondary care. Irretrievable translated full texts.

Reading the Studies

Included studies were read in detail and findings sections (including participant quotes and author interpretations) were assessed for extent of relevance to the research question and conceptual richness. Relevance was categorized as: ubiquitous (whole findings section), substantial (more than one theme, less than the whole findings section), moderate (one theme or equivalent), or minimal (a small section, one or two sentences). "Extent of relevance" informed the order in which studies were considered during synthesis (see below), but not exclusion decisions. Conceptually rich studies were defined as those with detailed findings about views, beliefs, and perspectives of the patient-practitioner interaction. Conceptually thin studies had minimal relevance or focused solely on diagnostic processes, treatment/decision making, or health-care systems. Conceptually thin studies were excluded, consistent with a meta-ethnographic approach (Barnett-Page & Thomas, 2009).

Data extraction tabulated: author(s), publication year, country and setting, aims, participants, data collection and analysis methods, and main findings relating to our research question. In parallel, studies were assessed for quality using the CASP qualitative appraisal checklist (Critical Appraisal Skills Programme [CASP], 2024). Mixed-methods studies were assessed using the MMAT mixed-methods appraisal tool (Hong et al., 2018).

Data extraction and critical appraisal were completed by KR and 20% checked by FB. Uncertainties were discussed and final decisions agreed upon. Quality appraisal did not inform exclusion—consistent with a meta-ethnographic approach (Barnett-Page & Thomas, 2009)—but was subjectively considered during the synthesis. KR checked and confirmed that derived concepts were not solely based on or led by low-quality studies.

Determining Relationships Between Studies

Studies with "ubiquitous" findings were used as index articles for initial, open coding of patient and primary care practitioner perspectives separately. Participant quotations and author interpretations (first- and second-order constructs, respectively [Britten et al., 2002]) were coded. "Findings" sections were coded by unit of meaning relating to interactions between patients and primary care practitioners. Semantic codes were derived inductively, keeping "close" to the first- and second-order constructs. Codes were reviewed and refined throughout the interpretive process. KR coded the included studies using NVivo 12 software (QSR International Pty Ltd, 2023), before discussion with the team (RDH, HE, LM, FB).

Translating Studies

Reciprocal and refutational translations of coded first- and second-order constructs were undertaken (France et al., 2019). Reciprocal translation involved finding shared meanings and generating underlying concepts between studies (Noblit & Hare, 1988). Refutational translation (Noblit & Hare, 1988), involved finding inconsistencies both between and within patient and primary care practitioner studies. KR led the translations before discussion with the team (RDH, HE, LM, FB).

Synthesizing Translations

A line of argument synthesis involves "building a picture" or creating a storyline (Noblit & Hare, 1988) of translated concepts. We created a new representation of perceptions of primary care consultations for menstrual problems by synthesizing the concepts from the translations. We identified an interpretative, core concept of patient-centeredness and explored how it relates to the other concepts identified. We also observed that the synthesized concepts relate to broader, sociocultural influences, and therefore considered sociocultural influences as an overarching concept.

KR led the synthesis; alternative interpretations were offered and discussed at team meetings and during the review of synthesis drafts. Before finalizing the synthesis, study findings were reviewed and KR explicitly searched for robust findings omitted from or contradicting the synthesis.

Expressing the Synthesis

The line of argument was developed, illustrated, and complemented by a narrative outlining concepts in turn. As a meta-ethnography, the synthesis does not assess prevalence or frequency, but interprets and translates concepts across studies to develop a deeper, contextually grounded understanding of primary care consultations for menstrual problems. The narrative was supplemented with quotations of first- and second-order constructs to demonstrate that interpretations were informed by and grounded in the findings from the included studies. Quotations selected by KR were used to support third-order interpretations, which reflect conceptual insights developed through synthesis across studies rather than direct attribution to individual quotations.

Throughout the line of argument, we use the terms *patient* and *practitioner* to reflect individuals' roles within the primary care consultation. While we acknowledge the power dynamics embedded in the term *patient* and recognize that practitioners also hold complex identities beyond their professional role, this terminology provides clarity for understanding positionality within the interaction.

Reflexivity

The review team comprised female primary care researchers with backgrounds in psychology (KR, RDH, LM, FB), public health (SH), and a practicing GP (HE). Most of the review team are White (KR, RDH, LM, FB, HE); one member is South Asian (SH). The review team ranged in age from the mid-20s to mid-50s. The team brought a range of qualitative research expertise, alongside experience across primary care research, health-care communication, behavior change, and supporting self-management. Several team members (KR, RDH, LM, FB, SH) also have lived experience of consulting primary or secondary care for menstrual problems, including endometriosis and adenomyosis, spanning both positive and negative encounters. These experiences shaped interests in the topic and sensitized interpretations to issues of communication within consultations. At the same time, the inclusion of a practicing GP with extensive clinical and research experience (HE) supported reflexivity around practitioner perspectives.

While lived experience has played a role in KR's and SH's interest in this area of research, screening decisions involved using a structured screening tool which ensured that study inclusion was not influenced by personal experience.

KR, who led the synthesis, had a mostly positive experience consulting primary care for her menstrual problems. While this meant she was less emotionally affected by the topic, she still felt a responsibility to represent those with more difficult experiences. As a non-clinician working in primary care research, she recognizes the structural pressures that shape practitioners' work and is mindful of how practitioners are represented in ways that may be unhelpful for achieving improved communication in this consultation context. Throughout the synthesis, KR aimed to strike a balance between acknowledging reported consultation challenges without diminishing the seriousness of patients' accounts or reinforcing negative portrayals of practitioners. Throughout the synthesis, KR kept a journal of reflections and discussed these during regular review team meetings. As part of this, the review team challenged KR's expression of the synthesis and interpretations. For example, early drafts of the synthesis prompted discussion regarding cautionary language or that which indicated the prevalence of findings (i.e., many, some, few). While KR recognized value in communicating prevalence to support understanding for readers, she decided that this language could potentially act as a means of either minimizing or overrepresenting perspectives. Some members of the review team had substantial familiarity with the literature, enabling them to comment on distinctions between bodies of work focused on particular conditions (e.g., endometriosis) or care contexts (e.g. primary versus secondary care). Others, who were less familiar, identified areas where interpretations required clarification or greater transparency.

Findings

Identification and Selection of Studies

The process of study identification, selection, and inclusion is presented in Figure 1. Electronic database searches yielded 2,700 studies, of which 200 full texts were reviewed and 24 were included.

Other search methods yielded 2,335 additional, unique studies, of which 51 full texts were reviewed and six were included. Overall, 30 studies were included in the review and synthesis.

Included Studies

Studies included 540 patients with menstrual problems and 265 primary care practitioners (GPs, gynecologists, nurses, and midwives). Some studies shared the same sample (O'Flynn & Britten, 2004, 2006) whereas others shared subsets (Chapple, 1998, 1999) or expanded on their sample geographically (Chapple et al., 1998, 2001). Studies were conducted in the UK ($n = 16$), Australia ($n = 7$), the Netherlands ($n = 2$), Sweden ($n = 2$), Canada ($n = 1$), and New Zealand ($n = 2$). Studies of patient perspectives generally focused on perceptions and general experiences of menstrual problems, and explored health-care needs, diagnosis, treatment, and primary care interactions within this. Studies of primary care practitioner perspectives mainly focused on the practicalities of diagnosis and management of menstrual problems and associated healthcare interactions; a few focused on language use and discourse surrounding menstrual problems. See Table 2 for more details.

Quality Appraisal

Whilst qualitative studies were clear in stating their findings and value and contribution to research and practice, many provided limited rationale for their design (i.e., use of phenomenological, grounded theory, or thematic approach) or details of the analytic process (see Table 3). Many did not mention the researcher-participant relationship; some noted particular characteristics of the researcher but did not elaborate on how this influenced the research process. Some studies explicitly described gaining informed consent, some used alternative wording (i.e., permission, agreed), but a handful did not mention obtaining informed consent.

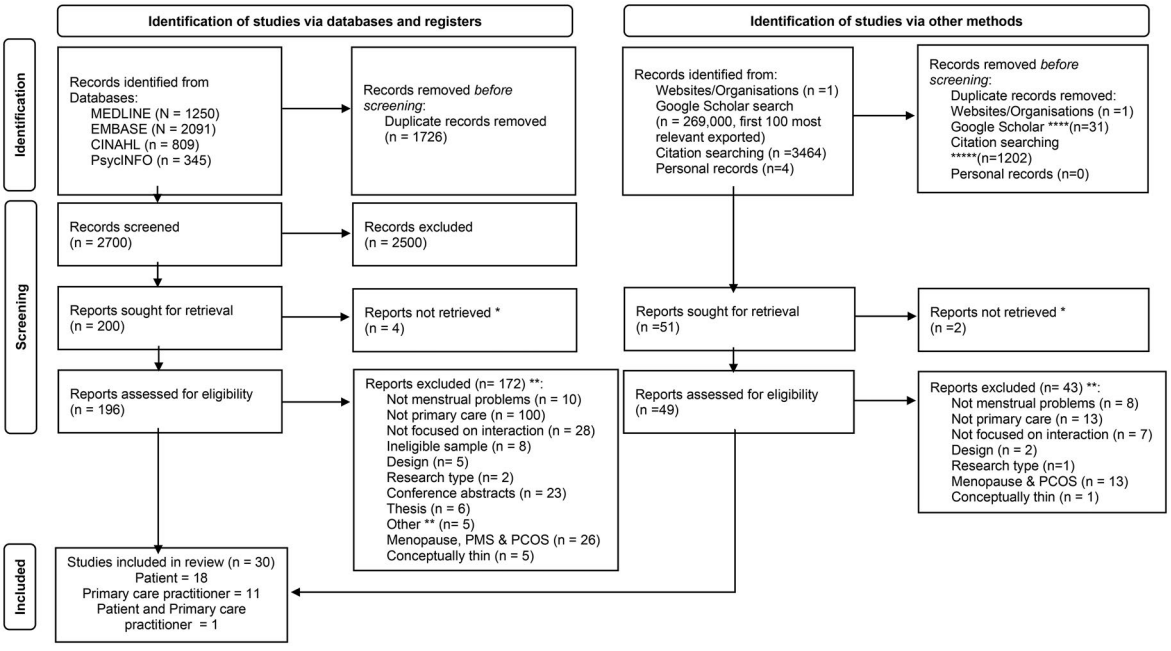

Figure 1. PRISMA diagram.
Note. Menopause, PMS, and PCOS were removed at later stages of screening, following refinement of the scope of "menstrual problems." * Includes full texts that were unsuccessfully translated. ** Number will exceed total of separate reasons as many articles were coded for multiple reasons. *** Includes books, commentary, a brief, a different publication with identical findings of an included study, and a study in which patient and practitioner perspectives are indistinguishable. **** Also against database hits (i.e., if the article had been detected in the database and in citation searching, it would have been retained as a database hit). ***** Also against full text articles screened.

Table 2. Study characteristics.

Study	Menstrual problem	Country	Patient or practitioner	Sample size	Gender/sex	Age	Ethnicity or background	Type of practitioner	Data collection	Data analysis
Ballard et al. (2006)	Endometriosis	UK	Patient	32 (only 28 included)	Women: 32	Range = 16–47 Median = 32	–	N/A	Semi-structured interviews.	Thematic approach.
Bullo and Weckesser (2021)	Endometriosis	UK	Practitioner	11	Female: 11	–	–	GPs: 11	Semi-structured interviews.	Thematic analysis.
Byles et al. (1997)	Menstrual symptoms: heavy, painful or frequent periods.	Australia	Patient	16	Women: 16	Range = 33–50	–	N/A	Focus groups.	No formal method reported.
Chapple (1998)	Menorrhagia	England	Patient	29 (13 in-depth, 16 short)	Women: 29	Short Range = 22–49	South Asian: 29	N/A	Semi-structured interviews.	No formal method reported.
Chapple (1999)	Menorrhagia	England	Patient	30	Women: 30	Range = 15–53	South Asian: 13 White: 17	N/A	Semi-structured interviews.	Grounded theory.
Chapple et al. (1998)	Menorrhagia	England	Practitioner	50 (only 30 included)	Female: 16 Male: 34	–	–	GPs: 30	Semi-structured interviews.	Constant comparison.
Chapple et al. (2001)	Menorrhagia	England	Practitioner	73	Female: 28 Male: 45	–	–	GPs: 73	Semi-structured interviews.	Constant comparison.
Cox et al. (2003)	Endometriosis	Australia	Patient	61	Women: 61	Range = 20–64	–	N/A	Focus groups.	Thematic analysis.
Denny and Mann (2008)	Endometriosis	UK	Patient	30	Women: 30	–	White British: 27 Afro-Caribbean British: 1 Indo-Caribbean: 1 South American Indian: 1	N/A	Semi-structured interviews.	Thematic analysis.
Dixon et al. (2021)	Endometriosis	UK	Practitioner	42	Female: 23 Male: 19	–	–	GPs: 42	Semi-structured interviews.	No formal method reported.
Dutton and Kai (2023)	Menorrhagia	UK	Patient	36	Women: 36	Range = 41–61 Median = 55 Mean = 54	White British/ English: 30 Black British/ Caribbean: 3 South Asian: 2 Mixed White/ African: 1	N/A	Semi-structured interviews.	No formal method reported.
Eldestrand et al. (2022)	Dysmenorrhea	Sweden	Practitioner	15	Female: 15	Range = 28–63 Median = 51	–	Midwives: 15	Semi-structured interviews.	Thematic analysis.
Ellis et al. (2023)	Endometriosis	New Zealand	Patient	50	–	Range = 18–48	–	N/A	Online discussion group.	Thematic Approach.
Frayne et al. (2023)	Endometriosis	Australia	Practitioner	9	Female: 7 Male: 2	Range = 26–51+	–	GPs: 9	Semi-structured interviews.	Thematic analysis.
Fredericks (2014)	Menstrual symptoms	Canada	Patient	9	Women: 9	Range = 23–57	White: 8 African Canadian: 1	N/A	Semi-structured interviews.	Thematic analysis.

(*Continued*)

Table 2. Continued.

Study	Menstrual problem	Country	Patient or practitioner	Sample size	Gender/sex	Age	Ethnicity or background	Type of practitioner	Data collection	Data analysis
Grundström et al. (2016)	Endometriosis	Sweden	Practitioner	25	Female: 18 Male: 7	Range = 33–71 Median = 53	–	GYs: 10 GPs: 6 Midwives: 9	Semi-structured interviews.	Content analysis.
Henry et al. (2020b)	Menorrhagia (or post-menopausal bleeding)	New Zealand	Patient	15	Women: 15	Range = 37–53 Median = 45	NZ European: 9 NZ Māori: 2 Pacific Islander (Cook Islander, Samoan, Tongan): 4	N/A	Semi-structured interviews.	Thematic analysis.
Markovic et al. (2008)	Endometriosis	Australia	Patient	30	Women: 30	Range = 20–78 Mean = 43.9	–	N/A	Semi-structured interviews.	Grounded theory.
Marshall (1998)	Menorrhagia	UK	Patient	43 (only 23 included)	Women: 43	Range = 21–53 Median = 43	Caucasian: 42 Asian: 1	N/A	Semi-structured interviews.	No formal method reported.
O'Flynn and Britten (2000)	Menorrhagia	UK	Patient	21	Women: 21	Range = 29–57	English: 10 Afro-Caribbean: 6 Scottish: 2 Irish: 2 Italian: 1	N/A	Semi-structured interviews.	Content analysis.
O'Flynn and Britten (2004)	Menstrual disorders	UK	Practitioner	22[a]	(Only for GPs) Female: 5 Male: 8	–	–	GPs: 13 Nurses: 7 Community GYs: 1 Not reported: 1	Semi-structured interviews.	Constant comparison.
O'Flynn and Britten (2006)	Menstrual disorders	UK	Practitioner	22[a]	(Only for GPs) Female: 5 Male: 8	–	–	GPs: 13 Nurses: 7 Community GYs: 1 Not reported: 1	Semi-structured interviews.	Constant comparison.
Protheroe and Chew-Graham (2005)	Menorrhagia	UK	Patient	15	Women: 15	Range = 21–49 Median = 38	Caucasian: 7 Pakistani: 3 Black-African: 2 Black-Caribbean: 1 East-African Asian: 1 Mixed-race: 1	N/A	Semi-structured interviews.	Constant comparison.
Rowe et al. (2021)	Endometriosis	Australia	Both	Patients: 46 Practitioners: 13	Patients: Women: 46 Practitioners: _	Patient Range = 21–62 Patient Mean = 31	–	GPs: 12 GY: 1	Patients: Online discussion group. Practitioners: Semi-structured interviews.	Framework analysis.

(*Continued*)

Table 2. Continued.

Study	Menstrual problem	Country	Patient or practitioner	Sample size	Gender/sex	Age	Ethnicity or background	Type of practitioner	Data collection	Data analysis
Santer et al. (2008)	Menorrhagia	Scotland	Patient	32	Women: 32	Range = 27–45	White British: 31 Arab/from Iraq: 1	N/A	Semi-structured interviews.	Constant comparison and narrative analysis.
van der Zanden et al. (2020)	Endometriosis	The Netherlands	Practitioner	43	Female: 33 Male: 10	–	–	GPs: 43	Focus groups.	Content analysis.
van der Zanden et al. (2021)	Endometriosis	The Netherlands	Patient	23	Women: 23	Range = 29–45 Mean = 33.9	–	N/A	Focus groups.	Grounded theory.
Wren and Mercer (2022)	Endometriosis	UK	Patient	9	Women: 9	–	–	N/A	Semi-structured interviews.	Interpretative phenomenological analysis.
Young et al. (2019)	Endometriosis	Australia	Practitioner	12	Female: 8 Male: 4	–	–	GYs: 8 GPs: 4	Semi-structured interviews.	Thematic discourse analysis.
Young et al. (2020)	Endometriosis	Australia	Patient	26	Women: 26	Range = 20-54	–	N/A	Semi-structured interviews.	Thematic analysis.

Note. GPs = general practitioners; GYs = gynecologists; – = missing data. N/A = not applicable. [a] Study only reported characteristics of 21 participants.

Table 3. Quality appraisal of qualitative studies.

Study	CASP 1	CASP 2	CASP 3	CASP 4	CASP 5	CASP 6	CASP 7	CASP 8	CASP 9	CASP 10
Ballard et al. (2006)	Y	Y	CT	Y	Y	N	Y	Y	Y	Y
Bullo and Weckesser (2021)	Y	Y	CT	CT	Y	N	Y	CT	Y	Y
Byles et al. (1997)	Y	Y	CT	Y	Y	N	Y	CT	Y	Y
Chapple (1998)	Y	Y	CT	Y	Y	N	N	Y	Y	Y
Chapple (1999)	Y	Y	Y	Y	CT	N	Y	CT	Y	Y
Chapple et al. (1998)	Y	Y	CT	Y	Y	N	Y	CT	Y	Y
Chapple et al. (2001)	Y	Y	CT	Y	Y	N	Y	Y	Y	Y
Cox et al. (2003)	Y	Y	Y	Y	Y	CT	N	Y	Y	Y
Denny and Mann (2008)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Dixon et al. (2021)	Y	Y	CT	Y	Y	N	Y	CT	Y	Y
Dutton and Kai (2023)	Y	Y	CT	Y	Y	CT	Y	CT	Y	Y
Eldestrand et al. (2022)	Y	Y	CT	Y	Y	N	Y	Y	Y	Y
Frayne et al. (2023)	Y	Y	Y	Y	Y	CT	Y	Y	Y	Y
Fredericks (2014)	Y	Y	CT	CT	CT	N	Y	CT	Y	Y
Grundström et al. (2016)	Y	Y	CT	Y	Y	N	Y	Y	Y	Y
Henry et al. (2020b)	Y	Y	CT	Y	Y	CT	Y	Y	Y	Y
Markovic et al. (2008)	Y	Y	Y	Y	CT	N	N	Y	Y	Y
Marshall (1998)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
O'Flynn and Britten (2000)	Y	Y	CT	Y	Y	N	Y	CT	Y	Y
O'Flynn and Britten (2004)	Y	Y	CT	Y	Y	CT	N	CT	Y	Y
O'Flynn and Britten (2006)	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Protheroe and Chew-Graham (2005)	Y	Y	Y	Y	CT	N	Y	Y	Y	Y
Rowe et al. (2021)	Y	Y	CT	Y	Y	CT	Y	Y	Y	Y
van der Zanden et al. (2020)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
van der Zanden et al. (2021)	Y	Y	Y	Y	Y	CT	Y	Y	Y	Y
Wren and Mercer (2022)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Young et al. (2019)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Young et al. (2020)	Y	Y	Y	Y	Y	CT	Y	Y	Y	Y

Notes. Abbreviations: Y = yes, N = no, CT = can't tell.
CASP 1: Was there a clear statement of the aims of the research?.
CASP 2: Is a qualitative methodology appropriate?
CASP 3: Was the research design appropriate to address the aims of the research?
CASP 4: Was the recruitment strategy appropriate to the aims of the research?
CASP 5: Was the data collected in a way that addressed the research issue?
CASP 6: Has the relationship between researcher and participants been adequately considered (in reporting)?
CASP 7: Have ethical issues been taken into consideration?
CASP 8: Was the data analysis sufficiently rigorous?
CASP 9: Is there a clear statement of findings?
CASP 10: How valuable is the research (is the research valuable)?

The two mixed-methods studies were variable in quality (see Table 4); however, the good quality of the qualitative component was noteworthy and therefore was given greater weight during the synthesis process.

Line of Argument

The line of argument synthesis is presented in Figure 2. The sociocultural context in which the primary care consultation for menstrual problems is situated and its potential influence is an overarching concept. Patient-centeredness (Stewart et al., 2024), on the other hand, is a core concept relating to all other concepts. Patient-centered care involves patient empowerment, sharing of power, exploring illness experiences, grasping an understanding of the whole person, finding a "common ground," and compassion and empathy (Stewart et al., 2024). Primary care practitioners recognize how taking a "patient-as-person approach" (author interpretation, O'Flynn & Britten, 2006, p. 52) is

Table 4. Quality appraisal of mixed-methods studies.

Study	1.1	1.2	1.3	1.4	1.5	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5
Santer et al. (2008)	Y	Y	Y	Y	Y	Y	CT	CT	CT	Y	N	Y	Y	Y	N
Ellis et al. (2023)	Y	Y	Y	Y	Y	Y	Y	Y	CT	Y	N	Y	Y	Y	Y

Notes. Abbreviations: Y = yes, N = no, CT = can't tell.
MMAT 1.1: Is the qualitative approach appropriate to answer the research question?
MMAT 1.2: Are the qualitative data collection methods adequate to address the research question?
MMAT 1.3: Are the findings adequately derived from the data?
MMAT 1.4: Is the interpretation of results sufficiently substantiated by data?
MMAT 1.5: Is there coherence between qualitative data sources, collection, analysis, and interpretation?
MMAT 4.1: Is the sampling strategy relevant to address the research question?
MMAT 4.2: Is the sample representative of the target population?
MMAT 4.3: Are the measurements appropriate?
MMAT 4.4: Is the risk of nonresponse bias low?
MMAT 4.5: Is the statistical analysis appropriate to answer the research question?
MMAT 5.1: Is there an adequate rationale for using a mixed-methods design to address the research question?
MMAT 5.2: Are the different components of the study effectively integrated to answer the research question?
MMAT 5.3: Are the outputs of the integration of qualitative and quantitative components adequately interpreted?
MMAT 5.4: Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?
MMAT 5.5: Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

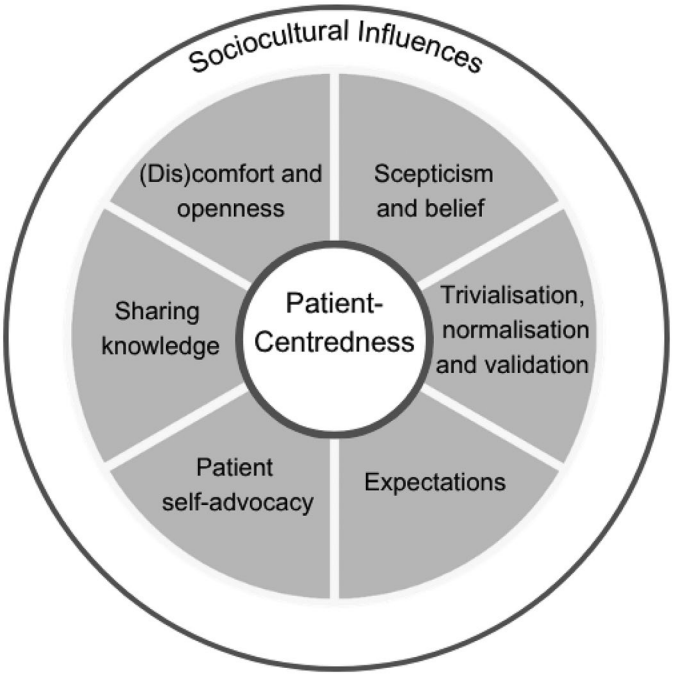

Figure 2. Perceptions of primary care consultations for menstrual problems.

"paramount when navigating and discussing treatment, investigation and referral decisions" (author interpretation, Dixon et al., 2021, p. 671). This approach involves listening to patients' concerns (O'Flynn & Britten, 2006; Rowe et al., 2021), utilizing their experiential knowledge and perceptions of their menstrual problems (Bullo & Weckesser, 2021; Chapple et al., 1998; Grundström et al., 2016; O'Flynn & Britten, 2004; Rowe et al., 2021; Young et al., 2019), as well as incorporating their priorities, wants, and needs (Dixon et al., 2021; Frayne et al., 2023; Grundström et al., 2016; O'Flynn & Britten, 2006; Rowe et al., 2021). As part of a patient-as-person approach, patients (Dutton & Kai, 2023; Rowe et al., 2021) and practitioners (Rowe et al., 2021) expressed the value of shared decision-making. Overall, both primary care practitioners (Dixon et al., 2021; Grundström et al., 2016) and patients (Denny & Mann, 2008; Dutton & Kai, 2023; Fredericks, 2014; Henry et al., 2020b) recognized how the consultation and perceived outcomes are enhanced by a trusting and supportive relationship between the patient and primary care practitioner. Potential imbalances of power, patient and primary care practitioner role ambiguity, uncertainty surrounding expectations, and incongruent

priorities (or assumptions about these) can impede sharing of knowledge for a "whole person" understanding.

(Dis)Comfort and Openness When Discussing Menstrual Problems

Studies found that patients hesitate to discuss menstrual problems unless asked (Fredericks, 2014; Marshall, 1998) or report being "too embarrassed to trouble" practitioners (author interpretation, Protheroe & Chew-Graham, 2005, p. 221; Chapple, 1998; Henry et al., 2020b; Protheroe & Chew-Graham, 2005). Primary care practitioners recognize both patients' (Chapple et al., 1998; Dixon et al., 2021; Eldestrand et al., 2022; Frayne et al., 2023; Rowe et al., 2021) and fellow practitioners' (Chapple et al., 2001) potential discomfort and embarrassment amid menstruation taboos. Multiple studies highlight how both patients (Chapple, 1998; Henry et al., 2020b; Marshall, 1998; Protheroe & Chew-Graham, 2005) and practitioners (Chapple et al., 1998; Frayne et al., 2023) believe practitioner gender (and sometimes intersections with ethnicity or culture) can heighten patients' experience of this discomfort:

> I had a male doctor. I felt embarrassed actually, because he was the same ethnic group. … I took my auntie too, to explain it. … As soon as I changed to a lady doctor I could definitely talk more freely to her. (South Asian patient qtd. in Chapple, 1998, p. 209)

> Rarely do they come in with (menstrual problems) as their primary issue … maybe women feel more comfortable talking to other women. … Sometimes when I ask questions, they say "That's all good," but when they see a female GP, they are more likely to open up. (male primary care practitioner qtd. in, Frayne et al., 2023, p. 550)

This discomfort can be problematic, as patients report valuing openness and comfort in this consultation context (Byles et al., 1997; Fredericks, 2014; Henry et al., 2020b).

Practitioners understand that sharing details of menstrual problems (and potentially related symptoms such as dyspareunia and painful bowel movements) can be challenging for patients but report finding this frustrating (Bullo & Weckesser, 2021; Chapple et al., 1998; Dixon et al., 2021; Frayne et al., 2023) as it limits their ability to gain a full understanding of their patients' menstrual problems. In these cases, practitioners report needing to ask specific questions or tease out information across consultations (Bullo & Weckesser, 2021; Chapple et al., 1998; Dixon et al., 2021; Frayne et al., 2023). While this varies (O'Flynn & Britten, 2004), primary care practitioners describe enquiring about both specific details and whole-life impact of menstrual problems (Bullo & Weckesser, 2021; Chapple et al., 1998; Dixon et al., 2021; Eldestrand et al., 2022; Frayne et al., 2023; Grundström et al., 2016; O'Flynn & Britten, 2006; Rowe et al., 2021). In some studies, patients explain how practitioners often do not ask the "right" questions (Cox et al., 2003; O'Flynn & Britten, 2000), failing to acknowledge whole-life impact (Denny & Mann, 2008; Dutton & Kai, 2023; O'Flynn & Britten, 2000).

Patient and practitioners highlighted how discomfort and embarrassment in discussing menstrual problems can influence information gathering and sharing during consultations. This risks an incomplete understanding of patients' symptoms and their concerns, but can be resolved by utilizing both enquiring about the whole-life impact and direct questioning regarding symptoms.

Skepticism and Belief Toward Those With Menstrual Problems

Patients recall feeling disbelieved, not taken seriously or listened to by their primary care practitioner (Ballard et al., 2006; Chapple, 1999; Cox et al., 2003; Denny & Mann, 2008; Dutton & Kai, 2023; Ellis et al., 2023; Markovic et al., 2008; Protheroe & Chew-Graham, 2005; Rowe et al., 2021; Wren & Mercer, 2022; Young et al., 2020). Patients explain how practitioners appear to make assumptions about personal tolerance of symptoms (Byles et al., 1997; Ellis et al., 2023; Rowe et al., 2021) or attribute them to psychological factors (Byles et al., 1997; Cox et al., 2003; Denny & Mann, 2008; Ellis et al., 2023; Markovic et al., 2008; Young et al., 2020):

> So I did a diary for three months of my symptoms and took it into the GP and said, "This is my life." And he tried to fob me off again and I did an hysterical fit on the floor, and that compounded the fact that they thought I was psychosomatic, but I just said that I am not leaving until I get a referral to a gynecologist.

> So he did that for me and wrote in it, "I don't think she's got a problem but she said that she's not going to leave it until she gets this referral." (patient qtd in Markovic et al., 2008, p. 359)

Some patients report feeling they are perceived as overly dramatic or exaggerating, and reject these notions during consultations (Ellis et al., 2023; Markovic et al., 2008): "It took a lot to convince doctors I was not faking or being overly dramatic. One even suggested I looked up the symptoms and [faked my symptoms]" (Patient qtd in, Ellis et al., 2023, p. 8). Other patients report internalizing the skepticism or psychologization, "that they were 'going mad' or that the 'pain was in my head'" (author interpretation, Ballard et al., 2006, p. 1,299) (Ballard et al., 2006; Ellis et al., 2023; Fredericks, 2014).

While some practitioners share their suspicions of the accuracy or subjectivity of patients' accounts (Chapple et al., 2001; O'Flynn & Britten, 2004; Rowe et al., 2021; Young et al., 2019), other emphasize the importance of utilizing patients' accounts (Chapple et al., 1998; Chapple et al., 2001; O'Flynn & Britten, 2004), "believing women when they say there's a problem" (primary care practitioner qtd in Rowe et al., 2021, p. 178) and validating their concerns (Frayne et al., 2023; Grundström et al., 2016; Rowe et al., 2021). Across multiple studies, patients report valuing this approach (Byles et al., 1997; Dutton & Kai, 2023; Ellis et al., 2023; Fredericks, 2014; Henry et al., 2020b).

Patients report not feeling taken seriously or believed by practitioners, potentially disempowering them during the consultation interaction. Whilst this is not reported by practitioners explicitly, their focus on accuracy and patient subjectivity may limit a clear understanding of patients' experiences and concerns. Although this can be overcome by incorporating compassion and empathy, which communicates a practitioner's understanding of patients' experiences and concerns.

Trivialization, Normalization, and Validation of Menstrual Problems

Across many studies, patients report feeling their menstrual problems are trivialized and normalized by primary care practitioners, including being told symptoms are "what a woman has to put up with" (patient qtd. in Markovic et al., 2008, p. 356; Ballard et al., 2006; Byles et al., 1997; Chapple, 1999; Cox et al., 2003; Denny & Mann, 2008; Dutton & Kai, 2023; Ellis et al., 2023; Fredericks, 2014; Henry et al., 2020b; Markovic et al., 2008; Marshall, 1998; O'Flynn & Britten, 2000; Protheroe & Chew-Graham, 2005; Rowe et al., 2021; Santer et al., 2008; van der Zanden et al., 2021; Wren & Mercer, 2022; Young et al., 2020).

Practitioners explain how some patients seem to normalize their menstrual symptoms or be unaware there is a problem (Chapple et al., 1998; Dixon et al., 2021; Eldestrand et al., 2022; Frayne et al., 2023; Rowe et al., 2021; Young et al., 2019), which is echoed by patients themselves (Ballard et al., 2006; Chapple, 1998, 1999; Dutton & Kai, 2023; Ellis et al., 2023; Henry et al., 2020b; Markovic et al., 2008; Marshall, 1998; Protheroe & Chew-Graham, 2005; Santer et al., 2008; van der Zanden et al., 2021).

Both patients (Ballard et al., 2006; Chapple, 1999; Fredericks, 2014; Henry et al., 2020b; Markovic et al., 2008; Marshall, 1998; Santer et al., 2008) and practitioners (Chapple et al., 2001; Dixon et al., 2021; Eldestrand et al., 2022; Grundström et al., 2016; O'Flynn & Britten, 2004) describe considerable uncertainty when distinguishing the "normality" of menstrual symptoms:

> And you see because for men it's automatically abnormal, you know, because it's not normal for them. Maybe their threshold is that bit different, I would find it very hard to judge how heavy is abnormal, how painful is abnormal. (male primary care practitioner qtd. in O'Flynn & Britten, 2004, p. 355)

> I would see doctors that always say things are fine. … They would say that's normal. … And I guess it's a difficult thing to know, because lots of women I know, that don't have endometriosis, have terribly painful periods as well. It's hard to measure that sort of thing. (patient qtd. in Markovic et al., 2008, p. 357)

Practitioners describe framing menstrual problems as normal (i.e., frequently seen in general practice and/or not indicative of any underlying disease process) as means of providing reassurance (Chapple et al., 2001; Eldestrand et al., 2022; Grundström et al., 2016). Other practitioners describe how their assessment is led by patients' perceptions and accounts (Chapple et al., 1998; Chapple et al., 2001; Eldestrand et al., 2022; Grundström et al., 2016; O'Flynn & Britten, 2004; Rowe et al., 2021).

Practitioners acknowledge how other practitioners may be dismissive (Dixon et al., 2021; Rowe et al., 2021; Young et al., 2019) and express how they understand validation to be important (Frayne et al., 2023; Grundström et al., 2016; Rowe et al., 2021). Patients report feeling reassured by this validation (Byles et al., 1997; Dutton & Kai, 2023; Fredericks, 2014; Henry et al., 2020b), in contrast to dismissive responses: "To have someone sympathetic: 'Yes, there is a problem.' It's not: 'Well, lump it you're a woman.'" (patient qtd. in Byles et al., 1997, p. 252).

Patients and practitioners recall trivialization and normalization of menstrual problems during consultations. They both highlight differing perceptions of "normality," which risks disempowering patients and prevents a shared understanding of concerns. Incorporating patients' perceptions and validating their concerns, as part of patient-centered care, supports a shared understanding of concerns and consequent next steps in care.

Differing Expectations of Consultation Outcomes

Patients report wanting both an explanation for their problems and something actionable from the consultation (Byles et al., 1997; O'Flynn & Britten, 2000; Protheroe & Chew-Graham, 2005). Patients describe this as a "power struggle" (author interpretation, Young et al., 2020, p. 33) when practitioners are perceived to be reluctant to investigate, diagnose, or refer (Chapple, 1999; Cox et al., 2003; Denny & Mann, 2008; Dutton & Kai, 2023; Markovic et al., 2008; Protheroe & Chew-Graham, 2005; Rowe et al., 2021; van der Zanden et al., 2021; Wren & Mercer, 2022; Young et al., 2020). In these cases, patients describe experiencing consultations as offering little more than advice to "put up with it" (patient qtd. in Dutton & Kai, 2023, p. 298), reassurance that their menstrual problems will self-resolve, or instruction to reconsult at a later point (Byles et al., 1997; Chapple, 1999; Cox et al., 2003; Dutton & Kai, 2023; Markovic et al., 2008; O'Flynn & Britten, 2000). In the absence of this action, patients explain that they disengage from further primary care help seeking, having not received the "satisfaction" they expected (patient qtd. in Byles et al., 1997, p. 251) (Byles et al., 1997; Chapple, 1999; Henry et al., 2020b).

Primary care practitioners describe how menstrual problems can present in multiple and complex ways, which contributes to their uncertainty around diagnosis and referral (Dixon et al., 2021; Frayne et al., 2023; Rowe et al., 2021; van der Zanden et al., 2020).

Practitioners recognize the potential value of a diagnosis and referral (Dixon et al., 2021; O'Flynn & Britten, 2006)—particularly in complex cases (Dixon et al., 2021; Eldestrand et al., 2022; Ellis et al., 2023; Grundström et al., 2016)—although they describe tension between responding to patient expectations and avoiding possible psychological harm associated with raising serious conditions (Dixon et al., 2021; O'Flynn & Britten, 2006; Rowe et al., 2021; van der Zanden et al., 2020; Young et al., 2019):

> It is a dilemma to say within 5 minutes of seeing somebody who comes in with a bit of bleeding, to say, "Well we've got to make sure you don't have a cancer." Is it fair to traumatize them, when they're probably going to end up totally normal, you know? (primary care practitioner qtd. in O'Flynn & Britten, 2006, p. 53)

Instead of receiving impartial support from practitioners, some patients report this caution as discouragement or scaremongering (Wren & Mercer, 2022).

Practitioners explain how they seek to reconcile this tension by prioritizing symptom management over establishing a diagnosis, despite recognition that this may carry the potential for harm (Dixon et al., 2021; Frayne et al., 2023; van der Zanden et al., 2020):

> If it's someone quite young, then at what point do you intervene and send them in for a laparoscopy? It might be that it can easily be managed with the combined pill or something like that, the symptoms, but then you're kind of worried […] is that ultimately doing them any good? Is this endometriosis going to get worse while you're doing that? (primary care practitioner qtd.in Dixon et al., 2021, p. 672)

Patients report perceiving that that primary care practitioners make assumptions about their concerns and expectations, such as presuming a desire for a quick solution or basing management decisions on age or anticipated reproductive plans (Cox et al., 2003; Fredericks, 2014; Henry et al., 2020b; Markovic et al., 2008; O'Flynn & Britten, 2000, 2004; O'Flynn & Britten, 2006; Protheroe &

Chew-Graham, 2005; Rowe et al., 2021; van der Zanden et al., 2021; van der Zanden et al., 2020; Young et al., 2020). Some primary care practitioners acknowledge making such assumptions instead of enquiring (O'Flynn & Britten, 2006; Young et al., 2019). These assumptions are particularly salient in discussions surrounding fertility and reproduction, which practitioners report approaching cautiously or using to determine urgency of action (Dixon et al., 2021; Frayne et al., 2023; van der Zanden et al., 2020). Some patients describe how practitioners have advised pregnancy to manage endometriosis, despite this misaligning with patients' priorities (Ellis et al., 2023).

Multiple studies describe how practitioners seek to elicit and incorporate patients' priorities, wants, and needs within discussions of symptom management, including diagnosis, investigation, and fertility concerns (Dixon et al., 2021; Frayne et al., 2023; Grundström et al., 2016; O'Flynn & Britten, 2006; Rowe et al., 2021). Patients report valuing this approach (Fredericks, 2014; O'Flynn & Britten, 2000) and, in some cases, it "affirm[s] [their] decision to seek help" from primary care (author interpretation, Henry et al., 2020b, p. 4).

A tension exists between what patients and practitioners expect from the primary care consultation: what answers (or diagnoses) are provided for the menstrual problems and what actions come from this. Suboptimal exploration of expectations risks an inaccurate shared understanding of priorities between patients and practitioners; conversely, explicitly exploring expectations as part of patient-centered care supports appropriate decision making and clearer next steps.

The Role and Perception of Patient Self-Advocacy

Patients explain how they know "when something isn't right" (patient qtd. in Young et al., 2020, p. 31; Markovic et al., 2008; Rowe et al., 2021; Young et al., 2020). They describe advocating for themselves across multiple consultations (Ballard et al., 2006; Chapple, 1999; Cox et al., 2003; Denny & Mann, 2008; Ellis et al., 2023; Henry et al., 2020b; Markovic et al., 2008; van der Zanden et al., 2021; Wren & Mercer, 2022; Young et al., 2020): "forcing" practitioners to listen (author interpretation, Cox et al., 2003, p. 7; Cox et al., 2003; Wren & Mercer, 2022) and "push[ing]" for action or referral (patient qtd. in Denny & Mann, 2008, p. 113; Chapple, 1999; Cox et al., 2003; Denny & Mann, 2008; Dutton & Kai, 2023; Ellis et al., 2023; Markovic et al., 2008; van der Zanden et al., 2021; Wren & Mercer, 2022; Young et al., 2020). Some patients state that this persistence and insistence is necessary in leading practitioners to relent (Markovic et al., 2008; van der Zanden et al., 2021; Young et al., 2020):

> It was left in the middle for a while by the general practitioner. At some point I demanded a referral to a gynecologist. My general practitioner thought it was ridiculous and unnecessary. But I persisted and then he said fine let's do it. (patient qtd. in van der Zanden et al., 2021, p. 336)

Practitioners recognize how consultation discussions are enhanced by self-advocating patients (Dixon et al., 2021; van der Zanden et al., 2020). For less engaged patients, practitioners note efforts to encourage reconsulting if problems persist, otherwise, "the years slip so quickly" for patients (primary care practitioner qtd in Dixon et al., 2021, p. 671).

Despite this, some patients report believing they are viewed as a "nuisance" (patient qtd. in Dutton & Kai, 2023, p. 298) or a "difficult patient" (patient qtd. in Markovic et al., 2008, p. 360) by practitioners for reconsulting. This is echoed by some practitioners who report perceiving reconsulting patients as challenging their ability to provide answers (Young et al., 2019), although others practitioners recognize the importance and benefit of continuity of care (Dixon et al., 2021; Grundström et al., 2016).

Despite patients and practitioners expressing the value of patient self-advocacy, there nonetheless remain residual negative attitudes and internalization. Patient advocacy and contribution should be valued both during consultations and encouraged across patients' wider care journey, particularly if symptoms persist.

Sharing Experiential and Medical Knowledge of Menstrual Problems

Primary care practitioners recognize how knowledgeable patients enhance discussion during consultations (Dixon et al., 2021; van der Zanden et al., 2020). Studies of both patients (Byles et al., 1997; Markovic et al., 2008; Wren & Mercer, 2022) and practitioners (Chapple et al., 1998; Eldestrand et al., 2022; Frayne et al., 2023; Grundström et al., 2016) highlight that some patients have limited

knowledge about menstrual problems. In some cases, patients (Cox et al., 2003; Wren & Mercer, 2022) and practitioners (Dixon et al., 2021; Eldestrand et al., 2022) explain how they seek to share knowledge about menstrual problems, although other patients report feeling ill-equipped to discuss their menstruation problems (Byles et al., 1997), or leave still lacking in understanding (Chapple, 1998; Henry et al., 2020b; Protheroe & Chew-Graham, 2005; Wren & Mercer, 2022).

Some patients explain how they are the expert in their body (Markovic et al., 2008; Rowe et al., 2021; Young et al., 2020). While some practitioners report valuing and utilizing this experiential knowledge (Bullo & Weckesser, 2021; Chapple et al., 1998; Dixon et al., 2021; Grundström et al., 2016; O'Flynn & Britten, 2004; Rowe et al., 2021; Young et al., 2019), others suggest the superiority of medical knowledge over this (O'Flynn & Britten, 2006; Young et al., 2019). In some cases, patients report being told that they know less about their experience than their practitioner (Ellis et al., 2023).

Across studies, practitioners recognize that medical knowledge can be subjective or unable to provide answers (Bullo & Weckesser, 2021; O'Flynn & Britten, 2004; Young et al., 2019) and that there remains a lack of knowledge, familiarity, and confidence, particularly of some related conditions (particularly endometriosis) (Dixon et al., 2021; Frayne et al., 2023; Grundström et al., 2016; Rowe et al., 2021; van der Zanden et al., 2020). While some practitioners report undertaking additional education (Denny & Mann, 2008), others—despite recognizing them as problematic—endorse menstrual myths (Young et al., 2019). Patients state feeling that primary care practitioners lack specialist or sufficient knowledge about menstrual problems (Cox et al., 2003; Denny & Mann, 2008; Protheroe & Chew-Graham, 2005; van der Zanden et al., 2021; Wren & Mercer, 2022; Young et al., 2020). They explain how practitioners have incorrectly suggested non-gynecological diagnoses (e.g., IBS, UTIs, food allergies, being overweight, strained muscle, appendicitis), disregard crucial indicators (Rowe et al., 2021; Wren & Mercer, 2022), have ruled out conditions based on the absence of particular symptoms (Ellis et al., 2023), or recite menstrual myths (Cox et al., 2003; Denny & Mann, 2008; Ellis et al., 2023; Markovic et al., 2008; O'Flynn & Britten, 2000; Rowe et al., 2021; Wren & Mercer, 2022; Young et al., 2020):

> Some of the women reported that their GP would repeat medical myths that the woman knew to be untrue, such as that having a baby would cure their pain, or that a woman in her teens or early 20s was too young to have endometriosis. (author interpretation, Denny & Mann, 2008, p. 113)

When discussing menstrual problems, a tension exists between the utilization of patients' experiential and practitioners' medical knowledge. Although patient knowledge can be variable, inappropriate prioritization of medical knowledge—particularly when inaccurate—over experiential knowledge can disempower patients, threatening the patient-practitioner relationship. Eliciting, valuing, and combining patient and practitioner knowledge can enable a better, shared understanding of the menstrual problems.

Discussion

This review aimed to synthesize both patient and practitioner perspectives of primary care consultations about menstrual problems. By bringing these viewpoints together, it revealed shared concepts, offering a deeper and more integrated understanding of the consultation dynamic. This targeted focus and deeper insights distinguish our review from previous reviews in this area and suggest novel directions for research and practice.

Patients' and primary care practitioners' prior expectations of the consultation and openness and comfort (or lack of) in discussing menstrual problems can influence how patients share their concerns and how practitioners enquire about these. Despite patients' self-advocacy, they can find it difficult to share information if they feel their primary care practitioner is skeptical toward their account or sees their menstrual problems as trivial or "normal." This, however, can be countered by expressions of validation by primary care practitioners. Sharing and combining patient and practitioner knowledge of menstrual problems can enhance discussions of potential explanations and diagnoses for menstrual problems, but such discussions can be impaired by apparent practitioner skepticism toward and filtering of patients' accounts. What patients and primary care practitioners expect from the consultation,

including how much either of them trivialize and/or normalize menstrual problems, and the extent to which patient self-advocacy is adopted and encouraged, can shape the consultation and its outcomes.

Some concepts—such as trivialization, normalization, and validation, and sharing experiential and medical knowledge—remained relatively consistent over time in studies from earlier and more recent decades. In contrast, concepts relating to expectations of consultation outcomes and the role and perception of patient self-advocacy were more prominent in recent studies, which may reflect broader shifts toward patient-centered care and increased public advocacy around menstruation. Earlier studies more commonly highlighted the concept of (dis)comfort and openness within consultations, which may align with wider societal changes in how menstruation is discussed. Interestingly, while expressions of skepticism and issues of belief became more pronounced in recent patient-focused studies, the opposite pattern was observed in practitioner studies, potentially indicating greater adoption of patient-centered approaches by practitioners.

Some of the concepts highlighted in this review are consistent with previous reviews. For example, the notion of embarrassment in talking about menstruation (Barrington et al., 2021; Briscoe et al., 2024; Harris et al., 2026; Henry et al., 2020a; Moreno Gómez et al., 2023), managing expectations (Briscoe et al., 2024; Garside et al., 2008), and insufficient or imbalance of knowledge surrounding menstrual problems, particularly in relation to normalization and psychologization of symptoms (Barrington et al., 2021; Briscoe et al., 2024; Garside et al., 2008; Harris et al., 2026; Henry et al., 2020a; Moreno Gómez et al., 2023; Peel et al., 2025; Robstad et al., 2025) are themes that have cut across patient and practitioner reviews. While themes such as skepticism toward patients with menstrual problems and the role of patient self-advocacy are well-documented in existing literature focused on patient perspectives (Harris et al., 2026; Henry et al., 2020a; Peel et al., 2025; Robstad et al., 2025; Young et al., 2015), these concepts appear to be less recognized or underexplored in reviews addressing practitioner perspectives (Briscoe et al., 2022). These concepts—skepticism and self-advocacy—were developed as shared concepts only through the synthesis of both patient and practitioner perspectives. The translational approach offered by meta-ethnography enabled a more nuanced understanding that would not have been captured by examining either viewpoint in isolation. The synthesized findings demonstrate that—despite patients and primary care practitioners highly valuing effective patient-practitioner communication and patient-centered care (Briscoe et al., 2024; Peel et al., 2025; Robstad et al., 2025; Young et al., 2015)—suboptimal communication persists.

The core, explanatory concept in the line of argument was the extent of patient-centered care (Stewart et al., 2024), a familiar concept among primary care practitioners and researchers in the field. Framing avenues for improvement in this manner may therefore enhance acceptance, understanding and motivation. For example, patient empowerment as part of patient-centered care relates closely to the concepts of self-advocacy and experiential knowledge sharing in this review, whereby a patient's knowledge, role, and engagement in the consultation is valued. However, patients can be disempowered when met with skepticism toward their accounts and trivialization of their menstrual problems. Using the patient-centeredness framework highlights how patient empowerment (and thus patient-centeredness) is compromised during these instances, highlighting potential intervention targets. Another component of patient-centered care is practitioner compassion and empathy (Stewart et al., 2024), which we found to mitigate patients' experiences of skepticism toward, and trivialization and normalization about, their menstrual problems. Encouraging primary care practitioner compassion and empathy will not only enhance patient-centeredness but improve patients' perception of these consultations.

While the synthesized concepts of this review occur within the context of the primary care consultation, they are encompassed by broader, sociocultural influences reflecting the history of medicine, menstruation, and women's health. As has been done for endometriosis (Hudson, 2022), it is important to recognize the sociocultural influences and context in which primary care consultations for menstrual problems is placed. For example, the embarrassment and lack of openness in talking about menstrual problems is unsurprising considering menstruation shame and taboo (Newton, 2016). Skepticism toward those with menstrual problems and perceptions that some patients can be difficult relate to the "hysteria" discourse (Young et al., 2019) portraying women as hysterical, crazy, irrational, and over-emotional (Merone et al., 2021; Perez, 2019). The role of patients and the sharing of

knowledge of menstrual problems may be remnants of the shift away from paternalism—sometimes described as doctor-centered care (Ong et al., 1995), the opposite of the currently considered "ideal" patient-centered care (Stewart et al., 2024). Some suggest that paternalism and insistence of medical knowledge superiority can function to dismiss menstruating patients, especially those less medically literate (Inhorn, 2006; Newton, 2016). On the other hand, patient self-advocacy (particularly involving resistance) has been perceived as a manifestation of greater patient power (Filc, 2006), leading some practitioners to view the self-advocating patient as difficult (Wileman et al., 2002). This suggests ongoing resistance to the departure from paternalistic models of care, as discussed in this review. The lack of knowledge and general normalization of menstrual problems highlighted by both patients and practitioners could be explained by gender data gaps in medical and women's health research, which consequently informs incomplete medical (and indeed general) understanding and education about the female body (Merone et al., 2021; Perez, 2019). Understanding the broader sociocultural context of these primary care consultations is essential for ensuring appropriate and effective change; however, this should not detract from the responsibility and necessary adjustments required from both patients and practitioners to address mismatches in communication and enhance consultations.

Strengths and Limitations

This review is the first to synthesize patient and primary care practitioner perspectives and provides an update on the existing literature in a high-profile area wherein society and expectations are changing rapidly. This review is consistent with and builds on other recent reviews (Barrington et al., 2021; Briscoe et al., 2024; Garside et al., 2008; Harris et al., 2026; Henry et al., 2020a; Moreno Gómez et al., 2023; Peel et al., 2025; Robstad et al., 2025; Young et al., 2015), showcasing shared concepts that are perceived to influence the primary care consultation by patients and practitioners, while also holding space for nuance and complexity between and within each of these groups. Any synthesis relies on the scope of its included studies. Although studies were excluded based on richness in relation to the research question, there remained heterogeneity in the studies' focus: patient studies focused on general experiences of menstrual problems, with health-care interactions as a part of this, whereas practitioner studies mainly focused on diagnosis and management and their associated health-care interactions. Variation in populations, settings, and conditions across studies was expected and valued, as it enabled exploration (through reciprocal and refutational translation) of both shared concepts and inconsistencies in how primary care consultations for menstrual problems are perceived.

Any synthesis relies on the quality of its included studies. Many included studies provided limited rationale for their design or description of their analytic process. These standards for qualitative research should be upheld in future research. Some of the included studies reflected on the influence of lived experience (Wren & Mercer, 2022) or interviewer-interviewee dynamics (Marshall, 1998; O'Flynn & Britten, 2006) on the research process. These valuable insights and further understanding of the research process should be encouraged.

Because date restrictions were not applied, it could be argued that synthesis findings are less transferable to current-day practice considering changes to the delivery of care and improving knowledge of menstrual problems. However, in this review, similar concepts were derived from articles published very recently and from articles published over 25 years ago. Despite not restricting country or language of publication, all included studies were based in Western, developed countries, limiting transferability. Studies from non-Western countries were found during the search process but were typically excluded for lack of focus on primary care. No included studies were based in the United States—atypical of most systematic reviews. The review's search strategy was developed to account for American spelling and phrases and detected studies from the United States. The lack of studies from the United States may reflect the health-care system structure in the United States (i.e., patients can go straight to their gynecologist) or more broadly the prioritization of research funding.

A limitation of this research area is the lack of reporting and representation of participant characteristics in the included studies. The gender of primary care practitioners is less frequently reported than that of patients, with some authors possibly underestimating its influence. Studies specifying

practitioner gender often only included female practitioners, thereby not capturing male perspectives. This may be due to male practitioners' selection bias rather than researcher oversight. Additionally, there is a concerning lack of representation of transgender or gender nonconforming individuals, who, according to a DHSC survey, feel less comfortable and listened to during health-care consultations compared to cisgender respondents (Department for Health and Social Care [DHSC], 2022). Both patient and practitioner studies also inadequately report ethnicity, with most samples consisting predominantly of White participants, except for studies focusing on specific populations (e.g., Chapple, 1998). The synthesis indicates that openness and comfort in discussing menstrual problems may be influenced by the ethnicity of both patients and practitioners, suggesting that greater insight could be gained by including diverse ethnic backgrounds in future research.

Differences between patient and practitioner perspectives may stem in part from differences in sampling or participation bias. Perhaps patients who are dissatisfied with their experiences or care are more likely to take part in studies, while primary care practitioners who are confident in their skills are more likely to take part. Consequently, there may be a "skew" of negative perspectives from the patient studies and more positive perspectives from the practitioner studies. Furthermore, patients in the included studies will not have consulted the primary care practitioners in these studies and vice versa, making the "putting together" of perspectives challenging. In this review, adoption of both reciprocal and refutational translation attempted to address this challenge. Future research or development of interventions that seek to "give voice" to patient and primary care practitioner perspectives must also consider this challenge.

A key strength of this review lies in the complementary expertise of the review team, spanning qualitative methodology, primary care research, health-care communication, and psychology. Having both clinical and non-clinical researchers supported the striving for a balanced interpretation of patient and practitioner perspectives. Variation in members' familiarity with the relevant literature strengthened rigor by allowing topic-specific expertise to be complemented by critical challenge and clarification during interpretation. Despite several team members having lived experience of consulting primary care for menstrual problems, patient and public contributors were not involved in the synthesis process. Although perspectives on the resonance of findings were discussed with patient and public contributors after completion, their absence during the synthesis may have shaped how the line of argument developed.

Implications

As this review highlights, concepts that influence the primary care consultation for menstrual problems are complex, impact patient-centered care and are shaped by the broader sociocultural context. Looking at society in general, much is to be done to minimize the taboo and negative perceptions surrounding menstruation and strategically prioritize women's health research. Until then, however, it is important to reflect on what patients and primary care practitioners can do (and be helped with) to enhance primary care consultations for menstrual problems for themselves and each other.

Based on the review's findings, Tables 5 and 6 summarize potential areas for researchers, policymakers, advocacy and campaigning organizations, and medical educators to explore and seek to enhance primary care consultations for menstrual problems. These points are not exhaustive or prescriptive but instead offer potential starting places that groups may draw on when seeking to address one or several of these areas of challenge. These suggestions are targeted at patients and practitioners respectively but also complement each other to respond to the complexity of the patient-practitioner context. For example, a potential patient-facing intervention could support patients to communicate their concerns, expectations, wants, and needs. A practitioner-facing intervention could support primary care practitioners to elicit patients' concerns, expectations, wants, and needs, and provide advice on how to respond to them during the consultation. Interventions related to those suggested in this review are already emerging, such as the recent NHS decision support tools for managing heavy periods (NHS, 2023) and Wellbeing of Women's Period Symptom Checker (Wellbeing of Women, n.d.). These are mainly targeted at patients but are also designed to be used with primary care practitioners to supplement consultations. These recent efforts are promising progress in enhancing primary

Table 5. Potential areas to explore for developing patient interventions to enhance primary care consultations for menstrual problems.

Potential patient interventions	Concept(s)
Encouragement and validation of the necessity to consult primary care for help with menstrual problems and guidance on when re-consult may be appropriate as part of an ongoing process of management in primary care.	Patient self-advocacy Trivialization, normalization, and validation
Guidance on what can be expected from the consultation and primary care practitioners regarding information gathering, discussions, shared decision making, and management within primary care. This could include reasoning, such as why specific questions asked are necessary or why certain management options are being suggested.	Expectations (Dis)comfort and openness
Tips on ways to self-advocate during a consultation, such as preparing a record of the menstrual problems experienced over time (e.g., diary) with the impact on their lives.	Patient self-advocacy Skepticism and belief
Accessible sources of education and awareness surrounding menstrual problems that acknowledge that experiences of 'normal' or 'problematic' menstruation can be experienced differently by different people.	Sharing knowledge Trivialization, normalization, and validation
Tips on how to feel more comfortable in discussing menstrual problems openly.	(Dis)comfort and openness
Advice or prompts on what to ask primary care practitioners when discussing menstrual problems, which include checking one's understanding.	(Dis)comfort and openness Sharing knowledge
Advice and tools on considering, recording, and communicating concerns, expectations, wants, and needs with primary care practitioners during the consultation as part of a collaborative patient-practitioner relationship.	Expectations Patient self-advocacy

Table 6. Potential areas to explore for developing primary care practitioner interventions to enhance primary care consultations for menstrual problems.

Potential primary care practitioner interventions	Concept
Advice on encouraging patients to discuss menstrual problems openly, showing awareness that this topic can be difficult to discuss, and on how to alleviate/address potential embarrassment while remaining sensitive to context (i.e., gender, culture).	(Dis)comfort and openness
Advice on sensitively navigating discussions surrounding the physical, emotional, and psychological aspects of menstrual problems in a holistic way.	Skepticism and belief (Dis)comfort and openness
Communication strategies to elicit patients' perceptions of their menstrual problems and fully acknowledge the whole-life impact to ensure patients feel listened to, believed, and validated in their concerns.	Trivialization, normalization, and validation Skepticism and belief
Advice on how to navigate potential differing perceptions of the term *normal* and how to convey reassurance while also providing acknowledgement of the impact of symptoms and support for managing menstrual problems.	Trivialization, normalization, and validation
Tips on acknowledging and valuing patients' accounts, interpretations, and understanding of their menstrual problems (despite potential subjectivity). This can include responding to and utilizing resources that patients bring to the consultation (e.g., symptom diary).	Skepticism and belief
Advice on how to encourage and support patients' engagement and overall role within the consultation as part of a collaborative patient–primary care practitioner relationship.	Patient self-advocacy
Prompts to reflect on one's biases towards patients, whether that be making assumptions about a patient's personal tolerance for menstrual problems or more willingly referring assertive patients.	Skepticism and belief Patient self-advocacy
Tips on how to incorporate information sharing and education between patients and primary care practitioners.	Sharing knowledge
Awareness and education on menstrual problems (and specific conditions such as endometriosis), which involves dispelling "menstrual myths"' and distinguishing between menstrual problems and other (perhaps related) conditions (e.g., IBS).	Sharing knowledge
Prompts to elicit patients' expectations, wants, and needs and advice on responding to these during information gathering and when discussing appropriate investigations, diagnoses, management plans in primary care, and referral to secondary care.	Expectations
Strategies on how to provide appropriate advice on next steps and follow-up plans and encouragement for patients to re-consult for their menstrual problems, should problems persist, as part of an ongoing process of management.	Expectations Patient self-advocacy

care consultations for menstrual problems and should continue to be expanded. However, these suggestions should be approached sensitively to avoid casting primary care practitioners as the "villain" (Toye et al., 2023, p. 765) and discrediting their current practice. Failure to be sensitive to these external perceptions may lead to resistance and consequently hamper progress.

Interventions to enhance communication about menstrual problems need to be evidence-based, engaging, novel, and relevant to target populations to maximize implementation and change. This can be achieved by ensuring components are derived from research on the perspectives of those for whom the interventions are designed (Yardley et al., 2015). For example, research looking to develop patient self-advocacy resources could seek to explore how comfortable patients feel advocating for

themselves and what barriers they perceive to doing so. Research to develop interventions that enhance primary care practitioners' communication could usefully explore current practices to elicit consultation elements that are potentially perceived as skepticism or trivialization and identify factors that influence validating and empathetic communication.

Conclusion

This meta-ethnography reviewed qualitative research findings of how the primary care consultation is perceived by patients and primary care practitioners when discussing menstrual problems. Synthesizing both patient and practitioner perspectives offered a more in-depth and alternative interpretation of existing research and underscores the importance of considering both perspectives to improve communication in this context. Specifically, we found feeling comfortable and being open when discussing menstrual problems is challenging, reflection on skepticism directed at those with menstrual problems is needed, and trivializing and normalizing attitudes toward menstrual problems overall need reframing. A tension exists between what patients and practitioners expect from the primary care consultation and consequently how this is discussed and actioned. Other tensions include the role of patient self-advocacy and the sharing of experiential and medical knowledge. At the core of this is the need and shared desire for patient-centered care. As researchers and intervention developers strive to enhance communication in primary care consultations about menstrual problems, they must be sensitive to all these influences.

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Data Availability Statement

The authors confirm that the data supporting the findings of this study are available within the article.

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