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Factors associated with unvoiced concerns of patients attributed to embarrassment, modesty or a fear of being judged

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Abstract

Background and objective It is important for patients to feel that they can address any topic during a consultation with a General Practitioner (GP), so that the care delivered is appropriate and relevant. This study aimed to investigate factors associated with unvoiced concerns of patients during a GP consultation, because of embarrassment, modesty and/or a fear of being judged.

Methods Cross-sectional, observational study between December 2023 and January 2024, using a ad hoc questionnaire completed by adult subjects who accepted to participate in the study. The factors associated with unvoiced concerns with a *p*-value < 0.20 by univariable analysis were included in a multivariable logistic regression model.

Results In total, 2104 participants were included (mean age 43.7 ± 15.9 years; 73% women). Of these, 680 (32.3%, (95% CI, 30.3–34.3)) reported that they had leaved unvoiced concerns during the consultation due to embarrassment, modesty and/or a fear of being judged. The main motives for embarrassment, modesty and/or fear of being judged were: "sexual behavior, libido, perception of your gender, erectile dysfunction, vaginal dryness" (15% of respondents), and "psychological disorders, low mood, anxiety" (14%). Factors associated with a higher likelihood of unvoiced concerns were female sex (adjusted odds ratio (aOR) 1.5 [95% CI 1.2–1.9]; $p = 0.0001$) and third-level education (aOR 1.3 [95% CI 1.05–1.7]; $p = 0.02$). Conversely, heterosexuality (aOR 0.7 [95% CI 0.5–0.98]; $p = 0.04$) and a relationship of trust with the GP (aOR 0.6 [95% CI 0.5–0.7]; $p < 0.0001$) were associated with a lower likelihood of unvoiced concerns during GP consultation. Forty-seven percent of respondents said that hearing their GP reaffirm the secrecy of anything said during the consultation would have helped them to be more forthcoming, and 78% reported that they would have felt more at ease if the GP had addressed the difficult topic first.

Conclusion Simple tools that could be used during primary care consultations could help to address sensitive issues and create an environment where patients can more comfortably address all their health issues without discomfort.

Keywords General practitioner, Primary care, Judgment, Doctor-patient relationship, Communication

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Introduction

During a consultation with a general practitioner (GP), patients should be able to express themselves freely and provide the GP with pertinent medical information [1, 2]. However, it's not always easy for patients to talk about certain subjects. Subjects such as mental health, sexuality, addiction or death may be considered embarrassing, too personal, too intimate or taboo [3, 4]. Eating disorders or body image can be accompanied by discrimination and stigmatization, which can prevent those concerned from seeking help [5]. Patients may also feel embarrassed or ashamed about urinary or digestive issues such as incontinence, and give up talking to their GP about it [6–8]. In such cases, unvoiced concerns may be present in the doctor-patient relationship. Yet, there are two sides to the doctor-patient relationship, and it can happen that the GP may be the cause of certain topics going unaddressed, either because they do not manage to address certain issues, or because they limit their communication with the patient for fear of causing offense, or for fear of a possible negative reaction [9]. A lack of awareness among GPs about certain topics, combined with a fear of not knowing how to answer certain difficult questions may also cause a reluctance to discuss certain subjects with patients [10]. Haley et al. showed that patient discomfort can be a factor in the GP's willingness to address sexual health [11], while Temple-Smith et al. similarly reported that GPs are less inclined to address a specific topic if they perceive the patient to be embarrassed [12].

These barriers to communication notwithstanding, the GP has a duty to collect the medical information necessary for optimal management of the patient. Thus, the GP's role is to create an environment in which the patient feels free to express themselves during a consultation, even about personal, intimate or taboo topics. For the patient to communicate freely, it behoves the GP to create a relation and climate of trust, considering the patient in the context of their whole life, with all its complexities [13].

This freedom to talk about any topic during a consultation with a GP is vital for the patient to receive the relevant appropriate care [1, 3]. Careful analysis of what the patient says can help the GP to detect any difficulties, or alert signals, and to initiate appropriate care or preventive measures. Furthermore, if the patient holds back certain information (either voluntarily or involuntarily), this could potentially be the cause of adverse events. Indeed, in France, there are an estimated 26 care-related adverse events per 1000 general practice encounters [14], and misunderstanding between the GP and the patient is one of the leading causes [15]. Medical errors, whether serious or not, inevitably alter the quality of the doctor-patient relationship [16], but it is precisely this relation of trust that breeds confidence, which in turn is the basis for a lasting therapeutic relationship [17].

In a study performed in the USA, Levy et al. reported in 2018 that up to 81.1% of patients avoided disclosing at least one type of information during an encounter with a clinician [18]. Embarrassment, modesty and a fear of being judged were among the reasons cited for failing to disclose. External factors, such as the duration or nature of the relation with the physician, or the atmosphere of the consultation have also been shown to be associated with unvoiced issues [18–20].

In this context, the objective of this study was to investigate factors associated with unvoiced concerns of patients during a GP consultation, because of embarrassment, modesty or a fear of being judged.

Methods

Study design and population

A cross-sectional, observational, prospective questionnaire study was conducted in France between 10 December 2023 and 12 January 2024. The questionnaire was distributed on the social networks LinkedIn® and Facebook®. A paper version was also distributed to nine GP surgeries and one pharmacy of the *Champagne-Ardenne* region. We included individuals aged 18 years or older who consented to participate in the study. We excluded anyone aged < 18 years, persons under any form of legal protection, and those who refused to consent.

Data collection

The questionnaire, developed specifically for this study, comprised 21 questions divided into 3 sections (additional file 1). The first section collected socio-demographic data, namely: age, sex, level of education, religious identity, and sexual orientation. The second part asked the respondent report the characteristics of their GP. Sex and estimated age of the GP (younger than the participant, about the same age of the participant and older than the participant) were asked as demographic similarities between patient and GP could facilitate patient-GP communication [21, 22]. Participants were also asked whether, to their knowledge, the GP had any specialized training (gynecology, addictology, palliative care, psychiatry) as it can be easier for patients to express their medical information when they know their doctor is qualified in this field [23]. How long the patient had been a patient of the GP and number of consultations the respondent had had with the GP in the previous year were also questioned as seeing the same doctor over a long period of time helps to develop and maintain the patient-GP relationship [24]. Participants were asked to give their perception of the type of relationship they have with the GP (relation of trust, neutral, often disagree,

conflictual relationship) because patients' trust in the GP, notably in his or her medical competence and expertise, is an important aspect of the patient–GP relationships [24–26]. The average duration of a consultation was collected as lack of time can limit communication between patient and GP and it's important that patients do not feel rushed [24, 27]. The fact that the same GP follows the participant's family (spouse, children, parents…) was questioned because it is necessary for each family member to be convinced that medical confidentiality will be respected and that he or she can broach all subjects without hesitation or fear of judgment [28].

The third section related to the unvoiced concerns during consultations, because of embarrassment, modesty and/or fear of being judged, as well as the factors potentially driving these unvoiced concerns; the topics that were affected (mental health problems, sexual life, alcohol consumption, drug consumption, smoking habits, abuse/harassment, eating disorders, end-of-life, alternative medicine…); whether the participant preferred to consult another GP or a locum to address these topics; potential obstacles to open discussion (e.g. presence of a student with the GP, presence of a family member during the consultation, GP late or behind schedule); and factors conducive to more open discussion (GP reminds that everything is kept confidential, GP addresses the subject first).

Ethical considerations

Participation in the study was voluntary. The message distributed on social networks explained the aim and the method of the study. Subjects interested to participate in the study clicked on a link directing them to an information note explaining precisely the scientific context of the study, the aim of the study, the participation in the study via a questionnaire to be completed and setting out all participants' rights. After this complete information, subjects had to agree to take part (by answering "yes" to the question "I accept to participate in the study") in order to complete the questionnaire. All participants have consented to complete the questionnaire and thus to participate in the study. Informed consent to participate was obtained from all of the participants in the study. The study was approved by the Ethics Committee "Comité de Protection des Personnes Sud-Est II" (Lyon) on 06 September 2023 and was approved by the national data privacy commission (Commission Nationale de l'Informatique et des Libertés, CNIL) on 16 November 2023. The study was registered with ClinicalTrials.gov under the identifier NCT06130605. The questionnaire was constructed and distributed using LimeSurvey®. All recorded data were anonymous, and data management was in compliance with current French legislation governing nominative personal data, the General Data Protection Regulation (GDPR) of the European Union.

Statistical analysis

All questionnaires were used in the statistical analysis, whether complete or incomplete. Considering the descriptive nature of the study's main objective and the low proportion of missing data (not exceeding 5%), no data imputation was performed.

Continuous variables are expressed as mean ± standard deviation (SD) or median and interquartiles. Categorical variables are expressed as number and percentage. Comparisons were performed using the Student t or Mann–Whitney U test for continuous variables, and the chi square or Fisher's exact test for categorical variables.

The factors associated with unvoiced concerns during GP consultations, because of embarrassment, modesty and/or fear of being judged were investigated. Factors associated with these unvoiced concerns with a p-value < 0.20 by univariable analysis were included in a multivariable logistic regression model. Results are presented as odds ratios (OR) and 95% confidence intervals (CI). A p-value < 0.05 was considered statistically significant. All data were analysed using SAS version 9.4 (SAS Institute Inc., Cary, NC).

Results

In total, 2104 participants were included. The characteristics of the study participants are described in Table 1. The mean age was 43.7 ± 15.9 years, the majority of respondents were female (73%) and had university-level education (79%). A total of 44.4% declared that they identified with a specific religious group. The vast majority (92%) reported being heterosexual.

Regarding the participants' GPs, 51% were men, 31% were described as younger than the respondent, 22% were the same age, and 47% were older; 69% were also their family's doctor. The GP-patient relationship was described as a relation of trust by 74% of participants.

Overall, a total of 680 respondents reported unvoiced concerns during consultations, because of embarrassment, modesty and/or fear of being (32%, 95% CI 30–34). The details of the unvoiced concerns are given in Table 2. The main causes of embarrassment, modesty, or fear of being judged were: "sexual behavior, libido, perception of your gender, erectile dysfunction, vaginal dryness" (15%); secondly, "psychological disorders, low mood, anxiety" (14%); thirdly, "urological or digestive problems" (9%), and "eating disorders, body image" (6%). Finally, 3% of participants reported restricted communication about the theme "violence, abuse, harassment".

Over one third (39%) of respondents reported that the length of time their GP had been following them did not

Table 1 Characteristics of the study population (*N* = 2104)

Variables	All (*N*=2104)
Age (years; mean ± SD)	43.7 ± 15.9
Female sex	1532/2098 (73)
Level of education	
– Did not finish school	36/2097 (2)
– Vocational qualification	221/2097 (10)
– High school diploma	189/2097 (9)
– University or higher	1651/2097 (79)
Identify with a Religion	928/2091 (44)
Sexual orientation	
– Heterosexual	1920/2097 (92)
– Gay or lesbian	61/2097 (3)
– Prefer not to answer	68/2097 (3)
– Other	49/2098 (2)
Sex of the GP	
– Man	1079/2099 (51)
– Woman	1020/2099 (49)
GP of opposite sex to respondent	1169/2093 (56)
GP's age	
– Younger than respondent	652/2098 (31)
– Same age as respondent	458/2098 (22)
– Older than respondent	988/2098 (47)
GP has additional qualifications in…	533/2104 (25)
– Gynecology	190/533 (36)
– Addictology	43/533 (8)
– Pain management – palliative care	47/533 (9)
– Psychiatry	28/533 (5)
– Nutrition	15/533 (3)
– Alternative medicine	47/533 (9)
How long have you been a patient of your GP	
– Less than 1 year	201/2097 (10)
– Between 1 and 5 years	676/2097 (32)
– More than 5 years	1220/2097 (58)
Number of consultations with the GP in the last year, median [interquartiles]	2 [1-4]
Duration of consultation with GP, minutes, median [interquartiles]	15 [15-20]
How do you qualify your relationship with your GP	
– Neutral	528/2099 (25)
– Relation of trust	1550/2099 (74)
– Often disagree	17/2099 (1)
– Conflictual relationship	4/2099 (0.2)
Is your GP also the GP of your family?	1452/2099 (69)

SD Standard deviation, *GP* General practitioner

influence the respondents' propensity to address intimate or embarrassing subjects; 37% were more comfortable addressing intimate or embarrassing topics with a GP they knew for a long time, while almost one quarter (24%) reported feeling more comfortable discussing such topics with a GP they would never see again. Among all respondents, 18% reported having taken advantage of the presence of a locum, or having consulted another GP to address an intimate or embarrassing subject. The presence of a family member during the consultation was reported as an obstacle by 69%, and the presence of a student with the GP by 43%. Conversely, hearing the GP's reassurance about professional secrecy would make it easier for 47% to broach intimate or embarrassing topics, while 78% would feel more at ease discussing such topics if the GP brought up the subject first.

The results of the multivariable analysis identifying factors associated with unvoiced concerns during a consultation with a GP are detailed in Table 3. Female (79% versus 70%; aOR = 1.5 [1.2–1.9]; $p < 0.001$) and university-level education (83% versus 77%; aOR = 1.3 [1.05–1.7]; $p = 0.019$) were associated with more frequently unvoiced concerns. Conversely, heterosexuality (90% versus 92%; aOR = 0.7 [0.5–0.98]; $p = 0.036$) and having a relationship of trust with the GP (66% versus 78%; aOR = 0.6 [0.5–0.7]; < 0.001) were the two factors associated with less frequently unvoiced concerns.

Among women ($n = 1532$), 240 (11%) declared that they refrained from addressing questions on the topics of "sexual behavior, libido, perception of your gender, erectile dysfunction, vaginal dryness", and this was unrelated to the sex of their GP ($p = 0.79$) or the GP having additional qualifications in gynecology ($p = 0.41$).

Discussion and Conclusion

Discussion

In this study of over 2,000 participants, almost one third (32.3%) reported unvoiced concerns during GP consultation because of embarrassment, modesty or a fear of being judged. In the literature, the fear of judgement is one of the leading causes for non-disclosure of medical information during a medical consultation, accounting for up to 81% of cases, while being embarrassed accounted for up to 60% of cases of non-disclosure [18]. In 2001, a study from the United States showed that after a visit to a GP's office, approximately 9% of patients interviewed had one or more unvoiced desires [29]. The difference in prevalence of unvoiced concerns could be explained by the fact that in that study, the participants were surveyed before and after one specific GP consultation, whereas in our study, respondents were asked to report whether they had ever had concerns unvoiced concerns at any time during their life. Studies about unvoiced concerns in France and neighboring European countries have mainly used qualitative method, which do not allow prevalence to be calculated.

The themes that were most likely to be at the root of a unvoiced concern during GP consultation were genital

Table 2 Unvoiced concerns during a consultation with the GP due to embarrassment, modesty or a fear of being judged

	All (*N* = 2104)
Participants who have, at any time, failed to address topics with the GP	680/2104 (32)
Issues not addressed because of embarrassment, modesty or fear of being judged	
– Psychological disorders, low mood, anxiety	291/2104 (14)
– Sexual behavior, libido, perception of your gender, erectile dysfunction, vaginal dryness	316/2104 (15)
– Urological or digestive problems	194/2104 (9)
– Sexually transmitted infections, extra-marital relations	61/2104 (3)
– Alcohol consumption	55/2104 (3)
– Drug use	21/2104 (1)
– Smoking	33/2104 (2)
– Violence, abuse, harrassment	52/2104 (2)
– Eating disorders, body image	132/2104 (6)
– End-of-life, serious diagnosis, advance directives	14/2104 (1)
– Alternative medicine	51/2104 (2)
– Conflict with employer or other, work-related problems	60/2104 (3)
– Pain and chronic problems, fear of hypochondria	8/2104 (0.4)
– Affection evoking lack of hygiene	3/2104 (0.1)
Participants would feel more at ease discussing intimate or embarrassing topics with	
– A GP you have known for a long time	766/2075 (37)
– A GP you don't know well, or will probably never see again	504/2075 (24)
– No preference	805/2075 (39)
Participants who reported taking advantage of the presence of a locum, or consulting another GP to discuss embarrassing issues	388/2104 (18)
Obstacles to addressing embarrassing issues	
– Presence of a student during the consultation	903/2104 (43)
– Presence of a family member during the consultation	1449/2104 (69)
– The GP's waiting room was full	364/2104 (17)
– The GP is behind schedule	508/2104 (24)
– None of the above	347/2104 (16)
Participant would feel more at ease if the GP reminded about confidentiality	989/2104 (47)
Participant would feel more at ease discussing these issues if the GP raised them first	1638/2104 (79)

Data are number (%) calculated among available answers

or sexual sphere (14.8%), and mental health (13.8%). This finding is in line with a previous French study by Hesschentier et al. in 2019, showing that 30% of their respondents reported feeling ill at ease discussing sexuality in a consultation with the GP, while 20% were ill at ease discussing mental health, and this discomfort could result in these topics not being discussed with the GP [30]. Sexuality is undoubtedly the most common taboo subject, and revealing such an intimate side of one's personality to the GP can be complex and intimidating. The fear of being judged for sexual practices that may not fall within what society considers as the norm, can be a reason for non-disclosure. Furthermore, raising the topic may prompt a clinical examination requiring the patient to undress, and very modest people may refrain from addressing such topics for fear of the examination that may follow.

It is important for patients to address mental health issues without taboo during primary care consultations. In a study published in 2020, Jerant et al. reported that delivering a tailored intervention designed to encourage middle-aged men to discuss suicidal thoughts with their GP significantly increased the likelihood that they would actually discuss this traditionally taboo topic [31], thereby facilitating detection of suicidal patients, and enabling initiation of appropriate antidepressant therapy. It is also important for GPs to seize opportunities during consultations to engage with patients about their mental health, especially in the presence of recurrent, medically unexplained symptoms (e.g. pain or asthenia). This is a relatively frequent situation, estimated to represent between 3 and 10% of adult consultations in primary care [32]. Addressing the topic of mental health in patients with somatic manifestations of psychological distress can often reveal psychological disorders [33].

Unvoiced concerns about the topics of violence, abuse and harassment were reported by only 2.5% of

Table 3 Univariable and multivariable analysis of the factors associated with unvoiced concerns during a consultation due to embarrassment, modesty or fear of judgement

	Restricted communication		Uni- variable		Multivariable analysis	
	Yes (*N* = 680)	No (*N* = 1424)	Crude OR [95% CI]	*P*	Adjusted OR [95% CI]	*P*
Age, mean ± SD, years	42.2 ± 15.9	44.4 ± 15.8	0.98 [0.97–0.99]	0.003	NS	NS
Female sex	533/678 (79)	999/1420 (70)	1.5 [1.2–1.9]	< 0.001	1.5 [1.2–1.9]	< 0.001
Level of education = university or higher	560/679 (82)	1091/1418 (77)	1.4 [1.1–1.8]	0.004	1.3 [1.05–1.7]	0.019
Identify with a religion	273/677 (40)	655/1414 (46)	0.8 (0.6–0.9)	0.009	NS	NS
Heterosexual	609/679 (90)	1311/1419 (92)	0.7 (0.5–0.9)	0.038	0.7 [0.5–0.98]	0.036
GP of opposite sex to respondent	368/676 (54)	801/1417 (56)	0.9 [0.8–1.1]	0.37	-	-
GP older than respondent	346/680 (51)	642/1418 (45)	1.2 (1.1–1.5)	0.016	NS	NS
How long have you been a patient of your GP				0.93		-
– Less than 1 year	66/679 (10)	135/1418 (9)	1.00 (ref)		-	
– Between 1 and 5 years	215/679 (32)	461/1418 (32)	0.9 [0.7–1.3]		-	
– More than 5 years	389/679 (59)	822/1418 (58)	1.0 [0.7–1.4]		-	
Number of consultations with the GP in the last year, median [interquartiles]	2 [1-4]	2 [1-4]	1.0 [0.9–1.1]	0.06	NS	NS
Duration of consultation with GP, minutes, median [interquartiles]	15 [15-20]	15 [15-20]	1.0 [0.9–1.1]	0.12	-	-
Relation of trust with GP	447/679 (66)	1103/1420 (78)	0.5 (0.4–0.7)	< 0.001	0.6 [0.5–0.7]	0.001
GP also follows respondent's family	466/680 (68)	986/1424 (69)	0.9 [0.8–1.2]	0.74	-	-
GP has additional qualifications	168/680 (25)	365/1424 (26)	0.9 [0.8–1.2]	0.65	-	-

SD Standard deviation, *GP* General practitioner, *CI* Confidence interval, *NS* Non significant

Data are number (%) unless otherwise indicated. Number and % calculated among available data

the population, and do not seem to be taboo subjects for the patients in this study. Domestic violence and sexual abuse are the topics least frequently addressed among the taboo subjects during gynaecological consultations performed by GPs [34]. The failure of GPs to address this theme is worrying, considering that approximately 295,000 individuals are victims of domestic violence every year in France [35]. Yet, one report undertaken by the French national health authority reported that 96% of female patients would like their GP to screen for these problems [36]. Indeed, since 2022, the French national health authority recommends systematic screening for domestic violence during GP consultations, and offers solutions for making it easier for GPs to raise the issue, such as including a reminder about the need for screening in the electronic medical record, or proposing self-report questionnaires prior to the consultation to create an opportunity for discussion [37]. However, many GPs may refrain from addressing the issue of domestic violence more because they are afraid they will have no solution to offer, than because no financial reward for this additional component is included in the reimbursement for the consultation. Accordingly, other solutions, such as the creation of a specific management pathway for women who are victims of domestic violence, and the distribution of guidelines and practical information leaflets [36] may better meet the GPs' needs in this regard.

The presence of a third party during a GP consultation can act as a barrier to communication between patient and doctor. In this study, the presence of a medical student constituted a barrier to patient-GP communication for 43% of participants, and 69% of participants stated that the presence of a family member constituted a barrier to communication between patient and GP. In both these situations, the presence of a third party increases the patient's exposure to feeling judged, and further limits his ability to discuss a sensitive subject with his GP. It is not known whether or not the patient's trust in the GP, which is an important element of the patient-GP relationship established over time [24] would limit the brake associated with a medical student's participation in the consultation. The presence of a family member limits the discussion of certain health problems such as sadness, suicidality, substance abuse or sexuality [28]. On the other hand, the family member is sometimes the one who brings up a subject that the patient was unable to verbalize. In all cases, it seems preferable to systematically offer the patient a consultation time without a companion or student.

In our study, female sex was associated with unvoiced concerns during GP consultation due to embarrassment, modesty or a fear of being judged, and this finding is in line with the existing literature [18]. A deeply-rooted culture of societal injunctions and patriarchal control restricting women's freedom of expression, and their right to control their own body could be one possible explanation for this association. Conversely, sex discordance between patients and GP has previously been reported in the literature to be an obstacle to women discussing embarrassing topics [10, 38], but this finding was not replicated in our study. Similarly, identification with a religious group, which the collective thinking may sometimes associate with modesty, was not significantly associated with the propensity to address embarrassing or intimate topics in our study. The absence of associations on these two aspects could be related to the French healthcare system, where patients are free to choose any GP, notably their preferred GP in terms of gender and/or cultural concordance [39, 40].

We also found that having a university-level education was associated with unvoiced concerns during GP consultation. Further investigations are warranted to explore this association in greater depth. One possible explanation could be that people with less education have less social privilege, which might be associated with fewer resources to support needs related to the issues they are more willing to bring up to their GPs. People with less privilege also stand to lose less in terms of perceived respect from others, and are therefore more likely to risk losing additional respect.

In our study, not being heterosexual was associated with unvoiced concerns during a GP consultation due to embarrassment, modesty or a fear of being judged. Indeed, the fear of being judged because of sexual orientation, or belonging to a minority, can be a cause of non-disclosure for some people [41]. The EGaLe-MG study analysed more than 3,200 responses from not heterosexual persons and reported that more than one in ten respondents interpreted a refusal of care (refusal to examine or prescribe screening examinations) as being linked to their sexual orientation. Furthermore, 44% of men and 57% of women feared being judged if they disclosed their sexual orientation to their physician [42]. Yet, sexual orientation and practices are key components of the medical history taking during a medical encounter. There are certain specificities for the LGBTQIA + community, notably in terms of prevention of sexually-transmitted infections [43], but also in terms of mental health issues, body image [44], and questions relating to access to procreation and contraception. It is therefore of paramount importance for healthcare providers to defuse this fear of judgement as early as possible, as it could affect the quality of care through non-disclosure of important information. Asking about sexual orientation during the first encounter could be one possible solution. Indeed, GPs must feel at liberty to address the topic of sexuality. It would seem that asking about gender identity or sexual orientation is more of a fear for the GPs (up to 80%), who are afraid of offending their patients, whereas only 11% of patients actually report taking offense [9].

Having a relationship of trust with the GP was associated in our study with a reduced risk of unvoiced concerns due to embarrassment, modesty or fear of judgement. A feeling of trust in one's GP, which is both a subtle and subjective feeling, is nevertheless a recurrent theme in the literature. A lack of trust in the physician has previously been reported as a source of unvoiced concerns during consultations [29]. The concept of a "relationship of trust" is complex, multifactorial and difficult to quantify. Correct diagnoses and prescription of efficacious therapy undoubtedly contribute to a feeling of trust and confidence in the GP. However, there are other, more subjective dimensions, and feelings that may be unique to each patient based on their previous experiences, character, social milieu, and education, which, collectively, may result in a feeling of trust being perceived vis-a-vis one individual but not another. Previous studies have even suggested that there may be a therapeutic effect to be yielded from this human connection and the positive perception of the doctor-patient relationship [27].

The main limitation in this study is the potential for selection bias, with an overrepresentation of women and highly educated individuals, which may be explained by the use of social media to recruit participants. Moreover, the embarrassment, modesty or fear of being judged, that are grouped together in this study, have different underlying social significance and other studies will have to complete this results in order to analyse in greater details these three reasons for unvoiced concerns. In this quantitative study, causes of unvoiced concern were broad categories as "sexual behavior, libido, perception of one's sex, erectile dysfunction, vaginal dryness" covering the whole genital and sexual sphere or "Psychological disorders, low mood, anxiety" covering the "psychological and psychiatry sphere". The term "homosexual" has been replaced by the more culturally appropriate terms "gay or lesbian" in the present article. Finally, the record of sex as a binary variable "male" or "female" and not recording gender identity is a limitation of this study, even if respondents were given the option of identifying themselves as "other" and specifying this.

Conclusion

In this French study, one third of respondents reported unvoiced concerns with their GP due to embarrassment, modesty or a fear of being judged. An enhanced understanding of the factors associated with unvoiced concerns during a consultation could help GPs to be more attentive to certain groups of patients or certain situations at risk of unvoiced concerns, with a view to identifying and defusing them more easily. Moreover, simple tools that could be used during primary care consultations could help to address sensitive issues and create an environment where patients can more comfortably address all their health issues without discomfort, such as systematically offering the patient alone consultation time and reminding the confidentiality of exchanges.

Practice implications

There is a clear expectation on the part of respondent patients for the GP to raise these subjects first. The creation of practical tools that could be easily implemented in general practice, could help GPs to guide discussions towards sensitive topics.

Abbreviation

GP General Practitioner

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12875-025-02804-2.

Supplementary Material 1.

Authors' contributions

Clémence Laurent contributed to: study conception and design, data collection; interpretation of results; drafting of the article. Aline Hurtaud contributed to: interpretation of results; drafting of the article. Leïla Bouazzi contributed to: statistical analysis of the data. Emilie Thery Merland contributed to: study conception and design, study supervision; interpretation of results and drafting of the article. Coralie Barbe contributed to: study conception and design, study supervision; methodology; project administration; interpretation of results; drafting of the article. All authors read and approved the final version of the article.

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Data availability

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Participation in the study was voluntary. The message distributed on social networks explained the aim and the method of the study. Subjects interested to participate in the study clicked on a link directing them to an information note explaining precisely the scientific context of the study, the aim of the study, the participation in the study via a questionnaire to be completed and setting out all participants' rights. After this complete information, subjects had to agree to take part (by answering "yes" to the question "I accept to participate in the study") in order to complete the questionnaire. All participants have consented to complete the questionnaire and thus to participate in the study. Informed consent to participate was obtained from all of the participants in the study. The study was approved by the Ethics Committee "Comité de Protection des Personnes Sud-Est II" (Lyon) on 06 September 2023 and was approved by the national data privacy commission (Commission Nationale de l'Informatique et des Libertés, CNIL) on 16 November 2023. All methods in this study were carried out in accordance with Declaration of Helsinki on human research participants.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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