Diagnosing menstrual disorders: a qualitative study of the approach of primary care professionals

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SUMMARY

Background: *Menstrual disorders are a common presentation in primary care. Wide variations in management as well as discordance between patient and practitioners in relation to presenting problems have been described.*

Aims: *To explore the model of menstrual disorders used by practitioners in practice.*

Design of study: *Semi-structured interviews with primary care practitioners.*

Setting: *One inner London health authority area.*

Method: *Constant comparative analysis.*

Results: *Medical practitioners were critical of the guidance provided by gynaecological definitions and texts. Practitioners put more emphasis on defining normality than on defining disorder. Practitioners used a wide range of criteria to judge their patients' complaints and decide on a course of action. Female practitioners had access to personal and professional experience and used this to develop an understanding of women's complaints. Male practitioners in particular were limited by problems in discussing menstruation in detail. Because of the difficulties in assessing patient history, other non-gynaecological factors such as patient age and consulting behaviour informed practitioners' judgements.*

Conclusion: *This study draws attention to practitioners' problems in using current definitions of menstrual disorders. The combination of unhelpful medical definitions, lack of standards of normality and difficulties in discussing menstruation resulted in individual practitioners making judgements in idiosyncratic ways. In the absence of a useful gynaecological model, practitioners develop individual, often subjective and gendered models to use in practice.*

Keywords: *diagnosis; gynaecology; menorrhagia; menstruation; primary health care.*

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Introduction

THE management of menstrual disorders in primary care has attracted increased attention over the last decade. This has been in part due to the high cost of treatment of these disorders.[1] Menorrhagia, or heavy bleeding, has been the main focus of this attention. Widespread variation in management of menorrhagia in primary care has been demonstrated[2] and efforts have concentrated on improving prescribing practice.[3] There is evidence, however, that in the case of menorrhagia diff-iculties for practitioners may lie not in lack of knowledge about treatments,[2,3] but in the conceptualisation and assessment of the disorder.[4]

The diagnosis of menorrhagia is treated as unproblematic in advice to practitioners in the United Kingdom (UK). Guidelines suggest that a history of heavy cyclical loss over several consecutive cycles is required, but the definition of how heavy is unclear.[5] Similarly, advice for practitioners suggests they ask questions about clots and flooding, but how the replies to these questions should be interpreted is usually not elaborated.[6] Warner and colleagues have questioned practitioners' labelling of menstrual disorders in general.[4] In a study of referrals to gynaecology clinics, they found significant discordance between patients' own accounts of their menstrual problem and the reasons cited for referral in practitioners' letters. Among those who did not report heavy bleeding as a severe problem or as a reason for seeking help, 63% had bleeding as a reason for referral in the practitioner letter. Discordance in the other direction was found for complaints of pain and patients reporting pain as severe but practitioners not reporting pain as a reason for referral. One interview study with general practitioners (GPs) explored how GPs assess women complaining of heavy periods.[7] Most responders reported attempting to assess blood loss using a standard medical history, with a minority, particularly male GPs, more likely to report that they regarded actual blood loss as less important than women's complaints of a problem. Practitioners rejected the use of objective tests of blood loss volume, but how the standard medical history was applied was not probed.

This paper reports on the results of a qualitative study of primary care practitioners' approaches to menstrual disorders. The aim of the study was to uncover the models of menstrual disorders used by primary care practitioners in everyday practice. The premise to the study was that practitioners' models may differ from scientific models,[8] but that attention to those everyday practice models is necessary to understand the outcomes from primary care consultations.

HOW THIS FITS IN

What do we know?

Widespread variation in the investigation and treatment of menorrhagia has been described in primary care. Guidelines and advice articles have aimed to improve practitioners' prescribing practice, but there is growing evidence that problems for practitioners lie in the conceptualisation and assessment of menstrual disorders.

What does this paper add?

The practitioners interviewed in this study found gynaecological definitions and texts unhelpful. Many were limited in their ability to discuss menstruation in detail by the lack of an appropriate vocabulary. Practitioners therefore used a variety of often idiosyncratic criteria to assess patients, with female practitioners informing their judgements by personal and professional experience.

Table 1. Characteristics of interviewees.

Characteristic	Data
General practitioners	
Registrars	
Female	2
Male	1
Principals	
Female	3
Male	7
Practice size (principals)	
Single-handed	3
Group practice	7
Time qualified (years)	8–33
Nurses	
Nurse practitioners with interest in women's health	2
Practice nurses	3
Family planning nurses	2
Community gynaecologists	1

Method

The study was conducted in one health authority area in 2000–2001. An initial strategy of maximum variation sampling was used. A variety of primary care practitioners may be consulted by women concerned about menstrual symptoms. Within general practice this includes practices nurses as well as GPs; outside general practice, nurses and doctors working in family planning clinics may also be consulted. Previous work indicated that women did choose to consult these other practitioners as well as or in preference to their GPs.[9] Maximum variation sampling aimed to include practitioners with differing experiences.[10] Initial sampling characteristics were professional qualification(s), sex, and type of practice. Practitioners with an interest in women's health and those without an interest were recruited. An attempt was made to include practitioners from different settings such as group or single-handed practice, family planning clinics, and those where the availability of female practitioners varied. As the interviews and data analysis progressed, length of time qualified emerged as an important characteristic, as the approach of practitioners developed according to their experience of community practice. Sampling was then directed to testing out the validity and scope of the emerging analysis. Details of GPs were available from primary care groups, and details of nurses from local nursing groups. Practitioners were targeted according to their characteristics and were first sent an introductory letter, followed by a telephone call. Recruitment continued until categories were saturated. Twenty-two primary care professionals were interviewed and their characteristics are listed in Table 1. No male nurses were located working in the targeted settings.

The interviews were taped and transcribed and constant comparative analysis was used to develop categories and themes.[11] The coding scheme was developed and agreed by discussion between the authors and the analysis conducted. NVivo was used to organise the developing analysis.

The subject of the interview was introduced as practitioners' experience of treating menstrual disorders in practice. Topics raised with practitioners included whether or not they saw women with menstrual problems, their approach to those women, and any difficulties they experienced in managing menstrual problems. Practitioners were encouraged to relate actual experiences of patient care and were free to raise any issues they considered important. 'Menstrual disorder' was used as a more generic description to allow practitioners' own definitions to emerge.

Formal ethical approval for the study was not sought. Information about the identities of practitioners was available in the public domain and the same potential for inequality between researcher and researched does not exist. All interviewees were assured of anonymity in any reports or publications of the findings.

Results

The interviews confirmed difficulties for practitioners in the diagnosis of menstrual disorders. Medical definitions were criticised as unhelpful in day-to-day practice. In the absence of useful gynaecological models, practitioners developed their own working models of menstrual disorders using their personal and professional experience.

Inadequacy of medical definitions

When asked about their approach to assessing menstrual disorders, GPs responded by using gynaecological terms such as dysmenorrhoea and menorrhagia. They described separate disorders of pain, blood loss and timing. Many automatically focused on heavy bleeding and were aware of the objective medical definition of menorrhagia as the loss of more than 80 ml of blood per period. Some of the interviewees recalled attempts to grapple with the objective definition by attending conferences or consulting gynaecological texts, but such definitions were ridiculed:

> *'I went to the college earlier this year and the president of the Royal Colleges of — this is Obs and Gynae — spent his whole life weighing tampons, as far as I can see and so he decrees that 80 g or whatever it is, or 80 ml, he's got all these graphs and weighed tampons*

and so there's no doubt, in his mind, there is a biomedical threshold at which you are, you know, "you're not having heavy periods, my dear".' (GP2, male.)

Practitioners were hesitant to reject gynaecological definitions outright. Some tempered their expression of the inadequacy of biomedical definitions by casting doubt on their own levels of understanding and knowledge. If only they could find the right book or piece of information, they could make sense of gynaecology:

'In fact, just yesterday, I got [another doctor] *to go into Foyle's, to get a basic book on gynaecology again, you see, because I just want to go over that again, to make sure I understand.'* (GP11, male.)

Other interviewees were critical of the lack of understanding of everyday general practice they perceived in guidelines and texts:

'... they say "oh we're really worried because some GPs are not doing the basics", and then they produce texts that are quite demeaning.' (GP1, male.)

Texts did not provide enough information with which to judge normality and were also seen as being unable to explain or help practitioners treat the problems they encountered in their clinical practice. Difficulties included the texts' lack of acknowledgement of the possible variability of cycles, and the poor predictive power of symptoms.

Despite these difficulties, practitioners continued to describe their practice using the standard Greek terminology. Greek terms were used interchangeably with English terms, and an interviewee could, for example, discuss attempts at diagnosing menorrhagia while simultaneously ridiculing the medical definition.

'Normal' periods

Practitioners, both medical and nursing, reflected on what might constitute a 'normal' period. How normality was defined was more prominent in accounts than how disorder was defined. Accounts regarding normal periods were not distinguishable by profession but were distinguishable by sex. Both male and female practitioners found it difficult to define a 'normal' period:

'... the problem is people tend to say what they think, because there aren't sort of strict views on what is a normal heavy period, what's a heavy period, what's a normal period.' (N3, female family planning nurse.)

Despite being unable to define normality clearly, female practitioners made judgements about women's complaints. The criteria they used were various and related to both personal and professional experiences. One female GP admitted using her own menstrual cycle as the starting point from which to judge the patient's complaint. Others reported gaining knowledge of what constituted a normal spectrum from their female friends and from their clinical work:

'I think it's through mostly personal experience of what my own period is like, yeah, and also when you talk to friends and because of the job we do, then we talk to other people.' (N1, female practice nurse.)

Nursing staff were aware that they lacked medical knowledge and were more likely to defend their approach. The practice nurse quoted above supported her approach by referring to the knowledge that commercial companies must hold. She presumed that sanitary protection was packaged according to average use by women:

'... it's just my own observation, if heavy periods were the norm, sanitary towels wouldn't come in packs of ten, they'd come in packs of fifty, like nappies.' (N1, female practice nurse.)

Female practitioners considered it appropriate to question why a patient considered her period a problem. Male practitioners were less likely to challenge women. Although one male practitioner felt his personal experience as a married man had given him some knowledge, he admitted he had no clear idea of how to judge normality. Explicit in the accounts given by men was the knowledge that subjective experience is used by practitioners, and that male and female practitioners might make different judgements according to sex:

'... 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.' (GP6, male.)

Discussing periods in detail

All practitioners reported that they would ask patients a standard medical history. When their accounts were probed, male and female doctors differed in the detail of history they sought. When talking about their approach to eliciting information from patients, practitioners used terms like 'flooding' and 'clots'. Interviewees recognised that patients may not understand these terms. Female practitioners were prepared to talk in detail about pads, tampons, and blood loss, but male practitioners were less likely to report asking about such detail. They defended this approach by indicating that women's reports were not necessarily reliable or not the most important part of the patient's complaint. The frequency of changing was thought to be a reflection of the fastidiousness of the patient rather than of blood loss. Male doctors' inhibitions about the questioning of their patients appeared to be recast as a problem created by the behaviour of women.

Interviewer: *'Do you ask questions about how heavy the bleeding is, in terms of using pads and tampons?'*

GP: *'I don't, no, you know how, because some women will change the pad when it's absolutely soaking, and some women will change the pads, you know, it's not very conclusive proof.'* (GP13, male.)

By contrast, although female staff recognised the same issues about fastidiousness, their approach was to ask for more specific information about use of sanitary material. The practice nurse in the same practice as the quoted above (GP13) explained how she would elicit detail about the degree of soaking of pads from her patients:

'... well, you've got a pad this shape, this big, how much of that is covered?' (N7 female practice nurse.)

Traditionally, medicine has used ordinary objects as comparisons when estimating size and volume. In gynaecology, blood loss and clot sizes have been estimated using comparisons with the size of coins and standard measures. These methods were discussed by the both male and female interviewees with some derision, and accepted as not being useful in their clinical practice:

'... you were trying to find out how many days the bleeding was going on for, it was how many pads, the old clots and flooding thing that always comes out, and a lot of people look at you in disbelief "what do you mean ...?", you know because these are words that doctors use and think they're sort of understood, and I remember being taught to actually ask about the size of clots as well, "is it a 50p or is it ...?", I'm afraid I don't do that often.' (GP6 male.)

The ability and willingness of female practitioners to question women in detail about periods further informed their approach. They had learned through experience that such detailed questioning could result in a different view of the patient's complaint than when the patient's complaint was accepted at face value. This experience encouraged them to continue probing women's accounts:

'I mean I'd take a pretty detailed history because an awful lot of it turns out to be nothing.' (GP8, female.)

Rules of thumb

'Rules of thumb' are heuristics that guide choices under uncertainty and time constraints.[12] The difficulties in communication and the lack of direction provided by gynaecological texts increased practitioners' dependence on often idiosyncratic 'rules of thumb' to guide their actions. Both female and male practitioners used 'rules of thumb', but female practitioners were able to use their 'rules of thumb' in conjunction with the detail of menstruation they elicited from patients. Male practitioners were more likely to make their judgement about a patient primarily according to patient behaviour. They would, for example, interpret the patient's presentation in the consultation as indicative of a problem per se. The fact that a patient had taken the time to consult and that the patient interpreted her period as a problem was sufficient. A complaint of heaviness or of interference in the patient's life was taken at face value:

'... but generally no, I go according to what they say, "do you feel that your periods are heavy?" their periods are heavy, then that's sufficient for me.' (GP11, male.)

Female practitioners were sympathetic to individual women not finding their cycle acceptable but some expressly rejected an assessment made on patient behaviour alone as being too subjective:

'I mean I know you can ask about "is it socially convenient" and factors like that. I find that that can be sort of subjective to the person, so I try to sort of keep it more objective, something that we can sort of see clearly is a certain level of, you know, that's quite heavy.' (GP3, female.)

Although female practitioners had access to more detailed menstrual histories, the lack of clear criteria regarding normal and abnormal menstruation resulted in practitioners again using their own experience as a touchstone to decide on appropriate management:

'I wouldn't live with it.' (GP12, female.)

One male practitioner reported using patient characteristics such as previous consulting patterns and racial origin as the basis for deciding how seriously to take the patient's complaint. A patient whose complaint was not judged to be serious would not be examined or have any investigations done:

'When was the patient last seen and how often do they come, with what problems, if someone I haven't for 2 years comes and says, "Oh Doctor, I think I am bleeding heavily", immediately I think about the worst.' (GP10, male.)

Other practitioners categorised all patients with menstrual complaints by age, presuming a pregnancy-related problem in younger women and a menopause-related problem in older women. A history of change in menstrual experience was generally considered to be an important indicator of potential pathology.

Some tests were organised to support or refute a specific diagnosis such as a scan to provide confirmation of fibroids. Investigations were often directed by practitioners' specific 'rules of thumb', for example, a hormone profile on women over a certain age, or by a general non-specific screening approach. Blood tests, swabs, a smear, and a pelvic ultrasound scan were organised by some practitioners. The rationale for this approach was the difficulty in assessing symptoms and the lack of clarity provided by medical definitions.

Discussion

Scambler and Scambler speculated that because of the inadequacy of the medical understanding of menstruation, almost any menstrual complaint couched in an appropriate vocabulary of distress could be labelled a menstrual disorder.[13] These interviews provide evidence to support that view. Practitioners were critical of the lack of guidance provided by gynaecological texts, particularly the lack of information about standards of normality. In practice, practi-

tioners developed a variety of working models. Female practitioners used both personal and professional experiences to inform their models and allow them to form a judgement about women's complaints. The ability to discuss menstruation in detail gave them the means to probe women's complaints and also to learn from them. The working models developed are reflected in practitioners' 'rules of thumb'. In a focus group study of GPs, 'rules of thumb' for somatic complaints are described as axiomatic simplified medical knowledge, while rules for psychosomatic problems were formulated as expressions of individual experience and were followed by an explanation.[12] In this study the 'rules of thumb' used were more like the latter, reflecting the problems expressed with available medical knowledge. This study provides some explanation for the widespread variations in GPs' management of menorrhagia.[2] It suggests that such variation is not necessarily due to a lack of knowledge, but occurs because clinicians do not have available a useful model of menstrual disorder and use individual, often gendered, and subjective models in practice.

These findings arise from practitioners' self-reported behaviour and not from direct examination of consultations. Responses may have been influenced by the desire to be seen as competent practitioners, but the expression of considerable uncertainty does not support this. Most interviewees were aware of the medical background of the interviewer and this may have allowed them to discuss the reality of practice. If professionals were providing an account as to how they thought they should practice, the result would be that differences between professionals are actually greater than they appear here. The findings are however consistent with female patients' accounts of primary care consultations for menorrhagia, where women reported not having their problems explored, not being adequately assessed and not being given a coherent explanation or label for their symptoms.[9,14]

These findings add to those of Chapple *et al* who similarly found differences in approach according to sex of practitioner.[7] Practitioners themselves have identified issues of gender as important in discussing sexually transmitted infections.[15] The approach available to each group has advantages. Female practitioners have access to information from their personal and professional experience and are more able to talk about menstruation, but male practitioners may be more open to women's own complaints. The lack of guidance provided by gynaecological texts means, however, that these approaches are used instead of, rather than alongside, clinical assessment. Although the difference in account according to the sex of practitioner was clear, other factors such as length of experience influenced the expression of this. The interviewee with least primary care experience was a female GP registrar who reported her problems in applying gynaecological definitions, but had not yet developed alternative strategies. Some experienced male GPs acknowledged problems in assessing what was normal, but said they were at ease with discussing details of menstruation. Two practitioners involved in education expressed their views that many clinicians need to overcome issues of personal embarrassment to allow exploration of patients' complaints.

Practitioners' accounts of their practice support other evidence of problems with current gynaecological models. Although standard menstrual terminology was used by medical interviewees, their working models did not conform to gynaecological definitions. Neither did working models reflect increasing evidence of co-morbidity in women's menstrual complaints,[4,14] as these practitioners concentrated on separate disorders such as pain or bleeding. Wilson has commented on the use of biomedical discourse in referral letters even though that discourse may not be used in clinical practice.[16] The discordance found by Warner and colleagues[4] may arise either from a lack of detailed discussion between practitioner and patient, or from practitioners reframing the patient's account into gynaecological models. Research is required to develop models of menstrual disorders that more accurately reflect women's complaints. More patient-centred models would allow practitioners to respond more appropriately to women's presenting problems.

While more appropriate models of menstrual disorders would be helpful to women and their healthcare professionals, adequate attention to specific communication skills is also required. Menstruation is subject to social rules[17,18] and these findings suggest that practitioners' medical education does not necessarily overcome these social influences affecting detailed discussion about sensitive topics. A recent study on the use of information in decisions about surgical treatment for menorrhagia found that information alone did not influence women's decisions, but detailed discussion about women's values and preferences did.[19] The ability of practitioners to discuss women's experiences in detail can therefore have an effect on outcome. Nurses in practice may have a role in exploring women's menstrual experience. Nurses were not surprised to be interviewed, and reported experience of women consulting about menstrual problems. All nurses interviewed were female. Unlike their medically qualified colleagues the nurses were unencumbered by gynaecological definitions and used common sense ideas of menstruation to assess patients' accounts. Their role in assessment of women should be recognised and evaluated.

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