General practitioners and women with urinary incontinence

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SUMMARY

Background. *Urinary incontinence is a common problem for adult women. It results in a large financial and psychosocial cost. Much urinary incontinence goes unreported. Women with urinary incontinence can be successfully assessed and treated in general practice but studies have shown that many GPs manage the condition inadequately.*

Aim. *This study aims to examine GPs' awareness of urinary incontinence in women and their management of, and attitudes to, female urinary incontinence.*

Method. *A qualitative study was conducted with 21 GPs responding to semi-structured interviews. Thematic analysis was carried out on these interviews, with recurrent views and experiences being identified and grouped.*

Results. *The interviews of 11 male and nine female GPs were suitable for analysis. GPs were aware of the prevalence and under-reporting of urinary incontinence in women. Many were unhappy with their own management of the condition and with the management options available to them. Male GPs in particular were reluctant to carry out gynaecological examinations, and few GPs expressed enthusiasm for teaching pelvic floor exercises or bladder drills. Medications were frequently used but generally considered ineffective or intolerable. The services of both public health nurses and practice nurses were under-used, largely because of lack of training in this area. Although incontinence nurses were employed in the area, many GPs did not know of their availability and, of those who did, few referred to them more than infrequently.*

Conclusion. *This study demonstrates that many GPs avoid dealing with the problem of urinary incontinence in women and that they find it to be a difficult, chronic problem to treat. Specialist options seem not to be useful in general practice. The findings need to be explored in other GP settings.*

Keywords: women's health; urinary incontinence.

Introduction

URINARY incontinence in adults is a common problem, with prevalences ranging from 8.5% in one general practice study[1] to 41% in another general practice-based study.[2] A more recent study of women who had ever leaked urine reported a prevalence of 53.2%.[3]

Apart from the financial cost, more than half the women in one study said that their incontinence affected their work.[4] It also affects their ability to go walking or shopping, use public transport, or travel long distances, and for many their social life is affected.[3,5] Sufferers report feeling that it is their fault and come to hate their bodies because of it.[6] Although over a third of women admit to worrying about their incontinence,[3] up to two-thirds of sufferers with moderate or severe incontinence are not known to their GPs.[7-9] In one study, a quarter of the women involved waited five years from when their symptoms first became troublesome before seeking advice from a doctor.[4] In the same study of women undergoing assessment at a urodynamic clinic, 73% of women had failed to seek help because they hoped the symptoms would improve on their own, while 47% were too embarrassed to discuss the problem with their doctor.

When women do attend their doctor, studies have shown that GP management of women with urinary incontinence is suboptimal. Of women who had discussed their incontinence with their GP, 50% had not been assessed for over a year and 30% had never had any form of assessment.[9] Indeed, few GPs refer to the continence advisory service even when the accessibility and success of it has been well established.[10] Analysis of data from a MORI poll suggests that medication is often prescribed even though a clinical examination has not been carried out and a diagnosis may not have been made.[5]

Algorithmic methods have been described for the assessment and management of women with urinary incontinence and have shown that 60% of invasive investigative procedures carried out on elderly women with urinary incontinence could be eliminated with minimal loss of diagnostic accuracy.[11] Jolleys reported that 88% of women with stress incontinence had improved after 12 weeks of pelvic floor exercises, explained by a GP, and that 41% were totally cured.[12] Ninety-four per cent were satisfied with having a diagnostic label and treatment plan regardless of whether or not their incontinence was cured. The effect of urinary incontinence successfully treated by general practitioners has been maintained one year later.[13] Although health promotion clinics have become very popular in the recent past, few practices run continence clinics.[14] Nurses can readily be taught the skills necessary to assess and advise women with urinary incontinence[15] and, in the study by O'Brien *et al*, the use of these nurses resulted in the cure of, or significant improvement in, symptoms in 68% of women with urinary incontinence.[9]

According to the Consensus Conference on urinary incontinence in adults,[16] most health care professionals ignore the problem of urinary incontinence and provide inadequate diagnosis and treatment, yet on a literature search no study of health care professionals opinions' could be found. This study was developed to assess GPs' current management and attitudes to women with urinary incontinence.

Methods

It was decided to use a qualitative approach in order to gain a deeper understanding of GP approaches to the problem. Twenty-one GPs within the catchment of Sligo General Hospital in Ireland were interviewed. The subjects chosen were those GPs who were willing to participate. Also interviewed were the only incontinence nurse in the area (who is working solely as an incontinence nurse), the physiotherapist in Sligo General Hospital (who has a special interest in incontinence), and the two local gynaecologists. The views of the specialist groups were obtained to add diversity, corroborate the GPs' interviews, and give a more comprehensive view of GPs' attitudes towards, and

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knowledge of, women with urinary incontinence.

Interviews were conducted from January to March 1996, in the interviewees' surgery or office. Semi-structured interviews were carried out, covering various aspects of urinary incontinence in women. Although discussion was encouraged, few interviewees had much to say on incontinence outside the areas covered. Most interviews lasted approximately 20 minutes, ranging from 15 to 40 minutes.

The iterative qualitative research process of continual planning, data collection, and analysis was employed. This allowed the nature of the interview, and the questions asked, to be modified as various aspects of GPs' attitudes to women with urinary incontinence came to light. Following transcription of the tapes and familiarization with their contents, thematic analysis was carried out. This allowed for the recurrence of particular views or experiences and emerging issues to be identified and grouped (Box 1).[6] Each transcript was reviewed in relation to each theme. In keeping with qualitative methodology the range and depth of opinion was the focus for analysis, rather than the proportion of participants expressing particular views.

Results

Twenty-six GPs were approached for interview. Three declined: two because they didn't want to be recorded, one because of lack of time. One recorded interview was unintelligible owing to poor quality of sound, and GPs in the other two interviews were not interviewed as no new themes were emerging from the previous interviews.

GPs' estimates of the prevalence of urinary incontinence indicated a good knowledge of the size of the problem. For patients aged 50 to 70 years, prevalence was generally estimated to be in the 30% to 50% range, while for those over 70 years of age most GPs gave figures in the 50% to 70% range. Variation was greatest in the estimate of prevalence in women under 50 years of age, ranging from 5% to 75%. All reported that women rarely present with urinary incontinence as their primary complaint.

> My practice is predominantly geriatric so it's probably fairly prevalent; at least, I'd say 50%. That would be my feeling, but that doesn't mean that it's necessarily presented. I think a lot of women just grin and bear it, they use pads and various other things to keep comfortable (GP 9; male (M)).

Women were asked directly by the GPs if they suffered from incontinence when they presented with a gynaecological complaint, for smears or postnatally; older women complaining of skin problems were also asked, and two female GPs said they would ask directly if they repeatedly noted a smell of urine coming from a woman.

Emergent themes from the literature:

- Prevalence and presentation of women with urinary incontinence
- Resources available
- Assessment of women with urinary incontinence
- Management of women with incontinence
- Results of treatment
- Self-assessment of performance
- Ongoing education with regard to women with incontinence.

Emergent themes from interviews:

- Motivation of women to obtain treatment
- Roles of male and female GPs
- Management problems from GPs' perspectives
- Means of improving women's quality of life.

Box 1. Predetermined and emergent themes discussed with GPs in the study of incontinence.

> Probably (don't ask) as often as I should — increasingly because of this whole sexual thing in practice. If you're going to ask about it you're going to have to follow it up and it does involve a vaginal exam, and if you're as long in practice as I am you'll know the women who'll let you do a vaginal exam and the woman who won't (GP 9; M).

> It's a private kind of subject; you have to get them to talk freely and some of them are embarrassed. I spent up to two hours one day talking to a lady — she gave me her whole life history before she got on to the incontinence (incontinence nurse).

Male GPs in particular commented that women themselves were slow to do anything about the problem of incontinence; they appeared to accept it as a normal part of ageing and didn't believe there was anything that could be done about it. Female GPs, in general, thought women *were* motivated to obtain treatment, especially the younger women.

All interviewees put the taking of a detailed history at the top of their assessment procedure. One GP, one gynaecologist, the physiotherapist, and the incontinence nurse got the women to keep a record of when they were wet or when they went to the toilet. Four of the GPs volunteered that they would do an abdominal examination. The female GPs were quick to say that they would do a vaginal examination. Many of the male GPs were more hesitant. Few considered doing a more detailed physical examination but all said that they would rule out a urinary tract infection and five specified that they would check the urine for glycosuria.

> I don't always do a vaginal examination. I appreciate it's not good medicine, but it's what you think you can get away with at the time (GP 9; M).

> I do a urine analysis on all of them and an MSU, if it's indicated; it's definitely the most important thing I do in assessing them (GP 12; M).

Fifteen GPs said they would explain pelvic floor exercises to the women, but most added that they didn't have much faith in either their ability to teach them or in the exercises themselves. Lack of time, inability to adequately teach exercises, and lack of success with pelvic floor exercises were given as reasons for not teaching them. Thirteen GPs said they would make some effort at explaining a bladder drill or bladder retraining, two of whom (a man and women from the same practice) said they would use charts. All the non-GP interviewees stressed the importance of bladder retraining with frequency and volume charts.

> I'd advise on bladder retraining but my conviction about it isn't enough to make me a convincing educator (GP 5; F).

> I don't know how good I am but I will tell them.... It's an obsessive-type lady who's going to take these charts on board (GP 8; M).

All but one GP said they would use medications, generally as an initial measure, but satisfaction with them was practically non-existent.

> I use them but they're not terribly helpful. It's an index of how bad people are if they tolerate the side-effects (GP 5; F).

Although GPs felt their practice nurses should be involved in managing women with urinary incontinence, they didn't have a serious role in this area in any of the practices, primarily because of lack of training. Other measures used before referring outside the practice were to give the patients educational leaflets or the loan of a short video on urinary incontinence.

All GPs readily referred to the gynaecology department and expressed satisfaction with the service provided. Two GPs expressed a preference in referring to a urology department rather than gynaecology, and eight others said they would con-

sider urological referral but this is difficult for patients as there is no local urology service. All GPs also referred to the physiotherapy department, with varying satisfaction regarding accessibility and success of management. All interviewees in the specialist group stressed the importance of physiotherapy in the treatment of urinary incontinence and their satisfaction with the service provided.

> I have no faith at all in all these pelvic floor exercises and physio, and that's really feedback from patients and my own gut feeling about it. I feel it's a lot of effort with little results... (GP 18; M).

Although, when questioned, 13 of the GPs said they might occasionally consider referral to the public health nurse, in only one case was this for anything other than advice about incontinence wear, particularly for elderly patients. Eight GPs were aware of the availability of an incontinence nurse and, although all GPs who knew of an incontinence nurse expressed satisfaction with the service, referral was infrequent.

> By the time I get to see a patient, she may have been suffering for more than 15 years and it's hard to break the habit of a lifetime (incontinence nurse).

Following 11 successive negative responses from GPs on attendance at continuing medical education (CME) meetings on urinary incontinence, the iterative process of modifying questions as various aspects of a subject come to light was employed, and this question was not asked thereafter. Eight GPs said they didn't read any literature on urinary incontinence and, of those who had read some of the literature and who elaborated on it, most said it was the same information they received from medical representatives and they didn't value it.

Lack of time to properly assess and manage the patient was the most commonly mentioned problem, with doctors commenting that it is a chronic condition that they find difficult to treat.

> If you want to do 10-minute consultations, this isn't the area you're going to like doing. It's time-consuming initially, like a lot of things, so if you want to put in the extra maybe 10 minutes on a couple of goes, it might be worth it; it's not that big an effort but it's on top of all the other things that the patient will want, so she may be in 20 to 30 minutes (GP 8; M).

> Long term, other than the pads, we don't have a lot to offer so it can be quite discouraging (GP 3; M).

Most GPs believed the most important thing that should be done to improve the quality of life for women with urinary incontinence was to make them aware that it is a common problem and that something can be done to improve symptoms in most cases.

Most GPs were happy with the resources available to them for the management of women with urinary incontinence. Improved access to physiotherapy and the availability of a community physiotherapist were seen as important, and the need to establish a urology service and urodynamic assessment was also stressed by the gynaecologists. A few GPs thought the facilities were adequate but that they needed to become more aware of what services were available and use them to their full potential. A couple of GPs felt their practice nurses should be more involved. Two GPs suggested more training for doctors both at an undergraduate and postgraduate level, and one suggested that reading the available literature might help.

Discussion

The main limitation of this study is that it is based on a small sample of GPs working in a small geographical area. It serves as a pilot study for a larger sample in a wider geographical area. This study indicates that GPs are only too well aware of the size of the problem, its effects on women's lives, and the ineffectiveness of their approach to incontinence. There is an air of defeat in the interviews, with all the GPs being unaware of the reported effectiveness of modern management. Their attitude is at variance with the local specialists, who are more positive and who are seen by GPs to be providing a good service but one that is not widely used. This variance may not be representative of a larger sample, but it is one that deserves scrutiny.

Anticholinergic drugs have been shown to be successful in the management of urinary incontinence but have a high rate of unacceptable side effects.[17] Medications were frequently used by the participants in this study with almost universal disappointment, owing either to the ineffectiveness or to the high incidence of side effects. The amount of time and effort spent in supporting patients on medications with high side effects is felt more keenly in general practice than in trials or specialist clinics.

Practice nurses in this study were not used to dealing with incontinent women. It is tempting to suggest delegation to nurses trained in this area, and indeed this was one of the suggestions given by many GPs. However, nurses' willingness to take on urinary incontinence needs to be explored and their training needs assessed. If their GP employers are unenthusiastic about the problem, a team approach to incontinence will be difficult.

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