

Short report: How family physicians can support discussions about menstrual issues

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Benign menstrual issues are common, but consultation rates vary and treatment is often delayed.¹ This variance has raised concern, particularly in North America, where high hysterectomy rates have directed attention to early intervention. Although alternative treatments exist for benign menstrual issues, 75% of hysterectomies are performed to treat such conditions.² As the first contact for many patients, family physicians have an important role in helping patients select appropriate treatments.

Failure to seek consultation with physicians about menstrual issues is often attributed to the characteristics of individual women; this provides a partial explanation but offers few suggestions to improve consultation rates. To understand why women do not discuss menstrual issues, it might be more productive to consider the social context of the topic. In Western culture, menstrual etiquette, the implicit rules regulating behaviour during menstruation, shapes consultation behaviour.³ In this context, women manage menstruation in an effort to conceal it from others, and discussing menstruation in public, even in a physician's office, is deemed inappropriate.⁴

A review of qualitative research on the experience of heavy menstrual bleeding suggested that women's decisions not to seek treatment were based on the following beliefs: that their experience was invalid, that suffering was normal, and that bleeding was healthy. Women also feared being dismissed by physicians and worried about wasting physicians' time.⁵ As patients are most likely to initiate discussions during medical consultations,⁶ it is important that physicians understand the social barriers that accompany the topic of menstruation and support patients in overcoming them.

Few studies have examined the factors that create an environment that encourages discussions during medical consultations. The objective of this study is to examine the ways in which family physicians and women with benign menstrual conditions can overcome social barriers during consultations and decision-making processes.

EDITOR'S KEY POINTS

- Some women with heavy menstrual bleeding will not seek treatment for reasons such as fear of wasting physicians' time or their uncertainty about what constitutes normal menstruation. It is important that family physicians encourage patients to discuss their menstrual concerns.
- Participants' interpretation of physicians' "openness" was the most important factor that encouraged them to share their menstrual issues. Openness was characterized by physicians' efforts to start conversations about menstruation.
- Building rapport with patients (eg, initiating discussions about menstruation, listening to patient concerns) during consultations contributed to more open discussions about treatment options and helped patients to believe they were making informed treatment choices.

POINTS DE REPÈRE DU RÉDACTEUR

- Certaines femmes qui présentent des saignements menstruels abondants hésitent à consulter un médecin de crainte de lui faire perdre son temps ou parce qu'elles ne savent pas bien ce qui constitue un saignement normal. Les médecins devraient donc encourager leurs patientes à discuter de leurs préoccupations d'ordre menstruel.
- Le facteur le plus important qui amenait les participantes à discuter de leurs problèmes menstruels était l'idée qu'elles se faisaient de « l'ouverture » du médecin à aborder ce sujet. Cette ouverture se caractérisait par les efforts du médecin à engager une conversation au sujet des menstruations.
- En améliorant ses relations avec les patientes (c.-à-d. en abordant le sujet des menstruations, en écoutant les préoccupations des patientes au cours des consultations) le médecin les encourageait à discuter plus librement des options de traitement et les aidait à penser qu'elles faisaient des choix de traitement plus éclairés.

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Cet article a fait l'objet d'une révision par des pairs.

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METHODS

This study was the author's master's degree project. With supervision, the author conducted data collection and analysis. A literature review was conducted using Sociological Abstracts and PubMed databases, using the key words *qualitative research*, *menstruation*, and *consultation*, with a date range of 1995 to 2011. In-depth, semistructured interviews were conducted with 9 English-speaking women from Halifax, NS, between the ages of 23 and 57 years who self-identified as having sought treatment for benign menstrual issues. Most participants did not have diagnoses but were considering various treatment options with their physicians, including hysterectomy, medication, intrauterine devices, and alternative surgeries (Table 1). Convenience sampling methods were used to recruit participants. Institutional review board approval, as well as informed consent from participants, was obtained. A qualitative approach was chosen to provide a detailed description of patients' decision-making processes. Thematic analysis was conducted to identify the main themes. As the study examined a narrow experience, saturation, the point at which no new themes were identified, was reached after 9 participants.

RESULTS

This study demonstrated that women were hesitant to consult with physicians about menstrual issues owing to their uncertainty about what constituted normal menstruation. Despite their uncertainty about whether or not heavy bleeding and pain were normal, all participants eventually decided to seek treatment from their family physicians. This decision often occurred when menstruation began to interfere with their lives.

Like is it worth bothering her about it because it's probably nothing? I lived with the heavy bleeding

for years, for 5 and a half years It was only when it started happening when it was outside of my period [cycle] that kind of sent me to my doctor.

After seeking treatment, most participants were relieved that treatments were available and regretted the years they had suffered without having consulted a physician.

Through those years, it was just this is the way it is. And then when it gets really bad then you do something about it. I mean that is what my [family] doctor said. She said, "Oh, it's too bad you didn't come years ago. We could have done ..." And I'm like, "Don't say that."

Having gone through the regret of delayed treatment, participants described ways in which family physicians could work with patients to encourage earlier consultation. The most common suggestion was to cultivate relationships with patients that facilitated discussions about menstruation. Participants' interpretation of a physician's "openness" was the most important factor that encouraged them to share their menstrual issues. Openness was characterized by efforts to start conversations about menstruation.

Absolutely, yes, I would have [told my physician earlier]. Because I think it is an area where you are not just going to say, "Oh and by the way..." But if she had said to me, "So how is menstruation and what-ever?" I would have said, "Well, probably not the best on certain days."

Participants wanted their concerns to be taken seriously by their physicians. This involved physicians taking time to listen to their concerns, empathizing with suffering, and suggesting ways to address symptoms.

Table 1. Characteristics of participants

| PATIENTS | YEAR OF BIRTH | ETHNICITY | NO. OF CHILDREN | EDUCATION LEVEL | HOUSEHOLD INCOME, \$ | DIAGNOSIS (IF AVAILABLE) |
|----------|---------------|------------------|-----------------|-----------------|----------------------|---------------------------|
| 1 | 1969 | White | 3 | University | 25 000–49 999 | No diagnosis |
| 2 | 1962 | White | 2 | University | < 15 000 | No diagnosis |
| 3 | 1962 | African Canadian | 3 | University | ≥ 50 000 | No diagnosis |
| 4 | 1963 | White | 4 | University | ≥ 50 000 | No diagnosis |
| 5 | 1950 | White | 2 | High school | ≥ 50 000 | No diagnosis |
| 6 | 1984 | White | 0 | University | 25 000–49 999 | No diagnosis |
| 7 | 1966 | White | 0 | University | < 15 000 | Endometriosis |
| 8 | 1964 | White | 3 | University | ≥ 50 000 | Abnormal uterine bleeding |
| 9 | 1958 | White | 2 | University | ≥ 50 000 | Uterine fibroids |

I mean is this really a medical problem or is it all whiny, only being whiny? And she's like, "No, this is not This is a medical issue. You have to look at it this way." And she was great ... You know, that it was a bona fide sort of medical issue that could be dealt with through a medical procedure rather than seen as sort of extraneous and taking up her time.

This does not mean that participants wanted their physicians to immediately suggest invasive medical interventions in order to validate their experiences. Participants reported being happier with their care when their family physicians took the time to test for underlying conditions and discuss available treatments. "And this doctor, she has been great, that we have been able to have some of those discussions. That it's not just, 'What is your problem? Here's the solution.'"

The decision to seek treatment for menstrual issues was an emotional one. Many participants had known people who had received potential treatments, and, as such, the positive or negative experiences of those people affected participants' opinions about various options, as well as their willingness to seek treatment. Family physicians need to recognize that there are emotions and preconceptions involved in women's decision-making processes and they should ask patients about their knowledge of different treatments.

If a physician was comfortable talking not only about just the procedures but how you would feel about those and what do you think about those. Because you know, you've had experiences of someone else having that or your mother or your sister or your friend or whatever.

The rapport family physicians were able to build with patients during discussions about menstrual issues contributed to more open discussions about treatment options. Following these discussions, participants were more likely to believe that they were making more informed decisions about their treatment choices.

DISCUSSION

These data suggest that women require an environment in which they can openly discuss menstrual concerns. Although this study is limited in size, it provides an important description of women's experiences in

consulting their physicians about menstrual issues and explains how family physicians can encourage earlier consultation. Social constraints, including misconceptions about what is normal during menstruation, concerns about voicing invalid concerns, and fear of speaking about menstruation, discourage women from discussing menstrual issues with their physicians. Earlier consultation might serve to lower rates of invasive treatments, such as hysterectomy, by identifying and treating menstrual disorders before they become severe. Also, delaying consultation about benign menstrual conditions might decrease the number of treatment options available to women.

Conclusion

By not asking patients questions about menstruation, family physicians contribute to the social barriers that accompany this topic. As women's first and most consistent contact with the health care system, family physicians have an important role to play in encouraging women to discuss menstrual concerns. While the social constraints of menstrual etiquette encourage women to conceal menstrual issues, physicians can recognize these constraints and break this silence. Family physicians can help patients overcome these barriers by initiating discussions about menstruation before problems arise, empathizing with patients' concerns, taking the time to test for underlying conditions, listening to patients' opinions about different treatments, and supporting patients in choosing appropriate treatments. 🌱

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Competing interests

None declared

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