A qualitative study of the assessment and treatment of incontinence in primary care

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Background. Although incontinence is a common condition, previous studies have suggested that access to appropriate treatment is variable. Recent guidelines recommend initial conservative treatment in primary care and this study explores GPs management practices and the feasibility of applying guidelines.

Objectives. To describe the assessment and management practices of incontinence by GPs in primary care.

Methods. Semi-structured interviews were carried out with 32 GPs practicing in South East Wales. Sampling was purposive to include a range of characteristics such as gender, age and size and location of practice. Interviews were audio taped and transcribed and a thematic analysis carried out using a grounded theory approach.

Results. The extent to which GPs felt adequately informed to carry out assessment and treatment of incontinence was varied. While most were aware of appropriate assessment and investigation, none felt in a position to undertake conservative treatments such as bladder training or to monitor pelvic floor therapy either due to lack of knowledge or organizational constraints. Access to specialist continence services was also variable across different localities with many GPs being unaware of the remit of specialist nurses. However, there was a high rate of referral to secondary care which will result in high cost to the National Health Service.

Conclusions. There are a number of barriers to provision of first-line treatments in primary care, including variability in training and knowledge of GPs, as well as practical barriers (such as time resource) to carrying out assessments and treatment in routine surgeries. This results in increased likelihood of referral to secondary care.

Keywords. Attitude of health professionals, incontinence, treatment.

Introduction

Incontinence is an extremely common condition occurring in around 23\% of women and 8.7\% of men over the age of 40 years.\textsuperscript{1} Around 6–8000 adults experience regular incontinence in an average Primary Care Trust.\textsuperscript{2} Most people who seek help consult their GP in the first instance but it is suggested that treatment provision is often poor.\textsuperscript{3} One study reported that while most women seeking help for stress incontinence received some form of treatment or advice, only 35\% received recommended treatments.\textsuperscript{3} A Department of Health report recommended that the initial management of incontinence is carried out in primary care and that a systematic approach be adopted.\textsuperscript{4} The report emphasized the need for an initial assessment by a suitably trained health professional followed by first-line treatments of pelvic floor exercises (PFE) for stress incontinence, bladder training and anticholinergic medication for urge incontinence. It was also recommended that all incontinent individuals be identified by proactive questioning of those at risk, such as pregnant and post-partum women, older people and their carers, people with disabilities, school age children and menopausal women. More recently, recommendations for treatment of women with urinary incontinence...
have been published by the National Institute for Clinical Excellence (NICE), which address assessment and treatment in both primary and secondary care.5

Although quantitative studies have suggested poor provision of care for incontinence within the primary care setting, there are little qualitative data, particularly in the UK, examining GP assessment and treatment practices in more detail. This paper reports the results of a qualitative study, which aimed to explore GPs' management practices and attitudes to continence care and service provision. This initial report is a descriptive account of GPs' reports of the assessment, diagnosis and management of incontinence in order to establish the range and variation in practice. This is discussed in relation to the treatment guidelines and the feasibility of GPs carrying out recommended treatments in primary care.

**Methods**

As the study was exploratory, a qualitative methodology, using an inductive approach (grounded theory), was considered the most appropriate (see Box 1).6

**Sampling and recruitment**

Sampling was purposive to include a range of characteristics that might reflect variation in management practices i.e. gender, age, size of practice and geographical location to reflect variation in socioeconomic status of patients. GPs were selected from the Local Health Board register and included 10 females, 4 non-European Union and 7 <40 years of age (See Table 1). Sampling and analysis were carried out in parallel and data collection continued until data saturation was achieved. Thirty-two GPs were interviewed, representing 59% of the GPs approached, which is appropriate for this type of qualitative study.7 The GPs were recruited by letter and were reimbursed £50 for their time.

**Data collection and analysis**

Semi-structured interviews, lasting ~30 to 50 minutes, were carried out by one of the authors (CA) in the GP’s surgery. The interviewer was a social scientist, which was considered a strength of the study as it encouraged GPs to explain their management strategies rather than relying on a shared understanding or language.

Questions focused on GPs’ views of the extent of incontinence, its impact on patients, their management of the condition, specialist service provision, and needs for information and education. Interview questions acted as a guide allowing the interviewer to explore topics further, depending on responses. Interviews were audio taped and transcribed into Nudist software. A coding frame was developed for the main concepts, which were then broken down further into subcodes creating a hierarchical coding tree. Definitions of codes were agreed by the authors and any inconsistencies or ambiguities discussed, with amendments to the coding framework as necessary. To ensure reliability of the coding frame and analysis, a sample of interviews were coded by two researchers.

The coding was an iterative process that developed as data collection progressed. As new codes were identified, the previous interviews were checked for any examples of the newly developed code. When coding was complete, relationships were sought between codes in order to identify explanatory patterns, including consideration of deviant cases. However, as the purpose of the present report is to establish current urinary incontinence (UI) management rather than to explore the ‘reasons’ for variation in practice, the analysis is largely descriptive.

**Results**

Five main themes were identified, which consisted of GP views of prevalence, impact on quality of life, management, information needs and organization of service delivery. This paper focuses on the core category of GPs’ views on management of UI. The subcategories of this theme included diagnosis and history taking, examination and investigations, treatments and referral to secondary care. A further subcategory of access to services will be touched on in so far as it affected management decisions.

**Diagnosis and history taking**

The majority of the GPs articulated a need to diagnose the type of urinary incontinence based on history and assessment, in order to devise an appropriate management strategy. However, history taking varied considerably in how systematic and comprehensive it was. Some GPs felt that only a few questions were necessary.

GP08: I just feel that you can get a pretty good picture from a few key enquiries … You get a couple of decent questions and you get a pretty good idea of …

Interviewer: Of what’s going on.
GP08: I think! (Laughs) Maybe um.
Female, <40 years, Urban

Others felt the issue to be complex and outlined more detailed history requirements.

GP38: Um, well, obviously, get them to describe what the problem is, and how bad the problem is; what sort of circumstances it arises in? Really try and work out is it a stress incontinence sort of thing? Is it more an Urge incontinence thing? Is it an overactive bladder? Does it bother them at night? Does it hurt when they go to ...? You know, all the sorts of normal questions you would ask. Any symptoms of a prolapse? ... Any other illnesses that may be contributing, like diabetes? How much they drink, that sort of thing? What sort of things do they drink? That often has a bearing on it. What medication, other medication may they be on? Sometimes it ties in with, well, diuretics or other things.

Female, >40 years, Rural

This was often accompanied by an expression of greater confidence in dealing with the problem.

GP38: I feel fairly sort of comfortable and confident dealing with it. You know, in my mind I feel that I know what things I need to know, and what examination will be appropriate, and what other things I will then want to organize, and what ways we can help somebody

Female, >40 years, Rural

None used any kind of formal or standardized assessment tool and it was unclear how symptom severity was assessed, although one GP talked about severity of leakage in terms of volume and several mentioned frequency of leakage. No one explicitly discussed attempts to quantify severity in order to assess response to treatment, apart from patient reports of ‘better/worse’.

Secondary to producing a diagnosis, the history was mainly aimed at identifying possible causative factors such as comorbidities, childbirth or, in particular, prolapse.

GP35: Well certainly the history is very important as to how it actually impacts on patients and what type of symptoms they’ve got ... But what you really want to know is what’s causing it if you can identify that.

Male, >40 years, Rural

Prolapse and prostate problems were mentioned frequently and were problems that GPs appeared comfortable in dealing with. Some GPs would provide and fit ring pessaries for prolapse rather than referring to secondary care. They expressed satisfaction in establishing a diagnosis for which there was something concrete they could do to alleviate symptoms and expressed frustration when they felt that there was little they could do. One GP suggested that he did not think it worth investigating problems for which he had no effective treatments.

GP54: ...unless you’ve got some effective means of helping the problem, it doesn’t seem hugely beneficial to put the person through a great deal of pulling about to, you know, I mean it’s almost like neurology in that it’s diagnostically interesting, but therapeutically barren.

Male, >40 years, Valleys

This type of attitude was present to varying degrees in relation to older patients with multiple problems who were frail. GPs did not want to expose patients to situations that they felt might be more distressing than the condition itself.

Other issues included in the history taking were bowel history i.e. constipation, symptoms of infection, pain or discomfort, obstetrical and menstrual history, fluid intake and obesity.

Although the majority acknowledged the impact of incontinence on quality of life, few asked patients explicitly about it, based on the view that it would cause embarrassment or distress.

CA: OK. How important do you think it is to ask patients, about their quality of life?
GP18: It’s very important isn’t it? If you’re wetting yourself life is miserable full stop, you know so ...

CA: Yeah. Is that a question that you would ask directly?
GP18: I probably don’t actually. No, I think it’s almost like a rhetorical question because we’re all human beings and if that’s happening then you don’t like ... Sometimes people are too embarrassed to talk about it but inevitably quality of life will be affected.

Male, >40 years, Urban

Investigations and examination
Following history taking, most GPs carried out some investigations, although a small number did refer directly on to secondary care at this point, particularly if there were indications of stress incontinence. Most mentioned urine testing for infection, some routinely carrying out midstream urine specimens and others only if they felt that the history indicated this.
GP08: Yeah, I mean I don’t... I wouldn’t say I always do that but I do occasionally do that, maybe if it’s a very short history or something and you think possibly it could be an infection. Maybe I should do MSUs even more now actually when I think of it but I don’t know, maybe not, if it’s longstanding it’s obviously stress or urge.

Female, <40 years, Urban

None of the GPs mentioned assessing for haematuria. The majority routinely assessed women for prolapse or other gross abnormalities. However, some GPs did not carry out physical examinations because of the time involved or the difficulty of obtaining a chaperone. Others would offer patients a return appointment for examination either by the practice nurse or a female partner. Men would be given a rectal examination to assess the prostate along with a prostate-specific antigen (PSA) test, and then immediate referral. One or two mentioned carrying out rectal examinations to assess for faecal impaction, particularly in the elderly group. While vaginal examination were carried out mainly to diagnose prolapse, a few GPs mentioned assessing for atrophic vaginitis in post-menopausal women and some also talked about pelvic floor assessment, but generally did not feel knowledgeable or confident enough to assess pelvic muscle strength. One or two had carried out a cough test to assess for stress leakage. This had been asked for by the specialist continence nurse prior to referral, and the GPs felt it was a useful test to carry out, if possibly embarrassing for the patient.

A number took the opportunity to carry out a blood screen. Most frequently mentioned was blood glucose to rule out diabetes. In addition full blood count, thyroid function and renal function were often assessed, particularly if the patient had not attended surgery for some time.

Bladder scans to assess post-void residual volume were not normally available in primary care, although a small number of practices did have access to a bladder scanner via the practice or district nurses. In most cases, if a scan was felt to be necessary the patient was referred to secondary care, although occasionally the GP could refer for a scan directly. None of the GPs felt equipped to carry out a bladder dairy or frequency volume chart.

Treatment

Most GPs made the distinction between stress and urge incontinence when embarking on a treatment plan although the boundaries tended to get blurred. Most confusion surrounded bladder training. None of the GPs undertook bladder training although one or two would give an overview, advice or leaflets. The majority felt that they were not equipped to carry out bladder training.

GP02: I mean they come back with a bladder diary and I’m looking and I’m thinking ‘What the hell is all that about!’ (Laughter) Go away! Go and see someone who knows what they’re doing! So no, that’s too tricky for a man like me.

Male, >40 years, Urban

Those who were more familiar with the concept felt it was too time consuming to carry out properly within the constraints of normal surgery and there was universal agreement that it was a nursing responsibility. Those who felt that it would be beneficial for their patients would refer to the district nurses, continence nurses or secondary care. Because it was not something that they came across during their working life, some tended to think that it was no longer a recommended treatment.

GP34: I mean I do tend to talk to patients about bladder training a bit but it’s gone a bit out of vogue as far as I’m aware really.

Female, >40 years, Rural

A few were completely confused by the concept.

CA: Bladder training, that sort of thing?

GP05: Kind of yes. Making sure you empty your bladder before you go out, don’t drink too much if you know you’re going out, things like that you know, which any sensible person would do anyway.

Female, >40 years, Urban

GP17: Yeah, I’m not really aware of that in incontinence. There’s obviously behaviour modifications you can make in terms of toileting people after meals and after drinks and things. Regular toileting for elderly. Particularly elderly confused. But in terms of a specific bladder drill, I’m aware of that as a problem for urgency, frequency and stress but I’m not aware of it as er... I suppose stress incontinence, yeah, you can do bladder training can’t you, bladder neck exercises. Yeah, yeah, yeah.

Male, <40 years, Urban

The above quote was an example of how bladder training was sometimes linked quite closely to PFE, as is the following:

GP54: Bladder training? Well, I mean, I’d regard bladder training and pelvic floor exercises as, well, different aspects of a similar thing.

Male, >40 years, Urban

PFE figured a little more prominently in the narratives, but commitment to it and belief in its efficacy as a treatment was frequently lacking.
GP08: You know I mean you tell them to do things like pelvic floor exercises but you know I don’t think they work really.

Female, <40 years, Urban

Leaflets were mainly used to instruct on PFE and a small minority referred for physiotherapy. Others assumed that this would be organized by secondary care. Some advised on PFE while waiting for a secondary care appointment, sometimes in conjunction with medication such as anticholinergics. It was considered more appropriate for younger women and was linked with post-natal incontinence. No one carried out monitoring of PFE.

Drug therapy was more readily used by GPs, often as a trial prior to referral or while waiting for their secondary care appointment. Some used anticholinergics specifically for urge incontinence whereas others would try them in cases of stress incontinence also. Many of the GPs were happy to use them feeling that they did no harm and so would try more than one, whereas as many other GPs were not so convinced of their efficacy or noted the unacceptability of side effects for patients.

Limited lifestyle advice was given apart from weight loss and attention to the amount of fluids consumed. Advice concerning fluid intake focused on issues such as restricting intake to avoid the need to pass urine in certain circumstances such as social occasions or during the night. Advice to maintain an adequate fluid intake to avoid concentrating the urine was rare.

Referral patterns were dependent on availability and knowledge of local services. Some practices had access to good nurse-led continence services and referred directly. Others preferred to refer to either the gynaecologists or the urologists, even when specialist nursing services were available. These GPs seemed unaware of the scope of the service provided by specialist nurses. Specialist continence nurses were still considered by some GPs to be a route to obtaining the gynaecologist, a lot of people don’t end up with either: um, the treatments seem to be, to a certain extent, arbitrary. Some of them have urological assessments by the incontinence service, some don’t. So it’s, it’s, it’s one of those areas that I do feel inadequate about dealing with. Because of my own problems about what I can do to help, but also because I think the service they go on to is not streamlined, and is not easily accessible.

Female, >40 years, Rural.

Discussion

The results of this study show that the ease with which GPs assess and manage urinary incontinence is variable. There were obvious differences in attitudes, with some feeling it to be a fairly major and difficult problem, whereas others had little exposure to it and tended to underestimate its significance. However, there were consistencies that highlighted the difficulties that GPs face in complying with recommended treatments, and also their information needs, exhibited by confusions around particular aspects of care.

There are a number of sources of guidelines for continence management which range from reviews or educational articles in academic journals,8–10 to Cochrane reviews of specific treatments.11,12 More comprehensive guidelines are published by the International Consultation on Incontinence (ICI) every 3 years in a systematic update of the evidence in all population groups.13 More recently, recommendations have been published by NICE for the treatment of urinary incontinence in women.5 Box 2 summarizes the assessment and treatment recommended for use in primary care.

The GPs in this study were working broadly in agreement with the above guidelines in relation to assessment, although none felt able or willing to carry out bladder diaries. This reluctance to use more systematic methods of assessment such as bladder diaries, and the assumptions made concerning quality of life impacts does question the reliability of any conclusions reached. Previous studies have shown poor agreement between physician assessments and patient reports, with physicians underestimating the patients’ extent of ‘bother’ 25% to 37% of the time.14 Similarly, high proportions of patients have been found to remain undiagnosed despite presenting with bladder symptoms indicative of overactive bladder, mixed incontinence and stress incontinence, as well as post-prostatectomy incontinence.15,16

The difficulties encountered by GPs in carrying out physical examinations has been highlighted in previous studies17,18 and for similar reasons. This was a combination of time factors, organizational issues and patient-centred issues, particularly in older people with mobility problems. Resource difficulties were also a barrier. For example, most GPs did not have access
to bladder scanners and had to refer directly to secondary care for assessment, which probably results in patients being referred unnecessarily.

Treatment aspects were particularly difficult for GPs as they had little experience or training in this area, and so first-line treatments of bladder training and PFE were considered the remit of secondary care. Patients were more likely to receive advice on PFE than bladder training but this was generally provision of leaflets and not supervised training. None seemed aware of the level of exercises required, some suggesting that patients would need to carry out hundreds a day. The ICI recommends that PFE should be taught and monitored by someone who is appropriately trained19 and this tends to be either a physiotherapist or specialist continence nurse. Access to and knowledge of these resources was variable. Many cited poor communication with secondary care for a lack of awareness of available services. Primary care physicians’ lack of enthusiasm for teaching PFE or bladder drills has been reported previously.18 In this study, there was an implication that, as well as a lack of knowledge, it was too time consuming to carry out in a routine consultation. Bladder training was considered to be a nursing responsibility although there were no explicit policies on practice nurse involvement in such activities.

GPs were more comfortable with medication use, irrespective of diagnosis, and tended to prescribe medication while waiting for referral as there was enormous frustration over waiting times for secondary care appointments. This has been identified as a particular problem in the UK in a cross European study.20 The high rate of referral identified in the present study has also been found previously.21 However, in relation to treatment overall, there was evidence of the therapeutic nihilism described in previous research with some GPs having little conviction in the efficacy of treatments17,18 in addition to general dissatisfaction with the availability of specialist services.

The study has a number of limitations that must be taken into account. It is a small, exploratory study carried out in a particular geographical location. As some of the issues relate to the service context in which individual GPs work, confirmation of findings should be sought in a wider population of GPs using quantitative methods. However, support for the findings in the wider literature does suggest some generalizability. Finally, as in all studies recruiting volunteers, there is the possibility of only those who have a particular interest agreeing to take part. The variability in findings in relation to GP knowledge and views would suggest that this was not the case in the present study.

In conclusion, there appear to be several issues acting as barriers to optimal treatment for urinary incontinence in primary care. Knowledge and training of GPs in relation to continence care is variable and appears to be a consistent failing of the system not only in the UK but across Europe, the US, Canada and New Zealand.15–18,21–23 Many are confused and feel inadequate, whereas others are fairly knowledgeable. As a result, management practices are inconsistent and generally unsystematic with high referral to secondary care.
care. This is costly to both the National Health Service and the patients (in terms of quality of life costs). Access to specialist nurse-led continence services was variable and sometimes underutilized by GPs because of lack of awareness. There are also practical barriers to carrying out these types of treatments within a GP surgery, and so it would seem appropriate to encourage primary care teams to enable practice nurses to undertake some of this work in collaboration with the GP in order to provide first-line treatments in a timely and cost-effective manner.

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