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ORIGINAL ARTICLE

## Urinary incontinence in the elderly: Attitudes and experiences of general practitioners

*A focus group study*

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### Abstract

**Objective.** To assess general practitioners' (GPs') attitudes to urinary incontinence in elderly patients and their experiences in the application of the Dutch College of General Practitioners' guideline in daily practice. **Design.** Two existed groups of six GPs working in villages and seven GPs working in urban practices. **Method.** Two focus-group discussions with recording of discussions and transcription. Transcripts were analysed by two independent researchers. **Results.** During the discussions three main themes of attitudes came forward: (1) *therapeutic nihilism* of GPs and low motivation of patients, (2): GPs experienced *lack of time* because of difficulties in explaining the therapy and because of impaired mobility of older patients, (3) because of *the complexity of the problem and co-morbidity*, GPs as well as patients were reluctant to treat the UI. The most remarkable findings in the application of the guideline were: (1) because of the barriers mentioned above, physical examination did not take place in spite of GPs' conviction as to the benefit of it; (2) GPs' *knowledge* of treatment options in the elderly with UI is substandard. **Conclusion.** Several patient-(comorbidity, impaired mobility, low motivation, and acceptance of the problem) and GP factors (therapeutic nihilism, lack of time and knowledge) interfere with good management of UI in the elderly.

**Key Words:** *Attitude, elderly, general practitioner, implementation, urinary incontinence*

Urinary incontinence (UI) is a common condition in elderly men and women, with prevalence in the community ranging between 15% and 30% [1]. UI affects general well-being, self-esteem, and social functioning [2–5]. Non-surgical treatment (bladder training, pelvic floor exercises, and medication) is effective in the treatment of involuntary loss of urine, even in elderly patients [6]. This treatment can be very well managed in primary care [7]. But only half of the elderly with UI contact their GP for this problem. The most important reasons for not seeking help are that they do not experience problems with their UI and they lack knowledge of the cause of the disorder and its treatment options [8,9].

In several countries – including the Netherlands (Dutch College of General Practitioners) – guidelines for UI in primary care have been developed

Several factors interfere with good management of urinary incontinence in the elderly.

- The patients' factors are comorbidity, low motivation, and acceptance of the problem.
- The GP factors are therapeutic nihilism, lack of time, and lack of knowledge.

[10–14]. The existence of guidelines, however, does not guarantee their use [15]. Sandwich et al. [16] investigated GPs' management of UI in the elderly in Norway. They found that old patients received pads, and to a certain extent drugs, but compared with younger patients they were not given pelvic floor exercises, were less often referred to a gynaecologist, and surgical intervention was less often proposed.

Penning-van Beest et al. studied the treatment of women with UI in the Netherlands [17]. They found only 13% of the women with newly identified UI were actively treated for their incontinence. However, the reasons *why* actual practice differs from proposed care (guidelines) has to the best of our knowledge not been investigated. It is important to gain insight into this – skills and attitudes may also play a role or guidelines may encounter problems with patients’ attitudes or healthcare facilities. Surveillance of such barriers can help the guideline implementation process [18]. This study analysed the barriers to implementation of the Dutch College of General Practitioners’ guidelines for UI. It can be anticipated that with only half of the elderly patients with UI actually seeking help there will remain unmet needs in the practice population, but there could be other barriers – for example in the GPs’ attitudes towards the elderly – resulting in substandard care for patients with UI. Empirical data on GPs’ experiences with the guidelines and insight into the existing bottlenecks in the care of older patients with UI can be used for training and education of GPs or amending the guidelines when they are reviewed for an update.

The aim of this study is to assess GPs’ current attitudes to UI in elderly patients, and their experiences with the application of the guidelines in daily practice.

**Material and methods**

This study is part of a large research project on uncomplicated UI in elderly people. In this project we evaluated prevalence, help-seeking behaviour, consequences, and impact of UI on daily life, and, reported here, barriers to the implementation of the UI guidelines in GPs’ care of elderly people with uncomplicated UI. As we were particularly interested in the GPs’ attitudes to elderly people with UI, we used a focus-group discussion as a qualitative research method, to enable in-depth exploration.

We selected GPs working in villages near the practice of the first researcher (TT) and GPs working in urban practices near the practice of the co-authors (ALJ). GPs of different ages, gender, different practice settings, and without any specific affinity with the problem of incontinence were invited to participate in the focus groups. To be able to explore GPs’ genuine thoughts and attitudes regarding UI it was essential to create a safe environment for an open discussion, and for that reason small groups of six to seven participants were formed. We decided to start with two groups and analyse the discussions for becoming repetitive. If this was not found, more

groups were to be recruited until saturation of themes and issues was reached.

Basic rules of confidentiality are a prerequisite for convening groups, and all participants had to agree to keep all discussions in the group strictly confidential.

The focus groups took place at the Department of General Practice of the Radboud University Nijmegen Medical Centre from June 2003 onwards and were led by a moderator experienced in leading groups but with no special interest in UI. A topic guide with eight key questions was developed (Table I). All these questions were used to generate discussion among the participants.

Each focus-group discussion lasted an hour and a half with a short break of 10 minutes and was recorded on audiotape and fully transcribed. The GPs received a small token of appreciation for their participation.

*Analysis*

Qualitative data were analysed using the ATLAS.ti software program (Visual Qualitative Data Analysis–Management–Model Building Version, version WIN 4.2). Two researchers independently searched the script for patterns that emerged from each question and subsequently they together defined the most important themes. Each researcher used a grounded theory approach in developing theoretical principles (or at least explanatory principles) [19]. This was to ensure that the coding of themes

Table I. Interview guide.

Attitude
A woman aged 75 years with moderate UI consults you because of UI; what is your first thought?
Do you send elderly patient with urinary incontinence more often to the physiotherapist compared with younger patients? If you do so, why? If you do something else, what and why?
Application of the UI guideline
What barriers do you experience in the case of older patients with urinary incontinence?
Do you do a diagnostic analysis as proposed in the guidelines?
Do you perform pelvic examination in the elderly with UI? If not, why not? If yes, why? What causes you to do so?
The guidelines for UI advise starting with pelvic floor exercises in the case of stress UI. What do you think about this? If you do something else what do you do and why?
The guidelines for UI advise starting with bladder training in the case of urge UI. What do you think about this? If you do something else, what do you do and why?
The guidelines for UI advise starting first with bladder training and after 6 weeks adding pelvic floor exercises in the case of mixed UI. What do you think about this? If you do something else, what do you and why?

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consistently and robustly followed grounded theory rules and that all the emerging themes were directly supported by verbatim data from the meetings. In the case of controversy both researchers tried to reach agreement to define the most important themes. In the case of discrepancies a third researcher read the transcripts and gave her opinion and mutual discussion took place between the three until agreement was reached.

## Results

In total 18 GPs were approached to participate in the focus groups. Five refused because of lack of time (three male and two female GPs) resulting in 13 participants. The participants were divided into two groups, seven in the first group and six in the second group. The demographics of the participants are given in Table II.

### Attitude

In both groups three main themes came forward: therapeutic nihilism, lack of time and complexity of the problem, and comorbidity.

*Therapeutic nihilism* was the first main theme. We started the discussions with the question about the first thoughts of GPs in the case of an elderly woman with UI. Spontaneously GPs noted that they could not do a lot about it:

*This case is not a challenge for me, because you can't do so much. . . .*

*I'm pessimistic in the case of an older woman with urinary incontinence. I will do a urinary analysis and if this is normal she will be given incontinence pads. . . .*

Because of this the GPs mostly did not do an optimal physical examination and consequently were pessimistic about the benefits of therapy.

Table II. Demographics of the focus-group participants.

Demographic characteristic	Number
Male/female GP	6/7
Practice type	
Solo	2
Group*	11
Full/part time	
Full time >or = 4 days	4
Part time <4 days	9
Age group (years)	
<40	6
40–50	3
>50	4

\*Two or more doctors in one family practice.

The first important reason for this pessimism was that in older women pelvic examination often showed very weak pelvic floor muscles. Half of the GPs were convinced that weak pelvic floor muscles strongly decreased the effect of training.

*In patients with a very wide introitus you know that treatment will not be very successful. . . .*

*When I find any strength in the pelvic floor muscles then I am more motivated to advise training. . . .*

As several GPs were also convinced that therapy was more effective in younger patients, almost all GPs were more inclined to refer younger patients than older ones to a physiotherapist.

*In younger women I push a referral to the physiotherapist more strongly because they have to live with it for so long. . . .*

*Because I'm not always convinced that therapy is efficient in elderly patients I'm reluctant to refer to a physiotherapist. . . .*

The second reason for pessimism was the low motivation for therapy GPs encountered in elderly patients.

*Most patients stopped the exercises because the severity of the incontinence was not worth the effort to do exercises. . . .*

*When you tell the patient they have to train the pelvic floor muscles for a long time they ask for incontinence pads because they feel that doing exercises at their age is difficult. . . .*

*I'm much more reluctant to start training for a patient who visits you frequently and who never does anything about my advice. . . .*

Several GPs mentioned that older patients were also less motivated to go to the physiotherapist, while half of the participating GPs believed that the physiotherapist had more expertise and more time to offer guidance to the patient.

*My experience with older patients is that if you suggest referral to a physiotherapist, almost all of them don't want to. . . .*

A few GPs put forward the proposition that a lot of the elderly accept UI as part of their life, believing that no effective treatment is available.

*Lack of time* was the second main theme during the group discussions. The majority of the GPs stressed the time-consuming aspect of the management of UI in the elderly.

*My first thought is “this takes me a lot of time”, especially in elderly patients. You have to ask about their medical history and after that they have to undress themselves and climb on the examination table. You need a lot of time to evaluate it and to motivate the patient. . . .*

Almost all GPs agreed with the statement regarding lack of time for a proper diagnostic analysis and consequent adequate treatment. The reasons why a lot of time is required were that in elderly patients it was usually more difficult to explain the therapy, and that older patients were less mobile so you had to visit them at home.

*In the case of an old woman living in a residential home who presents with UI, I usually don’t do a physical examination. This would take too much time, and it is too difficult to perform an adequate pelvic examination. . . .*

*When I get a request from a residential home for incontinence pads, it’s much easier to prescribe than to visit the patient for an analysis of the incontinence problem. . . .*

Lack of time was also a reason given for referral to a physiotherapist. The GPs especially proposed a referral when he/she thought that the patient needed a lot of explanation. But, as described earlier, elderly patients are less motivated to attend for physiotherapy.

*During training on incontinence I learned that most female patients need a month before they know how to tighten the pelvic floor muscles. I don’t have enough time to instruct a patient. . . .*

Most GPs experienced requests to the practice assistant for the prescription of incontinence pads as very bothersome. Although they were convinced that they had to invite the patient for a proper analysis of the UI problem first, this was too difficult to manage in daily practice. As a consequence they prescribed the pads without further analysis.

The last main theme was the *complexity of the problem and comorbidity*. Elderly patients often had comorbidity, and because of this the GPs as well as the patients themselves were reluctant to treat the UI as well.

*They most often also have a lot of other medical problems. I focus my attention on the most serious problems. For me and the patient the incontinence frequently is the less serious one. . . .*

In addition, the experience that UI was often presented at the end of a consultation as a new problem, irritated the GPs and did lead to insufficient management.

*When the problem is presented as part of many other problems, my heart sinks. . . .*

*If a patient consults me only for this problem then I will do a pelvic examination. If the patient comes with several problems including UI then I feel frustration about this way of presentation. Then I ask the patient to make a new appointment or sometimes I decide to give a prescription for incontinence pads without further discussion. . . .*

#### *Applying the UI guidelines*

During the discussion on the application of the UI guidelines two major themes came to the fore. The first was *the barriers* experienced by GPs in elderly patients with UI. These barriers have already been reviewed in the previous section: low motivation, impaired mobility, difficulties in understanding the explanation of the therapy, comorbidity, and acceptance of the problem. All GPs were convinced of the benefit of a pelvic examination. But because of the barriers physical examination did not always take place. It was also clear to GPs that pelvic floor exercises were the first treatment option in stress incontinence. But, as already elaborated, many elderly patients did not comply with this because of the aforementioned barriers.

The second major theme during the discussion on the feasibility of the UI guidelines was GPs’ *lack of knowledge* about treatment of UI. For example, only four GPs prescribed, according to the guidelines, bladder training as the stand-alone first treatment option in urge UI. Only two did so with detailed instructions and a follow-up appointment and just one GP used the recommended frequency volume chart. Three GPs started always with bladder training and medication together because they were used to it and had good experience of this method.

Two GPs were accustomed to start with medication alone. Neither knew that bladder training was effective in this case.

*I have to admit I never give bladder training; I always start with medication. . . .*

*I have good experience of the use of medication in the elderly with urge incontinence. I think that bladder training is difficult for them. . . .*

The same pattern was found in the first-choice treatment in mixed UI. For five GPs mixed UI was a reason to refer to the physiotherapist because of the complexity of the problem. Just one of the 13 family physicians started with bladder training in mixed UI and later added pelvic floor exercises, in accordance with the UI guidelines. The other participants did start with bladder training and pelvic floor exercises together, because they were used to doing so, because they expected a lack of time to see the patient for follow-up appointments, and because they did not know what the UI guidelines advised.

## Discussion

This is the first study into GPs' attitudes to UI in elderly patients and the barriers experienced to performing sufficient management in daily general practice. This study gives us insight into several reasons why the treatment of elderly patients with UI by GPs is substandard. The most important ones are the therapeutic nihilism of the GP and the low motivation of the patient, which intensify each other. But also GPs' lack of knowledge and lack of time declined the quality of care. A very interesting finding is that comorbidity in the elderly and the complexity of UI often result in a dilemma, because GPs and patient have to decide which medical problem will receive priority. UI is not always experienced by patients as the most serious problem threatening the quality of life. Good cooperation and shared decision-making can lead to priority being given to medical problems other than the UI.

Lack of knowledge on the part of the GP and patient regarding treatment options nevertheless leads to substandard care.

Our study is somewhat limited by the small number of GPs. But because in the second focus group no new themes came up, a third focus-group discussion was not necessary. Apparently, the themes that emerged represented the view of the profession. The strength of this design is the opportunity to explore GPs' attitudes and experiences and to approach this in depth. Although this study was exploratory in nature and our findings cannot be generalized to all GPs, this was the first in-depth analysis of this topic. And – at least in the Netherlands – GPs showed a high level of homogeneity in their dealings with elderly patients with

UI. From the answers and comments, we cannot identify specific issues from Dutch patients or the structure of healthcare in the Netherlands in the GPs' comments. That makes our findings relevant for further testing in an international primary practice setting.

The lack of knowledge of GPs is in accordance with a study in Denmark by Lose et al. who found that only 24% of the GPs felt that their knowledge was sufficient to manage incontinence, and more than 50% would refer a patient to a specialist [20]. Grealish et al. also found that many GPs avoided dealing with women with UI because they found it a difficult and chronic problem to treat [21].

Our conclusion is therefore that different factors related to older patients interfere with good management of UI, such as comorbidity, impaired mobility, low motivation, and acceptance of the problem. Also GP factors interfere with optimal care, such as therapeutic nihilism, lack of time, and substandard knowledge about treatment options and their effectiveness. This makes it imperative to focus our attention on several domains in implementing UI guidelines.

First, we have to improve GPs' knowledge of therapeutic options and their effectiveness in UI. GPs are only able to motivate patients if they are convinced themselves of the benefits of therapy.

Further investigation is necessary to verify the low motivation for treatment in elderly people with UI. Is this because of incorrect information, because of the unconvincing explanation of the therapy, or because of the effort of the exercises?

Furthermore, in the future UI guidelines have to take into account the complexity of UI in the elderly. Comorbidity is a main feature of the health status of elderly patients. UI might be influenced by the treatment of other diseases – in particular pharmacotherapy. Several drugs exert an influence on bladder, bladder neck, and diuresis and will influence UI [22]. Therefore, a critical look at polypharmacy in the elderly is imperative and this includes the treatment of UI itself. Consequently, treatment of UI might, in individual cases, be sidelined because of (treatment of) other morbidity.

Lastly, to tackle the time load experienced by GPs and patients' low motivation, the effectiveness of the contribution of the practice nurse in the treatment and guidance of elderly patients should be assessed in future research.

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## References

- [1] Teunissen TAM, van Weel C, Lagro-Janssen ALM. Prevalence of urinary, fecal and double incontinence in the elderly living at home. *Int Urogynecol J* 2004;15:10–3.
- [2] Robinson D, Pearce KF, Preisser JS, Dugan E, Suggs PK, Cohen SJ. Relationship between reports of urinary incontinence symptoms and quality of life measures. *Obstet Gynecol* 1998;91:224–8.
- [3] Simeonova Z, Milson I, Kullendorff AM, Molander U, Bengtsson C. Prevalence of urinary incontinence and its influence on the quality of life in women from an urban Swedish population. *Acta Obstet Gynecol Scand* 1999;78:546–51.
- [4] Lagro-Janssen T, Smits A, van Weel C. Urinary incontinence in women and the effects on their lives. *Scand J Prim Health Care* 1992;10:211–6.
- [5] Hagglund D, Walker-Engstrom ML, Larsson G, Leppert J. Changes in urinary incontinence and quality of life after four years. *Scand J Prim Health Care* 2004;22:112–7.
- [6] Teunissen TAM, de Jonge A, van Weel C, Lagro-Janssen ALM. Treatment of urinary incontinence in the community-based elderly: Conservative therapies that work. A systematic review. *J Fam Pract* 2004;53:25–32.
- [7] Lagro-Janssen ALM, van Weel C. Long-term effect of treatment of female incontinence in general practice. *Br J Gen Pract* 1998;48:1735–8.
- [8] Teunissen TAM, van Weel C, Lagro-Janssen ALM. Urinary incontinence in older people living in the community: examining help-seeking behaviour. *Br J Gen Pract* 2005;55:776–82.
- [9] Teunissen D, Lagro-Janssen T. Urinary incontinence in community dwelling elderly: Are there sex differences in help-seeking behaviour? *Scand J Prim Health Care* 2004;22:209–16.
- [10] Moore KN, Saltmarch A, Query B. Urinary Incontinence. Non-surgical management by family physicians. *Can Fam Physician* 2003;49:602–10.
- [11] Harninkontinente [urinary incontinence]. Dusseldorf: Deutsch Gesellschaft fur allgemeinemedizin und familiemedizin/omikron publishing; 2003.
- [12] Abrams P. Assessment and treatment of urinary incontinence. *Lancet* 2000;355:2153–8.
- [13] DSAM: Danish College of General Practitioners. Clinical Guidelines: Management of urinary incontinence in general practices. Redistributed as klaringsrapport nr.1, 2000 to all Danish physicians 1999 [available at: <http://www.dsam.dk>].
- [14] Lagro-Janssen ALM, Breedveldt Boer HP, van Dongen JJ, Lemain TJ, et al. NHG-standaard: incontinentie voor urine [Dutch College Guidelines on urinary incontinence]. *Huisarts Wet* 1995;38:71–80.
- [15] Grol R, Thomas S, Roberts R. Development and implementation of guidelines for family practice: Lessons from the Netherlands. *J Fam Pract* 1995;40:435–9.
- [16] Sandvik H, Hunskaar S, Eriksen BC. Management of urinary incontinence in women in general practice: Action taken at the first consultation. *Scand J Prim Health Care* 1990;8:3–8.
- [17] Penning-van Beest FJ, Sturkenboom MC, Bemmelmans BC, Herings RM. Undertreatment of urinary incontinence in general practice. *Ann Pharmacother* 2005;39:17–21.
- [18] Burgers JS, Zaat JOM, Spies TH, van der Bij AK, Mokkink HGA, Grol RPTM. The quality of Dutch clinical guidelines for general practice. Appraisal of 130 key recommendations from 28 guidelines developed by the Dutch College of General Practitioners. *Huisarts Wet* 2002;45:349–53.
- [19] Glaser B, Strauss A. The discovery of grounded theory. Chicago: Aldine; 1957.
- [20] Lose G, Jacobsen AT, Madsen H, Thorsen P, Tiback S, Johansen B. General practitioners' knowledge of and attitude to assessment and treatment of women with urinary incontinence: A questionnaire among general practitioners in Denmark. *Ugeskr Laeger* 2001;163:7086–7.
- [21] Grealish M, O'Dowd TC. General practitioners and women with urinary incontinence. *Br J Gen Pract* 1998;48:975–8.
- [22] Gormley EA, Griffiths DJ, McCracken PN, Harrison GM. Polypharmacy and its effect on urinary incontinence in a geriatric population. *Br J Urol* 1993;71:265–9.