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An exploration of osteopaths' views and experiences regarding the identification of, and provision of advice for, urinary incontinence in women: A qualitative study using framework analysis

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ABSTRACT

Background: Urinary incontinence (UI) may be defined as a storage symptom of the lower urinary tract resulting in the involuntary loss of urine. UI is common in women, but many of those affected do not mention symptoms to healthcare providers. The prevalence of the condition makes it likely that a large proportion of women attending for osteopathic care will be affected by symptoms of UI. It is not known whether osteopaths routinely ask about urinary UI, or provide advice.
Aim: The primary aim of this research was to explore osteopaths' views and experiences regarding the identification of UI in women.
Methods: This research was undertaken as an exploratory, qualitative study. A purposive sample of 11 osteopaths participated in semi-structured interviews. The data were analysed using a framework approach.
Findings: A wide variation in views and experience of identifying and providing advice for urinary incontinence in women was found. Identification of UI occurred either by practitioners asking about symptoms; by following up on comments or observations; or, by patient led discussions.
Conclusions: This study has identified barriers to discussing UI in routine osteopathic consultations. UI is common in women and those affected are often reluctant to seek help. Women can be helped to improve their symptoms if they are given appropriate advice. More awareness of the condition and appropriate advice may encourage more osteopaths to consider UI as part of routine care.
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Introduction and background

Urinary incontinence (UI) may be defined as a storage symptom of the lower urinary tract and is broadly categorised by the International Continence Society [ICS] [1] as:

- Stress urinary incontinence (SUI) - involuntary leakage of urine on effort or exertion, or on sneezing or coughing.
- Urge urinary incontinence (UUI) - the involuntary leakage of urine accompanied or immediately preceded by urgency.
- Mixed urinary incontinence (MUI) - involuntary leakage associated with urgency and also with exertion, effort, sneezing or coughing [1].

UI may affect females of all ages and at all stages of life. Women are generally affected more than men and there are differences in risk factors according to gender [3]. It is estimated that roughly one third of women over the age of 40 suffer from some form of urinary incontinence [2], with one quarter of women of all ages are affected [3]. There is evidence to suggest that the prevalence of UI increases up to middle age, levels off between 50 and 70 and then steadily increases again after the age of 70 [3]. The proportions of UI type differs somewhat with age, with older women suffering more with UUI and MUI and younger women more with SUI [3]. There are some sub-groups of women where prevalence rates are higher, most notably pregnant women and those living in residential care [3]. The menopause also has an effect on urinary symptoms and atrophic changes in the tissues can contribute to storage symptoms such as urinary frequency and urgency; however, there is inconsistency in the literature with regard to an increase in UI related to menopausal status [3].

Despite UI being a commonly experienced condition, the

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number consulting a health-care professional about urinary symptoms is relatively low. UI has been described as an "ice-berg" condition with only a minority seeking care [4]. Healthcare professionals similarly, may not routinely screen for this condition and in many cases are likely to be unaware that their patients are affected by it [5]. There is inconsistency in terms of how women are assessed and treated, depending on the NHS pathways available in a particular area. Some women are assessed and treated in primary care by GPs and practice nurses, whilst others are referred to secondary care and are seen by specialists such as physiotherapists or urologists [2]. In addition to the gaps in identification of UI, assessment and treatment are currently suboptimal and there exists opportunities for better collaborative working across health care professions [6].

The prevalence of UI in adult women means that a considerable proportion of patients affected by this condition are likely to present to osteopaths in the UK. A critical literature review undertaken by the first author identified that women with symptoms of urinary incontinence were reluctant to seek help from healthcare providers [7]. The literature review identified that healthcare providers could raise awareness of the condition by proactively asking all women about urinary leakage symptoms. Since there were no studies specifically looking at this issue in osteopathic practice, it is not known whether women are equally reluctant to seek help from their osteopath as from other healthcare providers, whether osteopaths in the UK do routinely ask about symptoms of UI, or, whether they provide advice or other management [7].

The primary aim of this research was to explore osteopaths' views and experiences in identifying urinary incontinence in women and to describe any advice or management provided.

Methods

This project was undertaken as part of an undergraduate, integrated masters award in osteopathy. The research was designed as an exploratory, qualitative study [8]. Since the literature review that informed this research had not identified any publications specifically aimed at osteopaths, an exploratory, qualitative methodology was considered an appropriate design, since it would provide a starting point in understanding the topic from an osteopathic practitioner's perspective. The methodology used in this study enabled participants to provide their own accounts, since open-ended questions were devised and an inductive approach in semi-structured interviews permitted themes to emerge. A framework approach as first described by Richie and Lewis (2003) [9], was used for this study; a schematic overview detailing the stages involved is included at appendix A. Framework approach was considered appropriate as it enabled a cross-case and cross-theme analysis of the coding frame, to identify key characteristics, categories and quotes suitable for inclusion [10]. The aim with the chosen methodology was therefore to map a range of osteopaths' opinions and experiences; to identify themes and patterns within these; to analyse these data in order to construct concepts and finally, to combine the emic and etic perspectives to provide the richest understanding in order to explain the meaning derived from the data by providing a summary [9].

Subjects

Eligible for inclusion in the study were osteopaths, practising in the UK; non-qualified/student osteopaths were excluded. Purposive sampling was undertaken. The sampling strategy aimed for a broad range of perspectives and length of experience to be included [11]. Representatives of selected osteopathic organisations were contacted via email and were asked to approach all of their members to invite them to take part; approved study information documents were included with the invitation. The following organisations were approached: National Council for Osteopathic Research (NCOR) Hubs, College of Osteopaths (lecturers and tutors), Osteopathic Pelvic, Respiratory, Abdominal Association (OPRAA), Northern Counties Society of Osteopaths, Western Counties Society of Osteopaths, British Naturopathic & Osteopathic Association (BNOA). No reminders were sent. 11 volunteered and took part in the study.

Data collection

Semi-structured interviews, with open-ended questions were used to collect the data. This format was deemed appropriate since it provides the opportunity to obtain comparable qualitative data and to ensure that all of the areas of enquiry are covered during interviews. It allows for topics to be expanded by both interviewees and researchers, according to how the interview flows [12]. A topic guide was developed in order to enable the research aims to be addressed. The guide was trialled with two student osteopaths initially. Since only qualified osteopaths were eligible for inclusion in the study, the data from the students were not included in the final data set. Subsequently two further pilot interviews were undertaken with qualified osteopaths, the data from these were included in the final analysis. The guide was modified iteratively to capture the feedback and learning from all of these pilot interviews. Following revisions, the topic guide was structured into a flowchart that enabled the interview to progress in one of two directions; the final copy is included at appendix B. Semi-structured interviews were undertaken by MR, 3 were face-to-face, and 8 were by telephone (with audio data collection only). Face-to-face interviews were carried out at the workplace of the participants, with due care given to confidentiality and privacy. Telephone interviews were undertaken at the home address of MR in a private room where confidentiality could be ensured. In addition to the topic guide, 4 brief vignettes (appendix C) were prepared and used to facilitate discussion using predetermined scenarios. The use of vignettes in qualitative research permits sensitive topics to be explored in a non-judgemental and non-threatening way [13]. The order of the questions and the exact phasing of interviews varied according to how the discussion progressed and participants had the opportunity to expand on the topics covered, or add detail that they considered relevant. The interviews lasted between 11 min and 52 min, with a median of 30 min. All interviews were recorded with participant consent. Recordings were labeled with a numeric identifier to protect confidentiality and were stored on a password protected, personal laptop, compliant with ethical approval conditions.

Data analysis

Interview recordings were manually transcribed and participants were assigned numerical identifiers. Each transcript was read and re-read whilst listening to the interviews. The study aims and objectives, along with the topic guide questions, were used to identify a priori themes; early impressions that emerged from the initial reading of the data [14] were combined with these to form the first iteration of the coding frame. The coding frame was therefore the product of both a deductive and inductive approach [14]. The main themes and the sub-themes within the coding frame were labeled using numeric codes. Using these codes, MR and SF systematically indexed the first of the transcripts by manually marking sections of data. The indexing was compared and discussed and the coding frame was then refined with additional codes added and others combined in order to reduce overlap and

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