CLINICAL PAPER

Reasons why patients referred to physiotherapy with continence or pelvic floor dysfunction fail to complete treatment

F. J. Lennard
Physiotherapy Department, Ipswich Hospital National Health Service Trust, Ipswich, UK

Abstract
The aim of this study was to identify why patients with continence or pelvic floor dysfunction (PFD) fail to complete their treatment. A postal questionnaire was sent to patients who had attended for, but failed to complete, treatment within a physiotherapy department for continence or PFD during a specific year. In 2006, 112 patients (27%) with continence or pelvic floor disorders failed to complete their courses of treatment. Questionnaires were mailed to the 109 surviving patients and 60 (55%) of these were returned. Various reasons were given by subjects for not completing treatment: 34% cited difficulty attending appointments; 27% stated that they were 'better'; 20% mentioned other health problems that took precedence; 18% reported that they either did not wish to be referred to physiotherapy or did not think that physiotherapy would benefit them; and 10% stated that they had undergone surgery for the problem (although 33% of this group reported that the surgery had been unsuccessful). Following the audit and in combination with the 18-week waiting initiative, the department gained more staff, which reduced the waiting times and allowed early-morning and lunchtime appointments to be offered. A patient information leaflet was produced that gave comprehensive explanations of conditions and treatments, and details of self-help groups. Extra emphasis was placed on pelvic floor exercises for all pregnant and postnatal women seen by the physiotherapists. In 2008, when the service was re-audited for patients seen in 2007, the percentage of patients who failed to complete treatment had reduced to 21.2%. Physiotherapists need to be aware of the barriers and costs faced by patients seeking treatment. Physiotherapy practice needs to continue to change to reduce these barriers and costs in order to maximize the benefits that physiotherapy can offer patients, and increase the effectiveness and efficiency of the physiotherapy services available to healthcare providers and users.

Keywords: failure to complete treatment, incontinence, pelvic floor dysfunction, physiotherapy.

Introduction

A number of studies have focused on the percentage of outpatients with both musculoskeletal and pelvic floor dysfunction (PFD) who fail to complete physiotherapy treatment, and figures varying from 24% to 59% have been reported (O'Brien *et al*. 1991; Holdsworth *et al*. 2006). These figures have cost implications for both physiotherapy services and the UK National Health Service (NHS) as a whole because they have a negative impact on the efficiency of services and waiting lists.

In 2006, 685 patients with continence or PFD were referred to the Continence and Pelvic Floor Physiotherapy Department, Ipswich Hospital NHS Trust, Ipswich, UK. A total of 411 individuals were seen and discharged in the same period. Of those, 299 patients completed treat-

Correspondence: F. J. Lennard, Finn Clinic, Physiotherapy Department, 9th Floor, Maternity Block, Ipswich Hospital NHS Trust, Heath Road, Ipswich, Suffolk IP4 5PD, UK (e-mail: fiona.lennard@ipswichhospital.nhs.uk).

© 2009 Association of Chartered Physiotherapists in Women's Health

Table 1. Outcomes of treatment for patients who completed treatment

Condition	Number of patients	Percentage of patients cured (90–100%)	Percentage of patients improved (50–89%)	Average number of treatments	Average length of treatment (months)
Stress incontinence	43 (14%)	28.0%	53.5%	7.0	7.5
Mixed incontinence	76 (25%)	25.0%	41.0%	6.0	6.6
Urge incontinence	17 (5%)	18.0%	65.0%	5.0	4.5
Faecal incontinence	13 (4%)	8.0%	61.0%	8.0	7.0
Male incontinence	17 (5%)	47.0%	36.0%	4.0	5.0
Prolapse	31 (10%)	29.0%	48.0%	6.0	5.7
Dyspareunia	12 (4%)	33.5%	50.0%	11.0	6.0
Multiple problems	90 (30%)	23.0%	51.0%	6.5	6.8

ment. At discharge, the patients are asked by what percentage they feel they have improved following treatment, and this is combined with objective measures of improvement (e.g. frequency and severity of symptoms at discharge compared to time of initial assessment, and pad usage, if relevant) and quality of life questionnaire scores. Their outcomes of treatment are collated in Table 1. The remaining 112 (27%) patients who were assessed either failed to return or failed to complete treatment. This resulted in at least 56 h of physiotherapy time being wasted.

The superintendent physiotherapist audits the outcomes of the Ipswich Hospital NHS Trust continence service each year and distributes the results to all services users. However, it is only possible to collate the outcomes of those patients who complete treatment since the outcomes for those who fail to return are unknown.

In 2006, the urogynaecologist consultant at Ipswich Hospital requested the outcomes for those who had failed to complete treatment. The superintendent physiotherapist decided to send a postal questionnaire to those patients who had not completed treatment in an effort to establish the reasons for this.

Background

Urinary incontinence is one of the most common chronic diseases. It has been estimated to affect 8.5% of women aged between 15 and 65 years, and this figure rises to 57% of women aged between 45 and 65 years (Miner 2004). While the incidence of incontinence is higher in women than men, a survey of adults aged over 40 years in Leicester, UK, found that 8.9% of men reported being incontinent several times a month (Perry *et al*. 2000).

Faecal incontinence appears to increase with age, with the incidence varying from 1% to 16% in healthy women to 50% in female residents of nursing homes (Jackson *et al*. 1997).

The incidence of pelvic organ prolapse varies depending on the population studied and the diagnostic criteria, ranging from 30% to 93% (Samuelsson *et al*. 1999).

Incontinence is a condition that impacts on all areas of life, from the ability to get a good night's sleep to the ability to travel. It affects the sufferer's physical, emotional and sexual health, reducing or removing the ability to take part in physical exercise and social activities. It commonly causes depression, embarrassment and anxiety, and may result in withdrawal from sexual relationships (Kelleher 2001). In a survey of community residents aged over 65 years, Rockwood *et al*. (1999) found that subjects with urinary incontinence, but without cognitive impairment or significant physical disability, were 70% more likely to be admitted to an institution and 20% more likely to die within 5 years than those who were continent. The lifetime medical costs of women with stress urinary incontinence are 1.8 times higher than those of women without the condition (Birnbaum *et al*. 2003).

Pelvic floor muscle exercises (PFMEs) and bladder training have been shown to be simple, low-cost and effective methods of treating incontinence (Melton 2002; Bond *et al*. 2004; Dorey *et al*. 2006). However, it has been found that most people with clinically significant symptoms do not find these bothersome, with only 3.8% of those affected reporting that they would like help (Perry *et al*. 2000).

A number of reasons have been cited that explain why people do not seek help for continence problems. Davis & Kumar (2003) reported that women with PFD do not seek help immediately unless their symptoms are severe and have a negative impact on their quality of life. Facione *et al*. (2000) found that some women view symptoms of PFD as normal and, indeed, inevitable after childbirth. Others may fear what

© 2009 Association of Chartered Physiotherapists in Women's Health

investigation and treatment involves, and therefore, hope that the symptoms will improve on their own (Norton *et al.* 1988). A significant number of women are embarrassed by their condition, and as a result, do not, or cannot, talk about it to anyone, including health professionals (Holst & Wilson 1988).

The Health Belief Model proposes that, for someone to seek medical help, they need to believe that illness can have a negative impact on their life and that taking action will successfully avoid the possible negative consequences (Holm *et al.* 1999).

Shaw *et al.* (2001) reported that fear of a serious disease, such as cancer, actively promotes help-seeking. Women with vaginal prolapse often present with 'a lump in the vagina' and many are concerned this may be of a sinister nature. If their fears of cancer are allayed, they may then drop out of a treatment programme if they no longer see their condition as a threat to their health and lifestyle. If someone perceives they have a high quality of life, they are less likely to recognize that they have a health problem (Shaw *et al.* 2001).

Cognitive and motor activities are employed by a person suffering from illness in order to preserve bodily function and 'cope' with the effects of the illness (Lipowski 1970). In the case of incontinence, this may involve the use of pads, toilet mapping, carrying a change of clothes and avoiding activities such as exercise that result in leakage.

Women have been found to use more strategies than men to cope, and therefore, they minimize the impact of disease (Sutherland & Jenson 2000). However, if their symptoms become worse and the coping strategies no longer work, individuals may recognize that the illness is a threat to their well-being and seek help.

Holm *et al.* (1999) reported that women either expect that health outcomes are the result of their own actions (i.e. the internal locus of control) or the actions of others (i.e. the external locus of control). In its treatment of incontinence, physiotherapy requires patients to take an active role in their treatment, which involves undertaking some lifestyle changes and individual home exercise programmes. Therefore, women with an internal locus of control may respond better to physiotherapy than those with an external locus of control, who may prefer surgical or pharmaceutical options.

It has been reported that individuals who intend to seek help may fail to do so following a cost–benefit analysis of the implications of carrying out the behaviour. If the perceived benefits of seeking help are outweighed by costs or other barriers to seeking help, then no action is taken (Oh & Park 2004). If a further trigger occurs, then the individual may start the process again.

Several barriers or perceived barriers to healthcare have been described. Moss (2002) reported that transport issues may prevent individuals from receiving treatment. The time of day when a service is provided can also impact on a person's ability to access healthcare (Currie & Wiesenberg 2003). Economic constraints were reported in women with breast cancer (Facione *et al.* 2000), and low expectations (Horrocks *et al.* 2004) have also been reported to be barriers to seeking help.

Subjects and methods

A tick-box questionnaire (see 'Appendix 1') was devised by the superintendent that listed common reasons given by the patients who did contact the department to cancel appointments. However, the questionnaire also allowed patients an opportunity to give other reasons and relevant details. It was also felt to be a good opportunity to discover this group of patients' experiences of the department and how the service could be improved. The superintendent felt that giving patients a range of options to tick would make completion of the questionnaire quick and easy. However, in the area of patient experience of the service, no suggestions were given, and therefore, patients completed this section in their own words without prompts. One possible failing of the audit was that the questionnaire was neither validated nor piloted. Each questionnaire was numbered corresponding to a patient's set of notes, so it was possible to identify who had returned the questionnaire. Before sending out the questionnaire and covering letter (see 'Appendix 1') to each patient who failed to complete treatment, the hospital database was checked to see if any patients had passed away. It was found that three (2.6%) patients had died. Because of the financial status of the Trust, the 109 questionnaires with a stamped addressed envelope were not sent out until May 2007.

Of the 112 patients who had not completed their treatments, 49 (43%) had only attended the initial assessment and the other 63 (57%) patients had failed to return at various points during their therapy.

© 2009 Association of Chartered Physiotherapists in Women's Health

Table 2. Diagnoses of patients who returned the questionnaire following failure to complete treatment

Condition	Number of patients	Number of patients who reported that they were better
Stress incontinence	10 (16%)	2 (20%)
Mixed incontinence	14 (23%)	2 (14%)
Urge incontinence	4 (6%)	0 (0%)
Faecal incontinence	1 (1.6%)	1 (100%)
Male incontinence	1 (1.6%)	1 (100%)
Prolapse	6 (10%)	3 (50%)
Multiple problems	24 (40%)	7 (29%)

Results

A total of 60 (55%) questionnaires were returned to the department. Although this response rate is slightly below the ideal return rate of 65% stated by editor of the journal of *Physiotherapy*, it was a higher response rate than the present author expected in view of the fact that these patients had failed to complete treatment and had not contacted the department to cancel their appointments.

There was found to be minimal bias among the respondents, with 25 (42%) having only attended for the initial assessment, and the other 35 (58%) having attended between two and 13 appointments (average number of appointments = 4.5). In addition, when comparing the initial diagnosis of the respondents with the initial diagnosis of those patients who did complete their treatment, the percentages were very similar (see Tables 1 & 2). Therefore, it was felt that the results were representative of the group.

Diagnosis of patients who returned the questionnaire

The average number of treatments for those patients who reported that they had got better was five treatments (Table 2).

Reasons reported for not completing treatment

Sixteen patients stated more than one reason for not completing their treatment, with 15 giving two reasons and one patient giving three reasons (Table 3). Ten of the patients who returned the questionnaires stated that they wished to return to physiotherapy. These patients were contacted by a letter explaining that, since they had not attended without contacting the department, in line with hospital policy, they had been discharged, but that we would be happy to see them again if they were to be re-referred by their general practitioner (GP), six of these patients subsequently returned for further treatment.

Table 3. Reasons reported for not completing treatment: (DNA) did not attend

Reason reported for DNA	Number of patients
'Got better'	16 (27%)
Other health problems	12 (20%)
Didn't wish to be referred	9 (15%)
Didn't think physiotherapist would help	2 (3%)
Family commitments	8 (13%)
Work commitments	6 (10%)
Had surgery for the problem	6 (10%)
Car parking too expensive/stressful	5 (8%)
Moved out of the area	4 (6%)
Difficulty getting to hospital	2 (3%)
Appointment cancelled – hadn't rebooked	2 (3%)
Referred back to consultant	1 (1.5%)
Done 'own experiments' – hadn't worked	1 (1.5%)
Other reasons (no details given)	1 (1.5%)

Table 4. Comments on the service

Comment on service	Number of patients
Very good	15 (43%)
Excellent	6 (17%)
Good	3 (8%)
Information received was helpful	6 (17%)
Staff were kind	5 (14%)
Staff were sympathetic	3 (8%)
Physiotherapist was very professional	1 (2%)
Area was very clean	1 (2%)

Comments on the service

The questionnaire asked patients to comment on the physiotherapy service as they had found it and 35 (58%) patients responded to this. The majority of comments on the service that were received were positive and are broken down in Table 4. In addition, one patient said, 'Thank you for sending me this letter. It shows you are concerned about your patients.'

Five patients gave negative feedback. The following criticisms were made:

- 'I was really happy with the treatment until it ended without a follow-up.'
- 'Didn't tell me anything that I didn't already know.' (This patient was seen by a junior physiotherapist.)
- 'It was OK, but I couldn't do the exercises and work.'
- 'I was not able to have a vaginal examination on my first appointment due to a senior member of staff not being available. I arrived

© 2009 Association of Chartered Physiotherapists in Women's Health

for my second appointment after the appointment time had finished and was told I had to rebook – I found it all too stressful.'

- 'Dreadful dirty area.' (This lady attended the department for her appointment a few days after the Trust had been on the national news following a high-profile case of methicillin-resistant *Staphylococcus aureus* (MRSA). She declined a vaginal examination at her assessment, stating that she did not wish to contract MRSA. The department is cleaned daily, and all therapists adhere to local and national infection control policies and guidelines. This demonstrates the importance of trusts reducing infection rates in order to regain public confidence.)

Patients' comments on how the service could be improved

Twenty-six (43%) respondents made comments and/or suggestions.

Five of the 26 patients (19%) said that the service could not be improved further. Three (11%) felt that the service needed to meet people's expectations. (These patients indicated that they wanted surgery, not exercises.) Three (11%) stated that the department needed more staff. Two (7%) said that the waiting time for appointments should be less. Because of the financial status of the Trust, we had not been able to recruit when our band 6 physiotherapist had left or to have cover for our band 7 while she was on maternity leave. This resulted in our waiting list, which normally runs at between 8 and 12 weeks, growing to 9 months at its peak.

Two respondents (7%) commented that they did not like having to leave a message on the telephone answering machine. Two (7%) said that they would like to book follow-up appointments at each visit, rather than having to call to make an appointment. (This was something that the department trialled for a short time in order to make the diary more flexible. However, it was found that the system did not work because patients forgot to call or the diary was already booked up, and thus, it was difficult to find available slots within a week of them calling. Therefore, we went back to the system of booking their next appointment face-to-face after their consultation.)

One patient (3.5%) felt that postnatal women should be given more advice on PFMEs because she hadn't been taught these exercises after she had delivered her children. Almost all women who deliver at the Trust are seen by a physiotherapist since ward cover is provided 7 days a week. All postnatal women are verbally taught PFMEs on the ward, and are able to self-refer up to 6 weeks postnatally if they experience any PFD. They are given a patient information booklet, and following the audit, the pelvic floor section was revised with the exercises being printed in bold and 'the Knack' was added. One (3.5%) suggested that a newsletter with self-help advice should be sent to all patients referred to the department. One (3.5%) requested more treatment rooms away from the office area, which would allow for more privacy and a more-relaxed atmosphere. One (3.5%) said that car parking should be free. One (3.5%) proposed a telephone advisory service. One (3.5%) said that the service should be provided on a more local basis. The department does have one satellite clinic in the community that is very popular and the superintendent has continually strived to set up other satellite clinics; however, to date, this has proved to be unsuccessful because of charges for rooms. One (3.5%) commented that she would like to be able to self-refer because having to see her GP was too stressful. Because of the tariff system for pregnancy care, the department has been able to accept self-referral for pregnant women or for women up to 6 weeks postnatally; however, as a result of payment by referral, all other patient groups currently have to be referred by a doctor. One (3.5%) thought the area was dirty (see 'Comments on the service' above).

One respondent (3.5%) said that she would like to see the same physiotherapist each time she attended the department. (Patients usually see the same physiotherapist at each session unless rotational staff rotate out of the department, or if staff are on long-term sick or maternity leave.)

Discussion

Difficulty attending appointments as a result of time constraints and/or expense was the commonest reason given for not completing treatment (with 13% citing family commitments, 10% mentioning work, 8% stating that car parking was too expensive/stressful and 3% finding it difficult to get to the hospital), accounting for a total of 34% of patients in the present sample. Physiotherapy has historically been a Monday–Friday, 9:00–5:00 service, and although there have been recent moves in some areas to change this, it is clear that this issue needs to be

© 2009 Association of Chartered Physiotherapists in Women's Health

addressed globally in order to meet the needs of clients.

The second commonest reason for patients not completing treatment was that they reported that they were 'better' and no longer felt that treatment was needed (27%). It is not known whether these respondents were actually better, or if their 'trigger factor' had resolved and their symptoms had been reduced to a level with which they could cope.

A further 20% of patients reported that they had other health problems that had taken precedence over their course of treatment. It is unknown whether these problems were related directly or indirectly to their continence problem, or were totally unrelated. However, Thom *et al*. (1997) reported that the risk of hospitalization was 30% higher in women and 50% higher in men following a diagnosis of incontinence. It was found that a total of 18% of patients had either not wanted to be referred to physiotherapy or felt that physiotherapy would not be beneficial to them, which suggests that referrers need to ensure that individuals are aware of what physiotherapy can offer and that they wish to try that treatment option before referral takes place.

Therapists should endeavour to ascertain that physiotherapy is the patient's preferred course of treatment, and that she is not just attending to please the doctor or family member who has pressed her into seeking treatment. Alternatively, a move to a system that allows self-referral would ensure that only patients who want physiotherapy would present for treatment. Holdsworth *et al*. (2006) reported that, '[S]elf-referring patients attended more reliably than patients referred by their GP, with a greater proportion of self-referring patients completing their full course of treatment, particularly when compared with patients referred at the suggestion of their GP (76% versus 69%).'

The present study found that the diagnosis is not a good indicator of those patients who are unlikely to complete treatment because the percentage of individuals who failed to complete their therapy was very similar to the percentages of patients with each condition who did complete treatment (see Tables 1 & 2). The literature suggests that subjects with stress incontinence may be more likely to drop out of treatment if their 'trigger factor' resolves. Women with vaginal prolapse were also thought to be likely to drop out of treatment once they were reassured that their condition was not of a sinister nature. However, these two groups may make up a significant number of the patients who fail to attend their initial assessment, an area that was not investigated in the present study.

Changes made to clinical practice following the outcomes of the audit

Because of the 18-Week Wait Initiative, the department was able to increase the level of staffing with the addition of an extra whole-time equivalent (WTE) band 5 and WTE band 6 physiotherapist, which enabled early-morning and lunch-time appointments to be offered to patients. Previously, outpatient appointments had only been offered between the hours of 10:30–4:30 because the three established WTE staff covered the wards first thing in the morning.

A detailed subjective and objective assessment, including a vaginal/rectal examination with consent, is routinely performed on the first visit. The negative comment received regarding this highlighted to the staff the importance of ensuring that this standard was met as much as possible.

All treatment choices (including medical and surgical options) and contraindications/risks are now explained on the first visit and the patient's preferred appropriate treatment programme is then initiated. Previously, surgical and medical options were only explained to those patients who openly expressed an interest, or to those whom it was felt, following assessment, would not respond favourably to physiotherapy.

Following the audit, a patient information booklet was compiled that contained descriptions of pelvic anatomy, bladder and pelvic floor function, types of vaginal prolapse and incontinence, how to perform pelvic floor exercises, voiding, and 'defer the urge' techniques. The booklet also includes details of support groups. Patients are given the option of returning for a follow-up appointment, having a consultation over the telephone or being placed on 'SOS', where their notes are kept for up to 6 months, so if they wish to return for another appointment, they can do so without a new referral.

If muscle stimulation is indicated, patients are given the option of attending the department or purchasing a home stimulator. Prior to the audit, advice on purchasing a home stimulator was only given to those patients who openly expressed an interest. Following the audit, all patients for whom stimulation was indicated were given information on purchasing their own machine as well as the option to attend for stimulation within the department.

© 2009 Association of Chartered Physiotherapists in Women's Health

It was hoped that there would be a reduction in the percentage of patients who failed to complete treatment when the service was audited again at the beginning of 2008.

At the beginning of 2008, it was found that, during 2007, a total of 366 patients completed treatment for incontinence and PFD, with a further 99 patients (21.2%) failing to complete treatment. A further questionnaire was not sent out to these patients since it was not thought to be of additional benefit to the service.

Conclusions

Physiotherapy has been shown to be an effective, low-risk and inexpensive treatment for incontinence and PFD.

Patients should be encouraged to access the treatment options that are offered by physiotherapy.

However, physiotherapists need to be aware of the personal barriers, both perceived and actual, that are faced by individuals who present for treatment, and be able to address these so as to ensure that every patient receives the maximum benefit from the therapies available at the minimum cost to themselves and their health service providers.

References

Birnbaum H., Leong S. & Kabra A. (2003) Lifetime medical costs for women: cardiovascular disease, diabetes and stress urinary incontinence. *Women's Health Issues* **13** (6), 204–213.

Bond E., Dorey G., Eckford S. & McDonnell K. (2004) The role of pelvic muscle exercises in reducing surgical management of women with stress incontinence: a clinical audit. *Journal of the Association of Chartered Physiotherapists in Women's Health* **95** (Autumn), 66–70.

Currie D. H. & Wiesenberg S. E. (2003) Promoting women's health-seeking behaviour: research and the empowerment of women. *Health Care for Women International* **24** (10), 880–899.

Davis K. & Kumar D. (2003) Pelvic floor dysfunction: a conceptual framework for collaborative patient-centred care. *Journal of Advanced Nursing* **43** (6), 555–568.

Dorey G., Sultan H., Eckford S. D., Parker J. & Lowe D. (2006) Pelvic floor muscle exercises and urge suppression techniques in women with urge urinary incontinence: a retrospective study from a dedicated urogynaecology clinic. *Journal of the Association of Chartered Physiotherapists in Women's Health* **99** (Autumn), 43–48.

Facione N. C., Giancarlo C. & Chan L. (2000) Perceived risk and help-seeking behaviour for breast cancer: a Chinese-American perspective. *Cancer Nursing* **23** (4), 258–267.

Holdsworth L. K., Webster V. S. & McFadyen A. K. (2006) Self-referral to physiotherapy: deprivation and geographical setting: is there a relationship? Results of a national trial. *Physiotherapy* **92** (1), 16–25.

Holm C. J., Frank D. I. & Curtin J. (1999) Health beliefs, health locus of control, and women's mammography behaviour. *Cancer Nursing* **22** (2), 149–156.

Holst K. & Wilson P. D. (1988) The prevalence of female urinary incontinence and reasons for not seeking treatment. *New Zealand Medical Journal* **101** (857), 756–758.

Horrocks S., Somerset M., Stoddart H. & Peters T. J. (2004) What prevents older people from seeking treatment for urinary incontinence? A qualitative exploration of barriers to the use of community continence services. *Family Practice* **21** (6), 689–696.

Jackson S. L., Weber A. M., Hull T. L., Mitchinson A. R. & Walters M. D. (1997) Fecal incontinence in women with urinary incontinence and pelvic organ prolapse. *Obstetrics and Gynecology* **89** (3) 423–427.

Kelleher C. (2001) Quality of life and urinary incontinence. In: *Textbook of Female Urology and Urogynaecology* (eds L. Cardozo & D. Staskin), pp. 47–58. Taylor & Francis, London.

Lipowski Z. J. (1970) Physical illness, the individual, and the coping process. *Psychiatry in Medicine* **1** (2), 91–102.

Melton L. (2002) Targeted treatment for incontinence beckons. *Lancet* **359** (9303), 326.

Miner P. B., Jr (2004) Economic and personal impact of fecal and urinary incontinence. *Gastroenterology* **126** (Suppl. 1), S8–S13.

Moss D. (2002) The circle of the soul: the role of spirituality in health care. *Applied Psychophysiology and Biofeedback* **27** (4), 283–297.

Norton P. A., MacDonald L. D., Sedgwick P. M. & Stanton S. L. (1988) Distress and delay associated with urinary incontinence, frequency and urgency in women. *British Medical Journal* **297** (6657), 1187–1189.

O'Brien J., Austin M., Sethi P. & O'Boyle P. (1991) Urinary incontinence: prevalence, need for treatment, and effectiveness of intervention by nurse. *British Medical Journal* **303** (6813), 1308–1312.

Oh H. S. & Park H. A. (2004) Decision tree model of the treatment-seeking behaviours among Korean cancer patients. *Cancer Nursing* **27** (4), 259–266.

Perry S., Shaw C., Assassa P., *et al*. (2000) An epidemiological study to establish the prevalence of urinary symptoms and felt need in the community: the Leicestershire MRC incontinence study. *Journal of Public Health Medicine* **22** (3), 427–434.

Rockwood K., Stadnyk K., MacKnight C., *et al*. (1999) A brief clinical instrument to classify frailty in elderly people. *Lancet* **353** (9148), 205–206.

Samuelsson E. C., Victor F. T. A., Tibblin G. & Svärdsudd K. F. (1999) Signs of genital prolapse in a Swedish population of women 20 to 59 years of age and possible related factors. *American Journal of Obstetrics and Gynecology* **180** (2, Pt 1), 299–305.

Shaw C., Tansey R., Jackson C., Hyde C. & Allan R. (2001) Barriers to help seeking in people with urinary symptoms. *Family Practice* **18** (1), 48–52.

Sutherland B. & Jensen L. (2000) Living with change: elderly women's perceptions of having a myocardial infarction. *Qualitative Health Research* **10** (5), 661–676.

Thom D. H., Haan M. N. & van den Eeden S. K. (1997) Medically recognized urinary incontinence and risks of hospitalization, nursing home admission and mortality. *Age and Ageing* **26** (5), 367–374.

© 2009 Association of Chartered Physiotherapists in Women's Health

Fiona Lennard qualified from Guy's Hospital in 1992. During her training, she spent 3 weeks with the great Margie Polden, who inspired her to develop an interest in women's health. This interest was further nurtured by Linda Maude, the superintendent of women's health at Ipswich Hospital. Fiona gained her Postgraduate Certificate in Health Studies: Continence from the University of East London in 1998. She is now the clinical specialist in women's health at Ipswich Hospital.

Appendix 1

Continence Specialist Physiotherapy Department Ipswich Hospital NHS Trust Patient Questionnaire

Please tick the appropriate box/boxes.
I did not return to physiotherapy because:

I did not wish to be referred to physiotherapy.	
I had other health concerns.	
Family commitments made it difficult.	
Work commitments made it difficult.	
Car parking/travel to the hospital was too stressful/expensive/difficult.	
I did not feel physiotherapy would benefit me.	
Personality clash with the physiotherapist.	
I got better.	
Other reasons – please give details.	

Please give comments on the service as you experienced it.

How could we improve the service?

Many thanks for your help.

Covering letter

The Ipswich Hospital NHS Trust
Directorate of Nursing and Patient Services
Continence Specialist Physiotherapy Department
The Ipswich Hospital
Heath Road
Ipswich
Suffolk IP4 5PD

Dear _____

The physiotherapists working in continence care at Ipswich Hospital are committed to providing the best possible care to all their patients and improving the standards of care provided.

Our records show that you were referred to the department, and that you attended for an assessment session and started treatment, but did not return for any further treatment sessions.

It would help us a great deal if you would fill out and return the enclosed questionnaire in order that we might address any issues and improve the quality of care we provide.

I enclose a SAE and thank you for your time.

Yours sincerely

Fiona Lennard
Superintendent Physiotherapist

© 2009 Association of Chartered Physiotherapists in Women's Health