Strategies to assist uptake of pelvic floor muscle training for people with urinary incontinence: A clinician viewpoint, Slade et al, Neurourology and Urodynamics, 2018, 1-11

Pelvic Distance Journal Club
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Elizabeth Lewis

Aims: To explore the experiences and information needs of clinicians who use PFMT to manage urinary incontinence

Methods: Qualitative analysis was done from data collected from interviews with pelvic floor PT’s and one continence nurse in Melbourne, Australia.

Qualitative research methods are best to evaluate people’s experiences via exam of narratives from recorded data. Focus groups were used, to trigger more responses/insights. Ranges of practice settings, experience levels were used. Individual interviews were only used with remotely located participants. Participants were assured of confidentiality, informed written consent was given and participants were de-identified by assigned numbers.

The research team members were all trained PTs with a range of experience with research and clinical practice. Facilitators for interviews were not known to participants. Participants were qualified by being registered PTs or continence nurses who utilized PFMT in management of UI.

Participants were chosen who did a signed consent and who gave evidence of using PFMT for UI. Recruitment was done until sufficient number for data adequacy.

Rigor was enhanced by: 1) having at least 2 researchers independently review data, develop codes/themes and conduct consensus building meetings, 2) recruit participants with sufficient yet also varied experience, 3) data collection and analysis be documented and replicable, 4) accurate and verified verbatim transcription of live and recorded interviews and 5) consistent emergent themes from/linked to, participant data.

Data collection: Focus groups- 2 hours, individual interviews (video-conferenced) - 1 hour. Questions were pre-set and derived from lit. and expert opinion as discussion guide. Table 1. Sessions were audio recorded /transcribed verbatim, with names replaced by numbers in the transcript. Field notes were made/used with de-briefing immediately after. Participants did anonymous questionnaires prior to group, including their demographics.

Data analysis: Two researchers independently reviewed, coded and organized into categories, with emergent themes. A consensus and also mathematical process was used to identify and build themes. Another researcher independently arbitrated throughout and the other consulted on final themes.

Results: There were 29 participants (all PTs plus 1 continence nurse) from public/private sectors and no drop-outs. There were 7 focus groups and 1 individual interview.

Main finding was that PFMT is a unique form of rehab that requires comprehensive descriptions of program details for implementation in clinical practice.

Data analysis and Discussion

Theme 1: PFMT tailored to the needs of each individual is essential. Participants believed that individualized training is essential but were unsure of how to achieve and wanted evidence based recommendations. They wanted details from the research about decision rules for tailoring therapy programs to the individual. (Box 1).

Discussion points: PFMT tailored to each individual’s needs is essential- CPG’s in many other areas of PT advocate individualized approaches. ICI (International Consultation on Incontinence) advises that there’s insufficient evidence for individualized training. Tailoring is when clinicians use methods to communicate that are individualized to the receiver and target mediators of attitude, norms and self-
efficacy to determine individual levels in patients and customize accordingly. Tailoring involves one or both goals: enhancing cognitive preconditions for message processing and/or, to employ strategies of personalization, feedback and matching of content/context.

**Theme 2 Training-specific cues and verbal prompts assist patients to learn and engage with exercises.** Participants said language, verbal prompts and visualization cues assisted them in teaching correct PFM contraction and engaging patients. They said these are unique to the field. They reported learning by sharing amongst colleagues or from courses/meetings. They agreed on need to engender understanding/safety (Boxes 2-5). They agreed on the need for a “bank” of cues, possibly added to a “hints” section of Clinical practice guidelines. Participants said that some could be generic to both men and women and some can be specific to each gender.

**Discussion points:** Extrinsic feedback can make up for lacks (my understanding of their vague wording) in intrinsic feedback mechanisms (if such are impaired), or with complex exercises. This can be provided as knowledge of results or of performance and is consistent with cues or phrases participants reported using. Verbal cues/prompts can include both an outcome and suggested action (PFM contraction or relaxation). (See Boxes 2-5). Quantity and precision of feedback can affect performance. They recommend collation/publication of a “bank” of these cues or phrases. They may be varied from what is provided by this sample, due to cultural/geographic differences.

**Theme 3: Clinicians can benefit from research reports that provide explicit and comprehensive descriptions about intervention content and decision rules for progression.** All clinicians saw a lack of specific details and decision rules in published PFMT programs (and this information would be helpful). Especially true for functional activities and ADLs application. Participants use their clinical reasoning and experience to guide in decision making.

**Discussion points:** All clinicians said they default to well-defined principles of exercise progression as defined in sports medicine. This includes systematic increases of demands on a muscle group via changing frequency, intensity, time or type once the body has adapted to the present dosage or exercise routine. Can include percent of max voluntary contraction, number of exercise reps to fatigue or perceived exertion. Many clinicians used RUSI (real time ultrasound imaging), digital pressure, vaginal EMG or pressure biofeedback to measure contraction strength (sic). They also use clinical experience for timing/type of ex progression.

Results of research support recommendations for more explicit guidance of when/how effective programs were progressed in clinical trials. Explicit reporting of exercise programs from clinical trials could help clinicians do clinical reasoning and translate research into practice more systematically. They recommend adding a PFMT part to the Consensus on Exercise Reporting Template (CERT), specifically regarding individualization, supervision, motivation (with verbal cues/prompts specific to PFMT) and exercise progression (such as number of max vol contractions to fatigue, change in urine leakage, # pads used) and also tailoring: clinician examples of how to individualize.

**Strengths:** Qualitative research conducted to enhance rigor and trustworthiness. They gained understanding of needs of clinicians and what factors may assist in using results of exercise research.

**Limitations:** Study was done in urban Australia and results may vary in other areas: urban vs rural, or other countries/cultures. Small number of participants, so replication in other parts of the world is warranted.
Questions
1) Did you find you agreed with the participants’ comments? What would you add or change about what they said?
2) Did you find any verbal cues from their suggested “bank” of cues that you haven’t already heard? Would you use them?
3) Do you use/have looked at any clinical practice guidelines? Were they useful?
4) What do you think about adding a “bank” to the end of CPG?