

Full length article

What went wrong?: Patient reasons for nonattendance at Women's health physiotherapy

Phil Reed^{a,*}, Emily Sharples-Carter^a, Emily Syder^a, Aemaan Javaid^a, Hannalee Lewis^a, Catherine M. Havard-Thomas^b, Simon Emery^b, Lisa A. Osborne^b

^a Swansea University, UK

^b Swansea Bay University Health Board, UK

ARTICLE INFO

Keywords:

Nonattendance
Pelvic-floor muscle training
Women's health
Pelvic girdle pain
Referral system
Transport
Psychological factors

ABSTRACT

Nonattendance at women's health physiotherapy sessions involves considerable cost in time and resources. Uncovering factors associated with nonattendance is one priority, and the current research aimed to enhance understanding of this issue. In each of two studies, women referred for women's health physiotherapy were interviewed. Study 1 ($N = 80$) compared participants who did and did not attend their appointment, and Study 2 ($N = 61$) compared reasons for nonattendance given by women with pelvic-floor muscle dysfunction and pelvic girdle pain. The results corroborated several key issues associated with nonattendance noted in previous reports, such as problems in the administration of appointments. Results further suggested attention to the information given by healthcare professionals at the time of referral may help remove some barriers to attendance. The issue of transport to appointments was raised, and developing links to affordable and reliable systems is critical, including development of dedicated transport systems. Finally, the psychological aspects of patients who do not attend appeared to differ and addressing these issues could form part of their treatment. Although each recommendation does involve cost, the savings from reduction in nonattendance may outweigh any initial costs of set up.

Missed medical appointments contribute to problems facing public healthcare resources [1–3]. Apart from potentially negative impacts on patient health [2], missed appointments cost the UK NHS around £216 million/year [4]. Given this, understanding reasons why patients may not attend booked appointments, and altering systems to mitigate the likelihood of such occurrences, is a research priority. These considerations apply across medical domains [3,5,6], and are recognised as issues for women's health physiotherapy (WHP) [7–10]. This report expanded this investigation by providing novel comparisons between views of women who did and did not attend scheduled WHP sessions, as well as novel comparisons between reasons for nonattendance across two varieties of women's health conditions treated by WHP (i.e. pelvic-floor muscle dysfunction, and pelvic girdle pain without incontinence).

WHP is typically a multi-modal intervention, involving physical therapy, such as pelvic-floor muscle exercises (sometimes referred to as Kegel exercises), self-management strategies, as well as education on fluid habits, and structure and function of the pelvic-floor [11]. WHP is clinically-effective, safe, patient acceptable, and cost-effective, across a

range of conditions [12,13]. For example, damage to the pelvic floor affects 25 % of adult women worldwide [14] with a yearly incidence of 1–2 % for adult females [15]. Such damage can result in urologic, colorectal, and gynaecological problems, pelvic organ prolapses, pain, and sexual dysfunction [16], as well as psycho-social issues (anxiety, depression, relationship breakdown, trauma, abuse) [13]. Sometimes many of these aspects are present, often referred to as pelvic-floor muscle dysfunction (PFMD) [16], and sometimes pain and psychological aspects are present without incontinence, referred to, here, as pelvic-girdle pain (PGP) [17]. While NICE-recommended first-line treatment for these issues is WHP [18], its potential effectiveness is hindered by patient nonadherence and nonattendance [19]. As such, understanding reasons behind missed appointments may help develop more effective services.

Several studies have examined reasons why women do not attend (DNA) WHP appointments [7,9,10]. Findings suggest a range of factors, falling into three broad domains: healthcare system issues; competing demands on women's time; and comorbid health concerns. Examples of

* Corresponding author at: Department of Psychology, Swansea University, Singleton Park, Swansea, SA2 8PP, UK.

E-mail address: p.reed@swansea.ac.uk (P. Reed).

<https://doi.org/10.1016/j.ejogrb.2025.03.024>

Received 15 January 2025; Received in revised form 24 February 2025; Accepted 8 March 2025

Available online 13 March 2025

0301-2115/© 2025 The Author(s). Published by Elsevier B.V. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

healthcare system issues include: problems with administration of appointments, such as appointment letters not being sent or received [20,21]; issues with transport to appointments [22]; confidence in healthcare systems [23]; and what healthcare professionals say to patients at referral that may induce ‘treatment overshadowing’, where patients form views of relative benefits of treatment options from the ways these are introduced during initial consultation [10].

Competing demands interfering with attendance can involve women not prioritising their own health [10,20], and/or prioritising care of others [7,10]. Another set of predictors is associated with having additional health conditions, such as the presence of co-occurring physical problems that are given priority [24], and/or presence of comorbid psychological issues attendant on women’s health issues [19,20,25]. Some of these factors can be dealt with by alterations at a systemic level [20], and others can be mitigated through providing additional support systems [26].

Although studies have explored patient reasons for DNAs, few, if any, have compared views of patients who did and did not attend appointments. Moreover, previous explorations have focused on PFMD, and other groups, such as PGP, have not been surveyed, and it is unclear whether reasons would be similar across populations. Given these gaps in the literature, in each of two studies, women referred for WHP were interviewed about their reasons for attending or not attending their scheduled appointment. Responses to interview questions were subject to a qualitative content analysis [13,27]. Interviews were constructed following previous suggestions, and resulting responses ‘mined’ from a neopositivist position [28,29]. The first study focused on comparing views of patients with PFMD who had, and had not, attended their appointment. The second study compared views of nonattenders with PFMD or PGP (see Fig. 1 for a schematic representation of the study plan).

Study 1

Study 1 interviewed women with PFMD who had, or not, attended their scheduled WHP appointment. Questions were based on previous literature, and general healthcare experiences of those diagnosed with PFMD, focusing on participants’ thoughts about their healthcare system, their own health and psychological state, and on variables that may have affected attendance. It was hoped this would expand knowledge of DNA reasons, and asking the same questions of women who had, and had not, attended provided a novel comparison.

Method

Participants

Participants were cis-gender women, proficient in the English language, with a diagnosis of PFMD (including urinary incontinence, faecal incontinence, and pelvic organ prolapse) from a medical professional. These women had been referred to the WHP unit at a large metropolitan hospital in South Wales, and invited to attend within the last year. Participants had to be between 18–90 years. Participants who were not native English speakers, and those with impaired hearing conditions, were excluded to prevent the impact of language barriers. Participants consisted of two separate groups: one comprising those who did attend their initial appointment; and the other comprising those who did not attend.

Participants were identified through the records of scheduled appointments over the last year, and were selected at random from amongst those who did attend (DA) and did not attend (DNA). In total, 198 women were contacted by telephone, and asked whether they would be willing to participate. 40 out of the 74 (54 %) women contacted who had not attended agreed and had a mean age of 50 (range = 27–77) years. 40 out of 124 (32 %) women who had attended agreed, with a mean age of 47 (range = 18–76) years. The majority of (78/80)

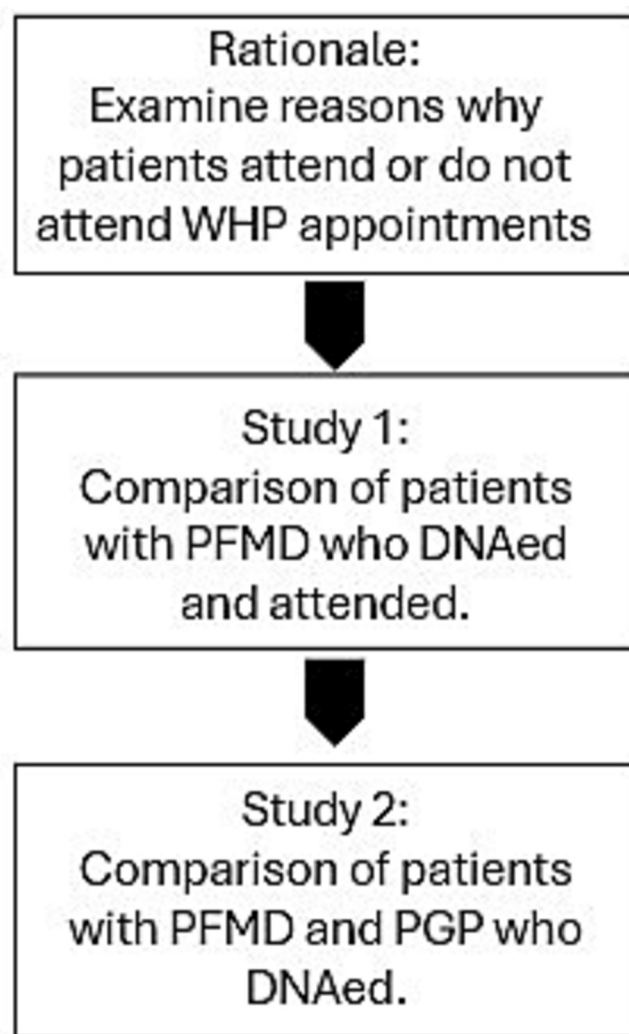


Fig. 1. Schematic representation of the study rationale and plan.

participants were white; 42 participants were married, 9 had a partner, 22 were single, 3 widowed, and 1 divorced. The overall number of participants recruited exceeds that typically suggested (9–17) to reach saturation for qualitative analysis, that is the point at which new themes cease to emerge from analysis [30]. Numbers in each group also exceeded these suggestions. Ethical approval was obtained from the Ethics Committee within the University Psychology Department. All participants gave informed consent in line with the Helsinki agreements.

Procedure

Semi-structured interviews were scripted to follow the same format as one another (see [supplementary materials](#)). The interviews were conducted via telephone, and none of the interviewers were members of the treatment team. Questions were asked in the same order for each interview, but participants could discuss any issues they wished, in as much detail as they felt appropriate. Once a question had been asked, and discussion engaged, the interviewer could ask about any responses made by the participant to elaborate their views. Interviews lasted for as long as participants wished to discuss the topic (typically 10–15 min). Table 1 displays the issues that the questions asked about during the interview.

Interviews were digitally transcribed, anonymously, and the anonymous transcripts were analysed using thematic content analysis, as used previously in Women’s Health and Physiotherapy contexts (see

Table 1

Study 1: Question themes used in the interview for Study 1.

1. How confident are you with the NHS in helping your problem?
2. Is your own health and wellness important and why?
3. Have you ever felt that feelings of uncomfortableness or uneasiness around PFMD?
4. Has the possibility of surgery impacted your decisions to engage in women's health physiotherapy (PFMT)?
5. How were you planning to get to your appointment?

supplementary materials). Table 2 outlines the stages in the analysis that were conducted. To verify the reliability of the coding of responses, Cohen's Kappa analysis established a high inter-rater reliability (0.80) between separate judgements.

Findings and discussion

Confidence in the NHS to help

A total 362 units-of information were extracted from the interviews (215 for DNA group, 147 for DA group). These units produced 6 themes, 3 of which were shared between the groups. Fig. 2a shows these themes, along with the numbers of units, and the percentage of units for each theme and group. The width of the arrows linking the group to the theme represents the relative strength of that theme for that group. Although expressing '**Confidence in the NHS**' was common to both groups, the perception of negative '**NHS Issues**' occurred more often for the DNA group. These negative issues typically involved perceived long wait times, or a lack of confidence in the system. '**Past Experiences**' were noted more often by the DA group, whose past experiences tended to produce positive comment (negative experiences represented only one third of these comments). In contrast, past experiences noted by the DNA group were almost universally bad. Other themes emerging from the comments of the DNA group included '**Personal Responsibility**' about taking accountability for treatment, and '**Women's Health Physiotherapy (WHP) Not Being Worth the Effort**'. There was an additional theme produced by the DA group relating to having '**Knowledge of WHP**'. Taken together, these themes and their relative strength for the groups (indexed by percentages of response which they accounted for), suggest that the DNA group tended to have a more negative view of the NHS, and sometimes WHP, prior to their appointment than the DA group [23]. This negative view was often based on their negative past experiences. The DA group had positive past experiences with the NHS, and more knowledge about WHP (often referred to by them as PFMT).

Importance of own health

The question about the importance of the participants' own health produced 114 units. These units generated 4 themes (2 shared), and are shown in Fig. 2b, along with the relative strength of the comments. A main theme shared by both groups was that health was important for the '**Self**' (56 units). This was a relatively larger theme in terms of percentage comments for the DA group (64 % of their responses) than for the DNA group (40 % of their responses). A variety of reasons were given for this importance, including: valuing health for its own sake; for maintaining independence; and to enable enjoyment of usual activities. The second shared theme concerned the importance of the patient's health for '**Others**', which was more pronounced in terms of percentage responses for the DNA than the DA group. Reasons in this theme

included maintaining health to help relationships with family, and due to needing to care for others. Two themes were produced only by the DNA group, a small set of responses noted that their health was '**Not Important**', and the other noted the impact of '**Psychological factors**', including anxieties about burdening others. Overall, this pattern of comments implies participants who had DNAed were more likely to devalue their own health, or to see it merely as important to conduct caring responsibilities and maintain relationships with others. These also were factors for the DA group, but this group tended to appreciate, to a greater extent, their own health for its own sake.

Feelings of uncomfortableness around PFMD

Responses to the question concerning any feelings of uncomfortableness around PFMD and its treatment produced 116 units, and fell into 3 shared themes, which are shown in Fig. 2c (along with their relative strengths). By far the largest theme for the DNA group was the feeling of a need to '**Avoid Discomfort**' caused by the condition and women's health physiotherapy. Although the DNA group did mention avoiding discomfort, often this theme arose in the negative. The DA group expressed more concern about the '**Stigma**' of having PFMD. The final theme that emerged, again more for the DNA than the DA group, was about severe '**Anxiety**' resulting from the PFMD. Together these responses suggest that those who turn up to their appointments have a greater degree of concern about the presence of PFMD, in itself. In fact, this mirrors quantitative findings [19] showing that some anxiety (but not extreme anxiety, as shown by some comments from the DNA group) is a predictor of attendance at WHP sessions. The responses also suggest a motivator to attend WHP may be overcoming perceived stigma (which may also be associated with anxieties). In contrast, those in the DNA group appeared more motivated by avoiding discomfort resulting from the condition (rather than avoiding the condition itself), and also avoiding discomfort associated with women's health physiotherapy.

Impact of surgery on women's health physiotherapy engagement

Responses to the question concerning the impacts of the possibility of surgery produced 78 units (falling into 3 shared themes), which are shown in Fig. 2d. Irrespective of group, most participants expressed a '**Preference for WHP**' over surgery. A greater percentage of the remaining comments in the DA group, compared to the DNA group, suggested that '**Surgery was Not Considered**' at the consultation. In contrast, a greater proportion of remaining comments in the DNA group suggested that surgery might have been preferred, but they agreed to WHP appointments as there were '**Barriers to Accessing Surgery**'. This implies that, for some of the DNA group, WHP was an unpreferred option, and maybe they had agreed to WHP only as a second-best alternative to surgery. Noticeable, was that the DA group commented that they had not discussed surgery prior to the WHP referral. This latter

Table 2

Stages of the content analysis (after Vaughn et al., 1996).

1. Identification of key themes, following reading and re-reading comments.
2. Identification of 'units of information' (phrases/sentences) relevant to research purposes.
3. Selection of category headings to sort 'units of information'.
4. 'Units of information' coded according to category headings, enabling units to be placed within categories.
5. Negotiation between researchers to agree category headings most economically accommodating 'units of information'.
6. Categories generated in first phase of data analysis reviewed and revised.

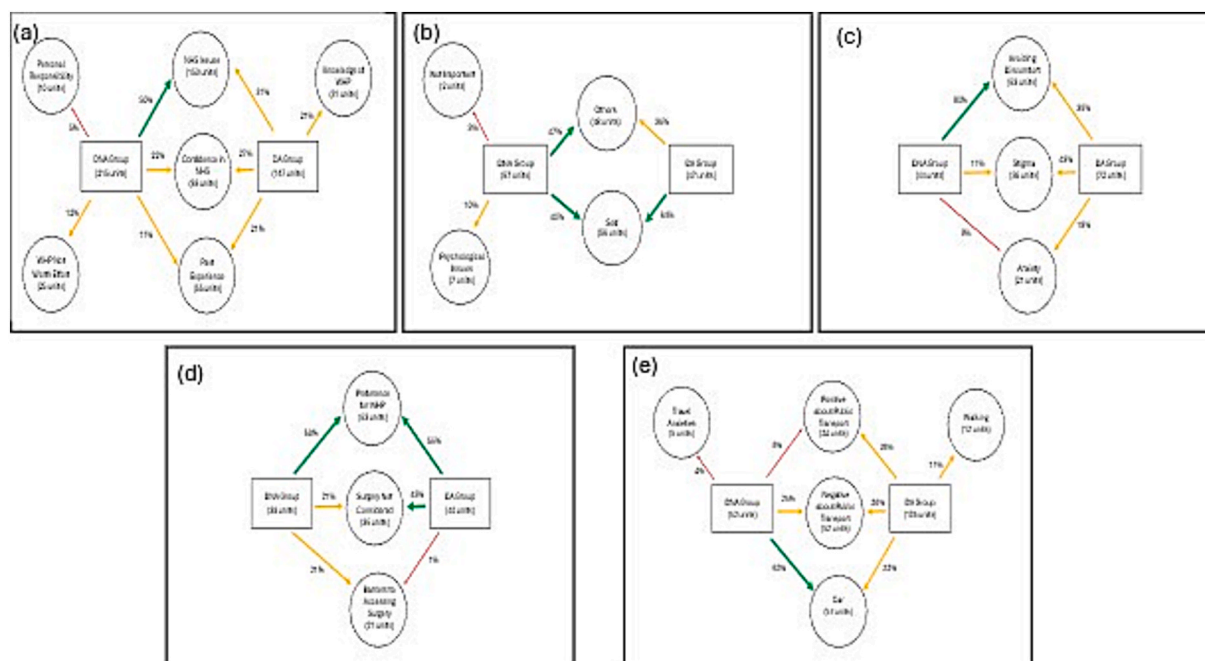


Fig. 2. Study 1: Schematic representation of overarching themes emerging from questions about: (a) confidence in the NHS; (b) whether patients' own health and wellness was important and why; (c) feelings of uncomfortableness or uneasiness around PFMD; (d) the possibilities of surgery; (e) plans to travel to their appointment. Numbers in brackets = numbers of units; numbers along lines = percentage units in theme for particular groups. Arrow width (thicker = more important) and colour (green $\geq 40\%$; amber = $11-39\%$; red $\leq 10\%$) represents the relative strength of that theme for that group. DNA = Did Not Attend; DA = Did Attend. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

finding is similar to the 'treatment overshadowing' effect [10], where the manner of introduction of one treatment at initial referral may interfere with the processing of information about another possible treatment option.

Transport to appointment

The question about getting to appointments generated 157 units of information (DNA = 52; DA = 105), which produced 5 themes (3 shared). These themes and relative strengths are shown in Fig. 2e. Overall, the pattern of responses suggested that the DNA group, compared to the DA group, was much less engaged with forms of transport other than the car. The theme '**Negative Issues with Public Transport**' more prevalent for the DNA group. These comments involved bus reliability, and complicated bus changes, as well as difficulties using public transport due to disabilities and medical conditions. A second theme was being '**Positive about Public Transport**', which was more likely to be made by the DA group. The '**Use of Car**' theme was key to describing many comments from the DNA group, which often noted problems with car travel to appointments. A theme arising only for the DNA group was '**Travel Anxieties**' referring to anxiety inhibiting use of public transport. One other theme, related just to the DA group ('**Walking**'), suggested greater openness to various transport options for that group. These findings corroborate previously reported issues connecting transport concerns with nonattendance [22], and suggests better facilities for parking, or provision of transport to appointments, would aid attendance. Although both would involve cost, this also holds for nonattendance, and relative costs could be considered.

In summary, current results for the DNA group replicate several issues noted previously; notably, a lack of valuing of their own health for themselves [31], systemic issues like confidence in the healthcare system [23], and transport problems [22]. Also noticeable was that the DNA group had less confidence in WHP, expressing a preference for surgery, which may be related to the consultation process they received on referral [10]. These findings from the DNA group contrast with those

from the DA comparison group; comparison of percentage units falling into these categories across the questions suggest they are more prevalently expressed by patients who DNA. This comparison has rarely, if ever, been made.

Study 2

Study 2 expanded the investigation by making comparison between participants with either of two different conditions. Although patients with PFMD are a key group for WHP, potentially representing around 25 % of all adult women [15], it is not the only reason for WHP. Another significant source of patients for WHP are those with PGP, defined here as experiencing pelvic pain but not incontinence, which has a prevalence of around 40 % [17]. This group of women has different demographic characteristics to those with PFMD, usually being younger and in the perinatal period, which may introduce a different set of reasons for non-attendance. To these ends, women invited for WHP in the last 12 months, but who had not attended without giving prior notice, were contacted and asked about issues concerning healthcare systems, what they were told at the referral, their beliefs about WHP, and the potentially interfering issues in their lives. These topics developed and expanded those emerging from Study 1.

Method

Participants

Participants were selected as described in Study 1, but could be diagnosed with PFMD or PGP, and referred by a healthcare professional (usually GP or Consultant) within the last year to an appointment that they did not attend without giving prior notification. In total, 141 participants were approached to participate, and 61 (43 %), aged 31–77 years, old agreed to participate. Of these, 15/56 PFMD (27 %) participants approached agreed to participate, with a mean age of 51.1 (± 1.86 ; range = 29–77) years; and 46/85 (54 %) of the approached PGP

participants agreed to participate; mean age = 30.7 (\pm 5.1; range = 21–42) years. The participants were typically white (58/61), and either married (35/61) or in a relationship (17/61).

Procedure

The interview questions were developed as in Study 1 (see [supplementary materials](#)). Each semi-structured telephone interview was conducted by the same interviewer who was not part of the treatment team, and [Table 3](#) displays the questions. The content analysis conducted on the responses was as described in Study 1 (see [Table 2](#)).

Findings and discussion

What are your thoughts about conservative management?

[Fig. 3a](#) shows the themes (numbers and percentages of units) emerging from 93 responses to the question about conservative management. 6 themes emerged, which all consisted of similar percentages of units for the two groups. A majority of responses indicated participants, despite their nonattendance, were **‘Positive and Open’** to WHP. Another set of responses indicted participants **‘Don’t Know’** what conservative management entails, and responses from both groups suggested there were **‘Problems Accessing the Service’**, or that participants had formed a **‘Negative View’** of the service. Small numbers of responses also mentioned that conservative management had advantages due to its **‘Non-invasive’** nature, and as it provided an **‘Alternative’** to surgery. Several themes corroborated the findings from Study 1 (see [Fig. 2d](#)), such as a generally positive attitude towards WHP, as well as a lack of detailed knowledge about what this entails, and concerns about accessing the service [22].

Why did you not attend women’s health physiotherapy?

[Fig. 3b](#) shows the themes derived from the 85 units concerning reasons participants gave for not attending their scheduled WHP. The most common response for both groups was they had been given **‘No Information’** about the appointment following the referral. **‘Life Events’** interfering with attendance were noted in a reasonable number of responses, although these responses were more likely from PFMD (30 %) than PGP (8 %) participants. Another relatively common responses, made only by PGP participants, was the discovery of **‘Alternative Treatments’** to WHP meant they did not attend. Smaller numbers of units for both groups suggested they had simply **‘Forgot’** their appointment, or prioritised their **‘Other Conditions’**. The predominant themes emerging from responses to this question corroborated those noted in Study 1, especially around the themes of a lack of information about the appointment [21], the impact of other responsibilities and life events [7], and the idea that other forms of treatment had been offered and may have been found preferable [10].

What did the referring clinician tell you about women’s health physiotherapy?

Responses to this question produced 147 units across all participants (35 PFMD; 112 PGP). These units were categorised into four themes shown in [Fig. 3c](#). The largest theme for the PGP responses (49 % units,

versus 11 % for PFMD) indicated they had been given **‘No Information’** about WHP. In contrast, the largest theme for PFMD participants (60 %, opposed to 26 % for PGP) concerned comments suggesting the **‘Purpose’** of WHP had been explained to them. The final theme mentioned similarly often by both groups, was that they had been given **‘Treatment Knowledge’**. A very small number of responses from PGP participants referred to feeling **‘Shame’** due to the consultation. These responses suggest that not having information may be a factor in nonattendance for some PGP participants, but that most PFMD participants who do not attend do have information about the treatment and its purpose. The latter finding mirrors study 1 for PFMD participants who DNA (see [Fig. 3](#)). However, this was not the case for PGP participants, and this finding suggests some differences in DNA reasons between groups, although the reasons for this difference are unclear.

Where other treatment options offered?

[Fig. 3d](#) shows the themes regarding other treatment options offered during referral. There were 67 units produced, falling into 4 themes. The percentages of units in each theme for both groups were broadly similar. Most responses indicated participants had been offered **‘Nothing’** other than WHP in terms of other potential treatment. A smaller number of responses suggested **‘Alternative’** treatments had been offered; others noted offers of **‘Medication’**, and a small number mentioned the possibility of **‘Surgery’**. This pattern of results stands in some contrast to Study 1, where participants who DNAed often noted they had been informed of other options. It also suggests that when more preferable treatment options are noted by participants (see [Fig. 3a](#)), these may not have been introduced at the initial referral, but discovered through their own research.

What do you think your role is in your treatment process?

The question about participants’ perceptions of their own role in WHP produced 81 units of information, which yielded 6 themes that were highly similar across the two groups (see [Fig. 3e](#)). The most common response involved participants saying that they **‘Don’t Know’** about their role. Two other relatively common themes emerging were that participants thought their role was to **‘Follow the Instructions’**, and to **‘Exercise’**. To a lesser extent, the theme of active **‘Self-help’** emerged for both groups. A small number of responses suggested participants thought they just needed to **‘Attend’**, or that they had **‘No Role’**. Overall, the results suggest that both groups of participants had either little, or a very passive idea, of their role in women’s health physiotherapy.

Throughout many questions in this study, a common theme concerned a lack of information being given about the treatment. This finding emerged in the responses to almost all questions. It suggests that investigation of information, education, and reminders about WHP may be beneficial for some patients, especially if provided alongside additional information that may motivate attendance [32]. The comparison between women with PFMD and PGP conditions did not reveal many striking differences in their reasons for their nonattendance. The similarity between the two groups suggests that, despite the different conditions and potentially differing demographics, many of the same considerations about DNA reasons apply (which is also true when cross study comparisons to other conditions than those associated with

Table 3

Study 2: Questions asked during interviews.

1. What are your thoughts about conservative management, like WH physio?
2. Why did you not attend WH physiotherapy?
3. What did the referring clinician tell you about the need for WH physiotherapy?
4. Did they offer you any other treatment options? If so, what were they?
5. What do you think your role is in your treatment process?

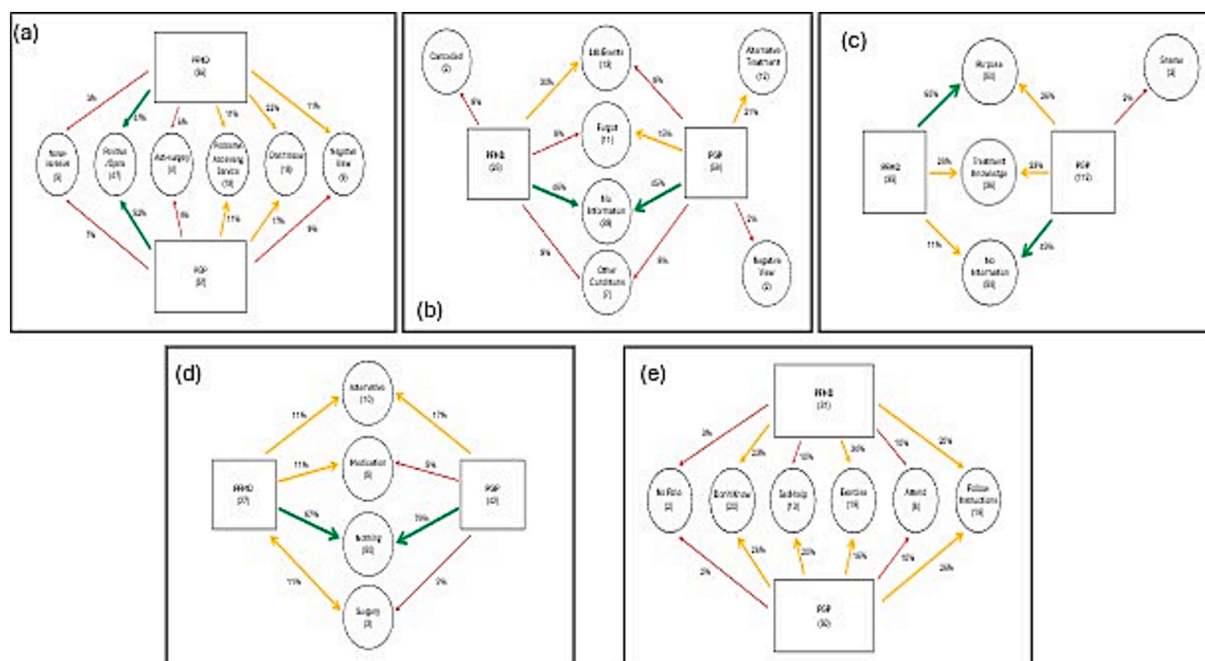


Fig. 3. Study 2: Schematic representation of overarching themes regarding responses concerning: (a) what patients think of conservative management options; (b) why patients did not attend women's health physiotherapy; (c) what options other than women's health physiotherapy patients were told about at referral; (d) what other treatment options were discussed at referral; (e) what patients think about their role in women's health physiotherapy. Numbers in brackets = numbers of units; numbers along lines = percentage units in theme for particular groups. Arrow width (thicker = more important) and colour (green $\geq 40\%$; amber = 11–39%; red $\leq 10\%$) represents the relative strength of that theme for that group. PFMD = pelvic-floor muscle dysfunction group; PGP = pelvic girdle pain group. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

women's health are made [3,5,6]).

General discussion

The current study explored reasons associated with nonattendance at WHP, and made novel comparisons between those who did and did not attend (Study 1), and between individuals with different conditions who did not attend (Study 2). Study 1 suggested that, in comparison with those who did attend, those who DNAed reported more previously bad experiences with the NHS (Fig. 2a). They prioritised avoiding discomfort from condition and treatment (Fig. 2c), and tend to put others' health above their own (Fig. 2b). Women with PFMD who did not attend appear to consider surgery more often (Fig. 2d). They reported less knowledge of WHP, or were more negative about it (Fig. 2a), and worried about getting to the appointment in public transport preferring their car (Fig. 2e). Several of these themes emerged in Study 2, and suggested, irrespective of condition, that while patients were open to WHP (Fig. 3a), they reported not having information about appointment details (Fig. 3b). They also commented that they knew its general goal (Fig. 3c), but not what it entailed, and tended to view of themselves as passive recipients of treatment rather than active collaborators (Fig. 3e).

These findings highlight several areas that might be helpful in promoting attendance at WHP. A first group of barriers are related to the medical treatment process, itself, and could be tackled relatively easily and cost effectively. Making sure appointments are properly notified, and/or reminders sent, is a key issue that needs to be monitored [20,21]. Providing greater information about WHP, and what it entails, may remove some barriers to attendance, and has been suggested previously in terms of pelvic health promotion [18]. There is good evidence that greater information about treatment can encourage attendance [33], and perhaps overcome any anxieties [19], especially around discomfort and sensitivities to examinations. This could be achieved through providing information leaflets or videos, signposted during initial referrals. The initial referral process could also be examined for any

consultant bias in describing interventions, as it is clear that those who DNA are susceptible to the idea of surgery, and focus on that alternative [10]. There is a literature on appropriate manners of informing patients about treatment options for other fields, such as for various cancers, and this literature has made analysis and recommendations about phrasing when discussing options with patients [34,35]. Of course, the relevance to WHP could be limited, and study of the best approaches to consultations could certainly be a research goal.

There are factors that are not directly under the control of the healthcare system, but which could be tackled. Transport to appointments is a concern for many women. In part, due to poor perceptions of the public transport system, and car parking resources provided; and in part due to constraints on travel requiring multiple changes that are unendurable for women in pain or incontinent. Providing greater parking facilities, although implicated by patients, may not be feasible, nor may it address the issues or the most disadvantaged groups who do not have access to such private transport [36]. Developing dedicated transport to hospital appointment, perhaps through NHS run minibus routes for patients with appointments, may be an option to consider. This has been noted as an affordable solution in other circumstances, and the cost may be recouped in savings from reducing missed appointments [19]. However, until a full economic cost-benefit analysis is performed, which may differ from location to location, these ideas should be regarded as possible methods of tackling the issue, rather than definitive solutions.

A third set of variables relate to the psychological state of patients who DNA, who appear to be more sensitive to previously bad experiences, and report less positive attitudes towards the treatment. This may reflect depression, which is common in those with PFMD, and produces negative bias in evaluations. Additionally, they seem less motivated to seek help for themselves, and prioritise others, in the sense they seek treatment in order to care for others [31]. The deprioritising of self, and negative bias, is common for those who have had past neglectful or abusive experiences, and such experiences are not uncommon in this set

of patients [37]. Although WHP may do little to alleviate these issues directly, treatment of these issues by multidisciplinary teams, including counsellors and psychologists, has been shown to help patients to engage in treatment [32]. In these cases, patients who display psychological or emotional problems on initial consultation can be referred to the team's counsellor/psychologist for assessment and treatment of these issues (either prior to, or alongside, referral to WHP). The psychological support can address motivation and/or health values [26], and directly target psychological issues underlying resistance [32].

There are limitations to the current study, as the sample is drawn from a single site, and patient experiences may differ elsewhere, depending on local circumstances, facilities, and resources (both in terms of health staff and transport etc.). Although the findings do resonate with previous reports, indicating a degree of generality. The sample is a relatively small in comparison to quantitative surveys, and this may constrain generality; for example, that agreeing to participate may have different characteristics and/or views to those who do not agree to participate. However, sample size was large enough to achieve saturation [30], that is, having sufficient participants to capture the majority of views that this population will express. The current conclusions are also reached based on comparison of numbers of responses falling into various categories in different groups. This should not be taken as a measure of generality of opinion, but of the strength of these opinions from this sample. Several of these issues could be addressed in larger scale, focused quantitative analysis. Such as study could adopt a multi-site prospective design, taking measures relating to the areas identified in the current work, as well as noting the form of consultation information and patient perception of that consultation, and then relating this information to subsequent attendance at physiotherapy sessions.

In summary, the current report corroborated several issues noted in previous reports, and extended the analysis by including comparison groups. It suggested that attention to the referral system, and information given at the time of referral, may remove some barriers to attendance. The issue of transport to appointments was raised, and developing links to affordable and reliable systems is critical. Finally, psychological aspects of patients who DNA should not be ignored, and could form part of their treatment. Although each recommendation does involve cost, the savings from reduction in nonattendance may well far outweigh any initial costs of set up.

Ethics approval and consent to participate

Ethical approval was obtained from the School of Psychology Ethics Committee, Swansea University. All participants gave their informed consent to participate

Consent for publication

Not applicable.

Availability of data and materials

Data and materials are available on request form the corresponding author.

CRediT authorship contribution statement

Phil Reed: Writing – review & editing, Writing – original draft, Supervision, Conceptualization. **Emily Sharples-Carter:** Writing – review & editing, Investigation, Formal analysis. **Emily Davis:** Writing – review & editing, Investigation, Formal analysis. **Aemaan Javaid:** Writing – review & editing, Investigation, Formal analysis. **Hannalee Lewis:** Writing – review & editing, Investigation, Formal analysis. **Catherine M. Harvard-Thomas:** Writing – review & editing, Methodology, Conceptualization. **Simon Emery:** Writing – review & editing,

Conceptualization. **Lisa A. Osborne:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Formal analysis, Conceptualization.

Funding

There was no funding for this research.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgement

Not applicable.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ejogrb.2025.03.024>.

References

- [1] Ellis DE, McQueenie R, Williamson A, Wilson P. *Missed appointments in healthcare systems: A national retrospective data linkage project*. SAGE 2020.
- [2] McQueenie R, Ellis DA, McConnachie A, Wilson P, Williamson AE. Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study. *BMC Med* 2019;17:1–9.
- [3] Parsons J, Bryce C, Atherton H. Which patients miss appointments with general practice and the reasons why: a systematic review. *Br J Gen Pract* 2021;71(707):e406–12.
- [4] NHS England. (2019). Missed GP appointments costing NHS millions. NHSE, 2019. <https://www.england.nhs.uk/2019/01/missed-gp-appointments-costing-nhs-millions/2019/> (accessed 3.7.24).
- [5] Jefferson L, Atkin K, Sheridan R, Oliver S, Macleod U, Hall G, et al. Non-attendance at urgent referral appointments for suspected cancer: a qualitative study to gain understanding from patients and GPs. *Br J Gen Pract* 2019;69(689):e850–9.
- [6] Lu JC, Lowery R, Yu S, Ghadimi Mahani M, Agarwal PP, Dorfman AL. Predictors of missed appointments in patients referred for congenital or pediatric cardiac magnetic resonance. *Pediatr Radiol* 2017;47:911–6.
- [7] Hay-Smith EJC, Pearson M, Dean S. 'Making sense' of urinary incontinence: A qualitative study investigating women's pelvic floor muscle training adherence. *N Z J Physiother* 2023;51(1):6–13.
- [8] Jack K, McLean SM, Moffett JK, Gardiner E. Barriers to treatment adherence in physiotherapy outpatient clinics: a systematic review. *Man Ther* 2010;15(3):220–8.
- [9] Mbada CE, Nonvignon J, Ajayi O, Dada OO, Awotidebe TO, Johnson OE, et al. Impact of missed appointments for out-patient physiotherapy on cost, efficiency, and patients' recovery. *Hong Kong Physiother J* 2013;31(1):30–5.
- [10] Osborne LA, Whittall CM, Emery S, Vij M, Reed P. 'Treatment overshadowing' as a patient reason for Pelvic-floor Muscle Training nonattendance. *J Pelvic Obstet Gynaecol Physiother* 2024.
- [11] Starzec-Proserpio M, Frawley H, Bø K, Morin M. Effectiveness of nonpharmacological conservative therapies for chronic pelvic pain in women: a systematic review and meta-analysis. *Am J Obstet Gynecol* 2024.
- [12] Dumoulin C, Hay-Smith J, Habée-Séguin GM, Mercier J. Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women: a short version Cochrane systematic review with meta-analysis. *Neurourol Urodyn* 2015;34(4):300–8.
- [13] Osborne LA, Reed P. Women's pelvic-floor muscle dysfunction. In: Bennett G, Goodall E, editors. *Encyclopaedia of disability*. London: Palgrave; 2024.
- [14] Kenne KA, Wendt L, Brooks Jackson J. Prevalence of pelvic floor disorders in adult women being seen in a primary care setting and associated risk factors. *Sci Rep* 2022;12(1):9878.
- [15] Milsom I, Gyhagen M. The prevalence of urinary incontinence. *Climacteric* 2019;22(3):217–22.
- [16] Frawley H, Shelly B, Morin M, Bernard S, Bø K, Digesu GA, et al. An International Continence Society (ICS) report on the terminology for pelvic floor muscle assessment. *Neurourol Urodyn* 2021;40(5):1217–60.
- [17] Robinson HS, Vollestad NK, Bennetter KE, Waage CW, Jenum AK, Richardsen KR. Pelvic girdle pain in pregnancy and early postpartum prevalence and risk factors in a multi-ethnic cohort. *BMC Musculoskelet Disord* 2024;25(1):21.
- [18] National Institute for Health and Care Excellence. Urinary incontinence and pelvic organ prolapse in women: management. NICE Guideline NG123. London: NICE; 2019.

- [19] Reed P, Whittall CM, Emery S, Osborne LA. Relationship between depression, anxiety, and attendance at pelvic-floor muscle training sessions. *Physiotherapy* 2023;120:10–6.
- [20] MacInnes CL. Why women leave therapy for stress incontinence. *Nurs Times* 2008; 104(41):50–3.
- [21] Prudden G. Quality improvement project exploring the factors in non-attendance at an NHS musculoskeletal outpatients department. *Physiotherapy* 2021;113:e151–2.
- [22] Hagen S, Bugge C, Dean SG, Elders A, Hay-Smith J, Kilonzo M, et al. Longitudinal qualitative case study. Basic versus biofeedback-mediated intensive pelvic floor muscle training for women with urinary incontinence: the OPAL RCT. *NIHR J Lib* 2020.
- [23] Brewster S, Bartholomew J, Holt RIG, Price H. Non-attendance at diabetes outpatient appointments: a systematic review. *Diabet Med* 2020;37(9):1427–42.
- [24] Gibson W, Wagg A. Urinary incontinence in the frail elderly: what do we still need to learn? *Clinical Practice* 2014;11(4):431.
- [25] Messer KL, Hines SH, Raghunathan TE, Seng JS, Diokno AC, Sampselle CM. Self-efficacy as a predictor to PFMT adherence in a prevention of urinary incontinence clinical trial. *Health Educ Behav* 2007;34(6):942–52.
- [26] Osborne LA, Whittall CM, Edwards DJ, Emanuel R, Emery S, Reed P. Randomised control trial of a values-based motivational interview support to promote attendance at pelvic floor muscle training physiotherapy treatment. *J Pelvic Obstet Gynaecol Physiother* 2016;119:38–46.
- [27] Vaughn S, Schumm JS, Sinagub J, Sinagub JM. Focus group interviews in education and psychology. Sage; 1996.
- [28] Kvale S. *InterViews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage; 1996.
- [29] Jacob SA, Furgerson SP. Writing interview protocols and conducting interviews. *Qual Rep* 2012;17:1–10.
- [30] Hennink M, Kaiser BN. Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Soc Sci Med* 2022;292:114523.
- [31] Reed P, Whittall CM, Osborne LA, Emery S. Impact of strength and nature of patient health values on compliance and outcomes for physiotherapy treatment for Pelvic Floor Dysfunction. *Urology* 2020;136:95–9.
- [32] Osborne LA, Whittall CM, Emery S, Reed P. Cluster randomised control trial of the effect on attendance and outcomes of multi-disciplinary teams involving psychologists during pelvic floor muscle training for pelvic floor dysfunction. *J Obstet Gynaecol* 2022;42(2):310–5.
- [33] Oldham M, Kellett S, Miles E, Sheeran P. Interventions to increase attendance at psychotherapy: a meta-analysis of randomized controlled trials. *J Consult Clin Psychol* 2012;80(5):928.
- [34] Gurren L, O'Sullivan E, Keogh I, Dunne S. Barriers to accessing psycho oncological support in head and neck cancer: A qualitative exploration of healthcare professionals' perspectives. *Eur J Oncol Nurs* 2022;58:102145.
- [35] Lobb EA, Butow PN, Meiser B, Barratt A, Gaff C, Young MA, et al. Women's preferences and consultants' communication of risk in consultations about familial breast cancer: impact on patient outcomes. *J Med Genet* 2003;40(5):e56–.
- [36] Mattioli G, Colleoni M. Transport disadvantage, car dependence and urban form. In: *Understanding mobilities for designing contemporary cities*; 2016. p. 171–90.
- [37] Laan E, van Lunsen RH. Overactive pelvic floor: female sexual functioning. *Overactive Pelvic Floor* 2016:17–29.