AMBULATORY GYNECOLOGICAL CARE SERVICES: A SURVEY OF PRE AND POSTMENOPAUSAL UTILIZATION

by

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This thesis is dedicated to M.A.H. who, through her positive example, has reduced my fears about growing older.

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CHAPTER I

Women of all ages consult gynecological care givers for their health care needs. Young women may initiate gynecological care by seeking contraceptive information, prenatal examinations, or treatment for menstrual problems in adolescence. Preventive procedures such as the Papanicolaou test (Pap test) may be interspersed with treatments for acute conditions. A continuing pattern of gynecological care may be seen throughout a woman's life as she seeks assistance with the birth of children or aid in preventing conception.

This study addresses the question: Does the use of gynecological care services decline with the cessation of menses? Postmenopausal women continue to need preventive gynecological care. Peak incidence of breast cancer occurs between the ages of 40-60. While risk of cervical cancer declines slightly in this age group, incidence of endometrial cancer increases (Martin, 1978; Bauer, 1981). Cancer of the endometrium is the most frequent geriatric genital malignancy, followed by cancers of the cervix, ovary, and vulva (Schneider, 1974). Thus, the need for pelvic examinations and Pap tests is as great after the climacteric as before.

The population of postmenopausal women is substantial

and increasing. According to U.S. Census Bureau figures (1980), there were 17 million women 55 years or older in 1960. By 1970 there were 21.5 million women in this age group. Projections show a possible postmenopausal population of 29 million by 1990, with a jump to 38 million by 2010. These statistics illustrate not only an increase in absolute numbers of aging women, but also an increase in the proportion of aging women in the total population. The significance of these data should be clear. There will be an increase in a potential gynecological patient population with continuing care needs.

The relevance of this challenge to nurses lies within the changing scope of nursing practice. Nurses are presently being educated to deliver preventive and supportive gynecological care. These nurse practitioners can promote maintenance of optimal health by preventive screening, health education, and counseling. While physicians and nurse practitioners have delineated the gynecological care needs of the postmenopausal client (Gray, 1977; Holloway, 1977; Pelegrina, 1977; Shearer & Shearer, 1977; Utian, 1980; Walsh, 1968), there is a dearth of published research as to whether the older woman utilizes gynecological services.

It is not clear why these women would not seek such care. It has been speculated that alterations in physical, emotional, and financial status dissuade the older woman from seeking care. Anticipated pain of a pelvic examination resulting from a narrowing vaginal vault may give

further reason to delay gynecological attention. Finally, some women interpret the absence of symptoms to mean that the menopause implies protection from gynecological disease (Keen, 1979; Gray, 1977).

This problem has multiple implications for nursing practice. While postmenopausal women need regular preventive care, care which is within the scope of nursing practice, the way to meet this need will likely differ depending upon the client. Patient education is needed if the older woman believes that care is no longer necessary. Counseling is indicated if the patient is afraid that disease will be detected. Researching less expensive resources is suggested if the older woman does not seek care because she cannot afford it. It is the nurse's responsibility not only to monitor a client's health, but to determine the obstacles to health seeking. Thus, the purpose in investigating the problem of possible changes in gynecological care use is twofold:

(1) To determine, by retrospective report, if the utilization of ambulatory gynecological services changes with cessation of menses.

(2) To determine what barriers to care seeking are identified by women who do not continue to seek gynecological care after menopause.

Review of the Literature

The menopause, as a focus for research, has received increasing attention. Researchers have focused upon women's

perceptions of the climacteric and its symptoms (Greene, 1981; LaRoca & Polit, 1980; McKinlay & Jefferys, 1974; Neugarten, Wood, Kranes & Loomis, 1968; Neugarten, 1967; Newton & Odom, 1964). The interactions between such symptoms and other social or demographic factors have also been widely explored by Uphold and Susman (1981), Crawford and Hooper (1975), and Neugarten and Kraines (1965). Yet little research has been published on the consequences of menopause for gynecological care utilization. The effects of premenopausal care seeking on postmenopausal care utilization have not been reported.

The following review will discuss those research findings pertinent to establishing a background for this study. These subject areas will be reviewed: physical problems associated with menopause, recommended gynecological care, use of gynecological services by menopausal women, and reasons for failure to use such services.

For the purposes of this review, the following terms will be defined as follows:

Premenopausal: prior to cessation of menses.

Menopausal: pertaining to the most active phase of endocrine change, marked by increased vasomotor symptoms.

Postmenopausal: following the cessation of menses by at least two years.

Natural menopause: cessation of menses following ovarian atrophy.

Surgical menopause: cessation of menses due to surgery.

Ambulatory gynecological care: procedures such as breast, bimanual, vaginal, and rectovaginal exams; cervical or endocervical cytologies, and other well women health procedures which fall within the scope of nurse clinician practice.

Physical Problems Associated with Menopause

Natural menopause occurs when the number of follicles and remaining ovarian epithelium is insufficient to maintain the customary cycle which ends in complete follicular maturation within the ovary. Cycles become anovulatory; progesterone and estrogen secretion diminishes. This leads to cessation of the menses and atropic changes in estrogen target areas such as the genital tract (Asch & Greenblatt, 1978; Jones, 1980; Rackoff & Nowroozi, 1978; VanLook, Lothian, Hunter, Michie & Baird, 1977).

Investigations of menopausal populations have attempted to document the incidence of symptoms commonly attributed to the climacteric such as hot flashes, dyspareunia, weight gain, skin changes, insomnia, emotional lability, and fatigue. Analyses revealed that in the majority of women only hot flashes were clearly associated with menopuase (Crawford & Hooper, 1973; McKinlay & Jefferys, 1974).

Kemman and J. P. Jones (1979) assessed occurrence of vasomotor symptoms as affecting 75% of a menopausal

population. Both Kemman and Jones (1979) and H. W. Jones and G. S. Jones (1981), editors of Novak's Textbook of Gynecology, state that only 25% of menopausal symptoms are severe enough to merit a doctor's visit. These data establish that there is at least one symptom which affects menopausal women, and that one-fourth of women may be expected to seek medical attention for relief of vasomotor discomforts.

Recommended Gynecological Care

There are recommended gynecological protocols for the postmenopausal population. It is suggested that all women in menopause, and especially those over the age of 65, should have a yearly pelvic examination, a rectovaginal exam, and endocervical smear (Rosenschiem & Rotmench, 1982; Schneider, 1974; Utian, 1980). On the other hand, Walsh (1968) advocates pelvic exams every six months for all menopausal women.

Women at risk for endometrial cancer, such as obese women, those taking exogenous estrogen, or women with a history of infertility, should be examined every six months (Utian, 1980). Rosenschiem and Rotmench (1982) stress "periodic sampling," by an unspecified schedule, of the endometrium for those women with high risk factors. Biopsy of suspicious lesions (Schneider, 1974) and curettage of postmenopausal women having bleeding or watery discharge (Walsh, 1968) are suggested.

The American Cancer Society (1980) has recently advised less frequent cervical cytologies for women with low risk

factors. However, the Society still strongly recommends that women over the age of 40 have an annual pelvic examination. The Cancer Society also advocates yearly breast exams for women over 40, and yearly mammograms for women over the age of 50. Such exams can be carried out best in the context of a health care setting.

In addition to the physical examination, a detailed history is important and should include:

Family history (especially incidence of cancer of the breast, cervix, uterus; heart disease; diabetes)

Personal history (menstrual/menopausal pattern, vaginal bleeding, liver or heart disease, thromboembolitic processes, gynecological operations, breast conditions)

Current disorders (hot flashes, palpitations, nervousness, irritability, headache, insomnia, depression, stress incontinence, dyspareunia) (Utian, 1980)

There are special care needs of an older woman that may present in an ambulatory gynecological setting. Holloway (1977) identifies key areas where intervention can be effected by a nurse practitioner: (1) informational needs about menopause and sexuality; (2) affective problems stemming from death of spouse, family members, and friends; (3) preventive health care needs; and (4) facilitating referral for problems requiring physicians, community agencies, or public health services.

While disagreement exists about the types of diagnostic procedures to be done and the duration of time between exams, there is clear agreement as to the need for regular gynecological evaluation of the older woman. The minimal evaluation would seem to include a careful history, assessment of psychosocial needs, a thorough pelvic exam, and additional endocervical or endometrial testing for women deemed at risk for malignancy.

Use of Gynecological and Health Services

Women in menopause are not likely to seek a health care giver even in the presence of climacteric discomforts. McKinlay and Jefferys (1974) reported the results of a postal questionnaire. Their survey included women from all socioeconomic groups in eight areas of greater London. Questionnaires were mailed to women randomly chosen from age-sex registers kept by general practice clinics. Their 80% response rate yielded data from 638 women between the ages of 45 and 54 years.

Of those women who were clearly menopausal, having menstruated last between 3 and 12 months prior to the survey, 75% reported at least daily hot flushes. While three-quarters of the women having hot flushes described them as embarrassing or uncomfortable, only 21% had sought medical treatment for the relief of vasomotor symptoms.

Newton and Odom (1964) reported similar findings in a much smaller interview study. Eighty menopausal patients were randomly selected from hospital and private services

at the University of Mississippi. Of that sample, 23% (14 women) sought medical treatment for climacteric complaints. Women most likely to have consulted with a doctor about menopausal symptoms had at least some college education. A causal relationship should not be assumed for it was noted that the lower educational groups contained more blacks and more women with previous hysterectomies. Either of these two factors may have had as much influence on health seeking behaviors as the stated variable of education.

One explanation for low utilization of medical relief for climacteric symptoms may relate to the era in which the data were actually collected. Data for the McKinlay and Jefferys' study (1974) were gathered between the years 1964-1965. The Newton and Odom (1964) sample was also taken prior to the popular acclaim of estrogen replacement therapy. It may be feasible that women did not seek climacteric care because no pallative relief for hot flashes was widely publicized.

Yet data obtained after the popularization of estrogen replacement therapy by the U.S. National Center for Health Statistics confirm low utilization of gynecologists' services by older women. Only 20% of office visits were made by females past the age of childbearing (Gold & Evrard, 1979). It is not known whether postmenopausal women do not seek gynecological care or whether care is received from nongynecological practitioners.

Other studies suggest that menopausal and postmenopausal women are not likely to initiate physician visits. A longitudinal study of 106 females (Crawford & Hooper, 1973) demonstrated that menopausal women actually are ill or have more minor complaints than is usual. However, they do not necessarily utilize such maladies as an impetus to seek medical attention. Of Crawford and Hooper's subjects, 31% had not seen a doctor for more than five years. A bias exists in the Crawford and Hooper study. Originally designed to explore the socio-psychological aspects of aging, two developmental landmarks--marriage of children and birth of first grandchild--were used as focal events. To recruit a sample, engagement columns in the paper and prenatal clinics were consulted. The sample shows a skew to the higher socioeconomic classes because of the selection methods. Yet even in this higher socioeconomic sample, menopausal women were no more likely than any other women to have seen a physician recently.

Cartwright (1967) reports that older persons, especially women, are unlikely to seek medical help. A random selection of approximately 1,400 persons, interviewed in their homes in England and Wales, comprised the sample. The perimenopausal age group--women aged 45-54--had the least number of physician consultations with a general practitioner. As for expressed desire for routine health examinations, more men stated that they would like a regular checkup then did the women. This difference was especially

marked between males and females in the age group 55-74 years--the postmenopausal years.

The studies cited above concur on one point: Women in the menopause are not more likely to seek a care giver, even in the presence of climacteric discomforts. This suggests that if older women are not likely to seek a care giver during the active phase of endocrine change, then they would not be inclined to seek gynecological care after the cessation of menopausal symptoms.

Reasons for Failure to Use Gynecological Services

Reasons for failure to utilize gynecological care services may be found in both demographic and attitudinal factors. Demographic variables that influence care seeking will be discussed first, followed by attitudinal factors.

Demographic variables. Increasing age is a disincentive to seeking care according to the literature (Battistella, 1971; Cartwright, 1967; Naguib & Geiser, 1968; Rosenstock, 1974; Wookey, 1971). Henderson, et al., (1958) in a study focusing on delay in pelvic cancer diagnosis, found that the greatest number of delaying patients were found in the age group 56-65. Studies involving over 2,000 women demonstrated a negative correlation between age and propensity to receive Papanicolaou tests. The smallest proportion of women having cervical cytology tests were those over the age of 65 (Breslow & Hochstim, 1964; Kegles, Kirscht, Haefner & Rosenstock, et al., 1965).

Education is another demographic variable correlated

to care seeking. In a population of 946 women, utilization of the Pap test was lowest among women of low educational status (Breslow & Hochstim, 1964). Of another 884 women surveyed, cervical tests for cancer increased stepwise with an increase in years of education completed, income level, and occupational status of head of household (Kegeles, et al., 1965). Rosenstock attributes preventive health behaviors to those women relatively better educated. Unfortunately, demographic variables rarely influence populations as discrete causal entities. As exemplified by the previously cited Newton and Odom study (1964), an apparently simple classification such as level of education may hide other, less obvious causal factors.

Financial status, which is sometimes considered independently, is often closely tied to educational level. Studies have found that persons of lower socioeconomic status use services less (Breslow & Hochstim, 1964; Kegeles, et al., 1965; Naguib & Geiser, 1968; Steele & McBroom, 1972). "Expense of treatment" was the second most often cited reason for delay in seeking treatment in the study conducted by Henderson et al., (1958). In addition to clearly marked socioeconomic factors, Breslow and Hochstim (1964) found that non-Caucasians were less likely to use preventive gynecological care services.

A financial factor which may operate across socioeconomic and racial boundaries is that of health insurance (Monteiro, 1973). Breslow and Hochstim concluded,

"Participation in a health insurance plan was positively related to obtaining the Papanicolaou test, particularly a health plan emphasizing screening examination" (1964, p. 112). Thus, absence of medical insurance may be a major obstacle to seeking ambulatory gynecological care.

In sum, a cluster of demographic variables can be associated with a disincentive to seek care. An older woman with relatively few years of education and few financial resources would be least likely to initiate gynecological care.

Attitudinal variables. Another impediment to seeking gynecological care is that of personal belief. In a review of literature delineating reasons why women delay seeking medical treatment for breast symptoms, "fear" is the most commonly cited factor (Green & Roberts, 1974). King (1950), in a random sample of 329 patients seeking diagnosis for general malignancies, discerned that delay was prompted by fear--fear of knowledge, fear of surgery or disfigurement, and fear of examination.

Scheffey (1953) coordinated a study of delay as related to diagnosis of pelvic malignancy. Delay attributed to patient responsibility, as opposed to physician or institutional delay, was reported as the greatest cause of procrastination. "Fear of truth" was attributed as the primary patient motivation for delay in seeking diagnosis. While the Scheffey population was large, 2,765 patients with pelvic cancer, the method of gathering data was not ideal.

Stated reasons for delay were gathered from the patients' relatives as well as the patients' doctors. Many studies have clearly shown that persons more readily attribute unfavorable traits, such as fear, to others. Scheffey also failed to present quantitative statistics to support his descriptive data.

Unlike Scheffey, Henderson, et al., (1958) were able to denote specific numbers of patients who cited fear as a reason for not seeking care. A convenience sample of 89 women and 11 men who had cancer of the breast, cervix, or large bowel and rectum were questioned. Of those patients who delayed in seeking evaluation (N=69), "fear of doctor" (24.6%); "fear of operation" (13.0%); and "fear of what they'll be told" (11.6%) were the most often cited reasons. It was reported also that the largest number of delaying patients was found in the 56-65 age group.

Wookey (1971), surveyed 1,169 women who attended a British clinic which offered free Pap smears and gynecological exams. In a four-year follow-up, the women were asked to give their reasons why they did not wish to participate in a mass screening. The primary reason for nonattendance was fear; both fear of finding cancer, and fear of the examination.

Fear of examination may relate to anticipated pain; or as Scheffey (1953) posits, reticence toward gynecological exams may stem from modesty. Harr, Halitsky & Stricker (1977) described the results of a self-administered

questionnaire, completed by 409 female patients in physician waiting rooms, concerning attitudes toward gynecological examination. The women cited insertion of the speculum as the greatest physical discomfort. Lithotomy position on the examination table was the most frequently mentioned emotional discomfort. A high percentage of respondents found that the breast examination also provoked emotional discomfort because of feelings of shame, or anxiety about pathology.

Haar, et al., attempted to survey a wider socioeconomic cross section by obtaining respondents in private and prepaid insurance plan waiting rooms. Nonetheless, the sample was skewed toward higher income and educational brackets. Patients from three types of physicians were used: internists, psychotherapists, and gynecologists. Of all respondents, 35% found the gynecological examination more "problematic" than other medical exams, with the exception of rectal examinations. However, those patients actually waiting to see gynecologists, as compared to patients of internists and psychotherapists, were the most likely to indicate difficulty in accepting the gynecological examination. This may indicate a high degree of anxiety in approaching the actual examination.

Although not studied directly, discomfort in examination was an incidental finding in a descriptive study by Debrovner and Shubin-Stein (1975). Nearly all of their subjects admitted to strong feelings of procrastination,

resistance, and psychic discomfort when needing a vaginal examination. Alexander and McCullough (1981) attempt to correlate this discomfort with overt avoidance of gynecological care:

> One consequence of some women's distaste for gynecological exams is postponement or avoidance of being examined. In fact, the fear of receiving a gynecological examination may prevent some women from requesting a general physical exam or result in their seeking a physician who does not include a gynecological exam as part of an annual physical checkup. (p. 124)

Petravage (1979) found that women were uncomfortable with doctor-patient interactions in gynecological care. Specifically, the women sampled stated a wish that the physician would initiate discussions of sensitive matters such as sexuality. A discomfort in talking with the care giver, coupled with any other reason to avoid gynecological care, may prompt the older woman patient to seize upon the rationale mentioned by Keen (1979) and Gray (1977): "I don't think I need female care anymore."

Many persons delay care seeking due to ignorance of potentially dangerous symptoms (Scheffey, 1953; King, 1950). Some 43% of the cancer patient sample of Henderson, et al., (1958) stated that they believed their symptoms were not serious enough to warrant medical attention. Misconceptions such as the belief that irregular bleeding of any type is normal around the change of life may prevent a woman from seeking care.

Most investigators have surveyed those women who finally do appear for gynecological care. Hesselius, Lisper, Nordstrom, Anshelm-Olson & Odlund (1975) in Sweden also interviewed 141 women who refused to participate in gynecological health screening. The most significant finding was that nonparticipants considered gynecological examinations more unpleasant than did participants ($P < 0.01$). In describing nonparticipants' reasons for not attending the free gynecological screening, the majority stated that they were receiving some sort of care elsewhere. The remainder stated: they did not have the time (10.8%); they felt quite well (9.5%); the questions were too personal (5.4%); they forgot (4.7%); unpleasant examination (4.1%); they had a previous experience of unpleasant gynecological exams (0.7%).

Overall, there are many attitudinal variables which might keep older women from seeking gynecological care. From the literature a list of most probable attitudes should include: anticipated pain, fear, discomfort with care giver, ignorance of dangerous symptoms, and perceived absence of routine gynecological care needs.

Summary

The literature describes women's perception of the climacteric and its symptoms. Yet, despite the existence of a recommended course of gynecological care for postmenopausal women, these women are not likely to see a care giver about "female problems" or to seek routine gynecological

care. There are both attitudinal and demographic factors which may act to impede care seeking. And it is not known whether premenopausal care seeking is related to postmenopausal care seeking behaviors.

A possible limitation of the available literature is the large number of studies which were conducted in Great Britain (Cartwright, 1967; Crawford & Hooper, 1973; McKinlay & Jefferys, 1974; Wookey, 1971) or Sweden (Hesselius, et al., 1975) where factors such as state subsidized medical care may have affected study findings. Thus, the generalizability of these studies to an American population must be made cautiously.

Conceptual Framework

Based upon the existing literature it appears that attitudinal and demographic variables may be partially responsible for affecting the health care seeking behaviors of postmenopausal women. The health belief model provides a framework for examining the influence of both types of variables on care seeking behaviors. The model will be described briefly with special emphasis on several components which have been selected as the framework for this study.

The health belief model posits that choice of "health" or "illness" behaviors is based upon the subjective perceptions of the health care consumer. Women may be seeking ambulatory gynecological care for two reasons. A "health behavior," according to Kasl and Cobb (1966) is "any

activity undertaken by a person who believes himself to be healthy for the purpose of preventing disease or detecting disease in an asymptomatic stage" (p. 246). For this study, women who seek gynecological care on a regular basis will be considered to be exemplifying a "health behavior."

By contrast, an "activity undertaken by a person who feels ill for the purpose of defining the state of his health and discovering a suitable remedy" is classified as an "illness behavior" (Kasl & Cobb, 1966, p. 246). For this study, women who seek gynecological care only when confronted with physical symptoms will be considered to be exemplifying "illness behavior." Both "health" and "illness" behaviors can be viewed as general types of care seeking philosophies likely to result in ambulatory gynecological visits. It is not known if women demonstrating a specific type of care seeking behavior in their reproductive years continue to seek gynecological care on that basis after cessation of menses.

Another component of the health belief model is an individual's psychological state of readiness to act or to delay in health matters (Rosenstock, 1974). Before action is taken the perceived benefits of treatment are weighed against perceived costs or barriers. Rosenstock (1974) targets the importance of perceived barriers to action which may include: expense, pain, inconvenience, or unpleasantness. At this point, even in the presence of favorable predisposing beliefs, avoidance of care seeking

may occur. This study was concerned with the relationship of such attitudinal barriers to preventive gynecological care.

The influence of demographic variables is also considered by the health belief model as a modifying factor which impacts upon an individual's readiness to seek care (Mikhail, 1981). Therefore age, income, and education were analyzed by this study for possible effects on an individual's care seeking behavior.

The following, relationship-seeking, questions were suggested by the review of literature and conceptual framework:

1. Is there a relationship between premenopausal gynecological care utilization and postmenopausal care seeking?
2. Is there a relationship between the demographic variables of age, income, and education and gynecological care seeking after the menopause?
3. What attitudinal variables, presumed to impede care seeking, are identified by women not receiving postmenopausal care?
4. How are these attitudinal variables related to demographic characteristics?

CHAPTER TWO

METHOD

This chapter describes the methods used to determine factors related to postmenopausal gynecological care seeking. The design will be discussed first. Following that the sample, setting, variables, instrument, and procedures involved in this study will be presented.

Design

The aim of this study was not to establish causality, but rather to describe the relationships among the variables. For this reason a descriptive correlational design was chosen. A "relationship-seeking" design (Diers, 1979) was employed to determine what variables were related to gynecological care seeking behaviors. It attempted to identify some of the individual factors associated with lack of ambulatory gynecological care in the postmenopausal population.

An ex post facto design, with the same women queried on pre and postmenopausal care was chosen so that greater control over individual confounding variables could be achieved. While some accuracy may have been lost due to memory errors, more consistent data were gained by using the same respondents.

Sample and Setting

The sample for this study consisted of women aged 55 to 70 years. This age group was selected as by age 60 nearly 100% of women have ceased menstruating. Only women who had not menstruated for at least two years were included in the sample. This lapse of two years since last menses was to assure that menopausal symptoms were not present. Women having surgical removal of uterus, ovaries, or fallopian tubes were not excluded from the study. The high percentage of women in this age group who have had gynecological surgery suggests that such women may constitute a large population of ambulatory patients.

A variety of settings were used to obtain the sample. Groups likely to include women of the target age such as church groups, fraternal and civic organizations, and a senior citizen's center were chosen. The following groups, representing both metropolitan and coastal areas participated in this study: an adult community center, a garden club, two fraternal groups, and two social organizations.

A convenience sample of 95 women was drawn. Since a nonprobability sample was used, the following biases may have influenced the findings:

1. Only women who join or participate in organizations may be represented. Such women may have specific personality traits, or health habits different from those women who do not join organizations.

2. Only women of a specific economic stratum or racial group may be represented by a certain fraternal organization or recreational group.

Variables Studied

The variables studied were: reported use of gynecological care premenopausally and postmenopausally, demographic characteristics, and attitudinal factors. Each will be described.

Dependent Variable

The dependent variable was postmenopausal utilization of ambulatory gynecological services. Utilization of gynecological care was defined as seeing a care giver for routine care procedures, or treatment of acute care needs. The postmenopausal respondents were asked to mark one of three options on the research questionnaire which best described gynecological care received within the last two years (see Appendix A). Each of the options was scored as a "yes" or "no" response. The options were:

1. I get female care such as Pap smears and pelvic (internal) exams at least once a year.
2. I have had female care in the last two years because of some problems or concerns (e.g., unusual bleeding, loss of urine with sneezing or exercise, worry about disease of the female organs).
3. I haven't had a female exam or care since my change of life.

Independent Variables

Data were collected on three independent variables: premenopausal gynecological care seeking, demographic variables, and attitudinal variables. Premenopausal gynecological care seeking was measured by the respondents' choice of three options on the survey questionnaire which were scored in the same manner as postmenopausal care:

1. I got care on a regular basis, every year or so, even when I was not having problems.
2. Only when I had a particular need (such as heavy bleeding, pregnancy, infection of the female parts, need for family planning, etc.).
3. Never had female exams or care that I am aware of.

The demographic variables identified by the literature as being related to postmenopausal care utilization were: age, income, and education. Thus, all subjects were asked their age, years of school completed, and general income bracket.

The attitudinal variables identified by the literature were worded to represent barriers to seeking postmenopausal care. These items were:

1. I don't think I need female care after the change of life.
2. I can't afford it.
3. I am afraid of what might be found.
4. I am uncomfortable talking with my doctor about female care.

5. I don't have the time.

6. Female exams are too uncomfortable for me.

Subjects were asked to rank items on a Likert-type scale using the responses: Strongly Agree (scored 1), Agree (scored 2), Disagree (scored 3), or Strongly Disagree (scored 4).

Additional Data

Data regarding extraneous variables which may have affected study outcome were also collected. These variables included: the number of years since last menses, use of exogenous estrogen (scored yes/no), history of gynecological surgery (scored yes/no), presence of chronic health problem (scored yes/no), and type of gynecological care provider in the pre and postmenopausal periods (gynecologist, internist, general practitioner, other, or no one).

A question (Item 5) was included to ascertain whether women who were receiving exogenous estrogens manifested a particular type of care seeking behavior. Use of exogenous estrogen clearly mandates a need for regular gynecological evaluation.

Question 7, pertaining to presence of a chronic health problem requiring at least one physician visit per year, was posed to determine if a relationship existed between doctor visits and gynecological care received by respondents. It might be expected that those women with chronic illnesses would be more likely to receive gynecological care from their internist or general practitioner.

Questions 10 and 11 determined if type of gynecological care giver changed with menstrual status. With approximately 80% of visits to the gynecologist focused upon reproductive functions (Gold & Evrard, 1979), the question exists whether postmenopausal women cease to seek gynecological care or merely shift to another type of care giver for gynecological care.

Procedure

The cover letter, survey tool, and study design were approved by the research review board for use of human subjects at the Oregon Health Sciences University. The consent form given to the sample was revised from the suggested format to feature simplified language. Both consent form (Appendix B) and survey questionnaire were designed to be easily read by using a large type face and simple wording.

The survey questionnaire was designed by the investigator based upon the review of literature and conceptual framework. The tool was pretested in a pilot study of 13 women meeting sample criteria. During the pilot study no questions about the tool were raised by the women. Only one questionnaire was returned with an appreciable amount of missing data. The survey tool was assured face validity only, based upon the literature. No reliabilities were obtained.

Target populations such as women's clubs and organizations were contacted by the investigator by telephone. The study was explained to a representative of the

group and permission was requested by the investigator to attend a group function where the questionnaire could be administered. At the group's meeting the investigator briefly described the study in very general terms. The questionnaires, with a decorative face sheet for privacy, were passed out with a cover letter assuring confidentiality to those who chose to answer the questions. At no time were any identifying marks, names, or numbers affixed to the questionnaires. All questionnaires were collected prior to leaving. A brief thank you note was sent to each site promising a summary of the study's findings for those members who had expressed an interest in the final conclusions.

In two of the settings the investigator was asked, by prior request, to address the group on the subject of "Female Care and the Older Woman." This was done after the questionnaires were collected to avoid biasing individual responses.

The majority of women did not have questions about the investigator's survey instrument. The most often repeated comment was respondent inability to remember the month and year of last menses. When this occurred the investigator suggested that approximate age at last menstrual period was an adequate response.

Analysis of Data

The statistical package for the social sciences (SPSS) was used as the computer program for this study. Descriptive statistics were used to describe and synthesize data

obtained. When appropriate, inferential statistics were utilized. A compete analysis of data will be presented in the next chapter.

CHAPTER 3

RESULTS AND DISCUSSION

This chapter describes the study findings. Within a "relationship-seeking" study the variables are identified, but it is not known how the variables are related. Therefore, the goal of this chapter is to describe the relationships which were found between the variables. A general description of the sample will be presented first, followed by discussions of the research questions. A discussion of incidental findings concludes the chapter.

Sample Descriptions

Some demographic characteristics of the sample are described in Table 1. Mean age was 63.2 years, and mean number of years of schooling completed was 13.9. Over half of the sample reported yearly incomes of $25,000 or greater, with modal income being $30,000 or more. This resulted in an income distribution with a slightly negative skew (-.74). Since income was measured using categories no mean is reported.

Nearly one-half of respondents (43.2%, N=41) reported surgical removal of uterus, ovaries, or fallopian tubes. The other respondents (56.8%, N=54) reported that they did not undergo such surgery. Of those women who had a natural menopause, mean years since last menses was 11.4 (SD=7.2).

Table 1

Age and Education of Women Reporting and Denying Gynecological Surgery

Demographic Characteristic	GYN Surgery (N=41)	No GYN Surgery (N=54)	Total Sample (N=95)
Age			
mean	63.4	62.9	63.2
SD	4.9	4.8	4.8
range	55-70	55-70	55-70
N	38	52	90[a]
Education			
mean	13.6	14.0	13.9
SD	2.0	2.3	2.2
range	10-18	10-20	10-20
N	38	54	92[b]

Note: a. 5 women did not report age.
b. 3 women did not report education.

While it cannot be assumed that gynecological surgery prompted an earlier menopause, those women reporting such surgery related more intervening years (19.8, SD=8.0) since last menses. However, this figure may reflect a skew caused by a few surgical castrations done early in reproductive life.

This proportion of women claiming gynecological surgery is much greater than is reported for the general public in the literature (Centers for Disease Control, 1982). Yet within this sample women reporting surgery when compared with women denying surgery showed little difference in their demographic profile, so will be considered as a single group for much of the data analysis.

Research Questions

This section describes the results related to each research question. Each question will be described and discussed individually.

Relationship Between Pre and Postmenopausal Care Seeking

Gynecological care utilization was measured as an ordinal scale with the three values being: regular care, episodic care secondary to a specific need or problem, and no care. As seen in Table 2, women who reported that they were currently receiving regular care also tended to report receiving regular care prior to menopause. Women currently seeking care because of a specific problem or need were most likely to claim episodic care in the past. Women currently

Table 2

Relationship Between Pre and Postmenopausal Care Seeking

	Postmenopausal Care			
Premenopausal Care	Regular	Episodic	No Care	N
Regular	50	3	3	56
Episodic	13	5	7	25
No Care	1	0	2	3
N	64	8	12	84

Table 3

Relationship Between Collapsed Variables

of Pre and Postmenopausal Care Seeking

	Postmenopausal Care		
Premenopausal Care	Regular	Episodic or None	N
Regular	50	6	56
Episodic or None	14	14	28
N	64	20	84

not receiving care tended to report episodic care during their reproductive years.

When the sample is collapsed into two categories, those receiving regular care and those receiving episodic or no care, a clearer pattern emerges (see Table 3). A significant number of women demonstrated consistency in type of care seeking behavior from pre to postmenopausal periods ($x^2 = 15.7$, $p < .001$).

When these data are considered as a whole, it would seem to indicate that the women demonstrating "health behaviors" (Kasl & Cobb, 1966) continue to seek care on that basis. By contrast, women who sought premenopausal care when confronted with physical symptoms or specific needs, who demonstrated "illness behaviors," tended to report that they were not currently seeking care. If this may be attributed to an absence of disturbing symptoms, then such women would still be considered as potentially motivated by "illness behaviors." Thus, general type of care seeking pattern would appear to remain relatively constant. However, two changes in pattern were evident among some women.

One group of women reported a decline in care received upon an episodic basis. Of 25 women with a history of episodic care, 13 shifted to receiving regular care postmenopausally. In the sample surveyed the greatest number of women reported getting gynecological care on a regular basis. Increased public awareness of the advantages and availability of Pap smear testing may have prompted more women to

seek regular care. Also, women in this age group may have an increasing need for health services in general. Such needs would provide a continuing contact with a physician or other provider. Within this context the likelihood of receiving regular gynecological examinations may be increased.

Yet even with increased information available to the public concerning preventive gynecological care, another group of women (N=12) were not receiving care in the post-menopausal period as compared to their reproductive years. This increase in number of women not seeking care may reflect the effect of barriers to care identified by the literature. These relationships will be examined later in this chapter.

Relationship Between Demographic Variables and Postmenopausal Care Seeking

There were few demographic differences between women who received care and those who did not. Among respondents not receiving care the general demographic profile shows a similar mean age and education when compared to the entire sample. Mean age was 63.8 years (SD=4.6) as compared with a mean age for the total sample of 63.2 (SD=4.8). Women not receiving care reported a mean of 13.0 years (SD=1.3) of education. The total sample reported a mean of 13.9 (SD=2.2) years of education.

Income figures show the most marked differences when compared to the sample as a whole. Those reporting no care stated incomes in the $15,000 to $19,999 range as compared

to the modal sample income of $20,000 to $24,999. However, the curve depicting measure of modal income shows a bimodal curve with elevations in the middle of the income scale, and toward the income brackets of $25,000 or greater. The same bimodal income curve is found when the entire group is surveyed.

Unlike the findings in the literature, there did not appear to be statistically significant relationships between demographic variables and type of postmenopausal care seeking for this sample. It might be assumed that the findings of this study differed from those reported in the literature for several reasons. Restrictions in the demographic range of the sample may have influenced findings. This sample included few women of very low income or educational levels. Thus, no measure was obtained of lower income or educational types of care seeking. Moreover, excluding women over the age of 70 may have obscured a different care seeking trend among older females.

Restrictions in the range of care seeking behaviors of the sample may have influenced findings, also. Most of this sample were receiving at least some gynecological care. Those receiving no care may have been too small a segment to compare for demographic variation.

It has been suggested that women who join or participate in organizations may have specific personality traits or health habits which are held in common despite demographic differences. A study done by Naguib and Geiser (1968) on

preventive screening for cervical cancer showed that membership in at least one social, religious or other organization was positively correlated to health screening participation. Those researchers concluded that a high proportion of non-participants cannot be reached through community organizations. Thus, women not likely to be receiving care would not have been represented in this study's settings.

Attitudinal Variables Identified by Women Not Receiving Postmenopausal Care

Those women who denied current care seeking were asked to respond to a list of attitudinal statements representing perceived barriers to care. As will be recalled the respondents were asked if they agreed, strongly agreed, disagreed, or strongly disagreed with the statements. For the respondents not receiving care (N=12) there was no agreement as to barrier to care. One woman did not respond to any of the attitudinal variables. Nine respondents answered all questions. Two respondents chose to write in their reasons for not seeking care. Table 4 illustrates that over 50% of respondent preference for each attitudinal statement went to the option of "disagree." No attitudinal statement received a majority of responses indicating agreement with the statement.

Only one attitudinal variable, "I don't think I need female care after the change of life," received any kind of respondent agreement. Of the two women who chose to write in reasons for not seeking care, both could have been

Table 4

Number of Women Not Receiving Care Who Agreed or Disagreed with Perceived Barriers to Care

	Attitudinal Barriers											
	Don't Need Care		Can't Afford Care		Fear of What May be Found		Discomfort with Dr.		No Time		Exam Pain	
	N	%	N	%	N	%	N	%	N	%	N	%
Agree	4	44.4	2	22.2	--	----	2	22.2	2	22.2	1	12.5
Disagree	5	55.6	6	66.7	7	77.8	6	66.7	7	77.8	6	75
Strongly Disagree	--	----	1	11.7	2	22	1	11.1	--	----	1	12.5

classified as not perceiving the need for care. One woman penciled in "had hisorctomy"; the other woman wrote, "My husband doesn't believe I need it." The first statement might indicate that the respondent perceived no need for care because her uterus had been removed. Perhaps absence of "female organs" or lack of apparent "female" functions such as menstruation or conception would prompt a woman to believe that she no longer needed preventive gynecological care. It is of note that "Don't think I need care" was the only variable suggested by the literature that was not tested in a previous study. Consequently, there were no data with which to compare this study's findings.

For the remainder of attitudinal variables suggested by the literature, none seemed pertinent for this sample. Perhaps this may be attributed to the narrow socioeconomic spectrum sampled by this study.

Relationships Between Attitudinal and Demographic Variables

Pearson's correlational coefficients, performed on attitudinal and demographic variables of women not receiving care, revealed three significant findings. First, as level of income increased, women tended to agree with the statement, "I don't have the time" ($r=-.74$, $p < .03$). This finding may suggest that women of upper income levels perceive that they have less time to expend on gynecological care. Or this finding simply may reflect the large proportion of upper income women in this sample.

A second conclusion was that with increasing age women

were more likely to state "I don't think I need female care after the change of life" ($r=-.80$, $p < .009$). It may be surmised that women perceive a declining need to seek care in the presence of many years without overt gynecological problems.

Finally, those women who reported that they were comfortable talking with their doctor about female care also reported that female exams were not painful ($r=1.0$, $p < .001$). This finding may be an indirect measure of the particular client's ability to be relaxed in the presence of her care giver.

Incidental Findings

This section addresses relationships between postmenopausal gynecological care seeking and variables not discussed with relation to the specific research questions.

Medical Treatment and Postmenopausal Care

It might be expected that gynecological surgery, chronic illness, or use of exogenous estrogens would effect postmenopausal care seeking. As seen in Table 5, there are some differences in pre and postmenopausal care seeking between women who claimed gynecological surgery and those who did not. However, the differences are small and not statistically significant. Interestingly, the changes in care seeking behavior were consistent for each group. Postmenopausally both groups were more likely to receive regular care, experience a decrease in the amount of episodic care, and experience an increase in the numbers not receiving any care.

Table 5

Relationship of GYN Surgery to Pre and Postmenopausal Care

		Type of Care					
	Menstrual Status	Regular Care		Episodic Care		No Care	
		N	%	N	%	N	%
GYN	Premenopausal	28	71.8	11	28.2	--	----
SURGERY	Postmenopausal	33	84.6	3	7.7	3	7.7
NO GYN	Premenopausal	31	60.8	17	33.3	3	5.9
SURGERY	Postmenopausal	34	70.8	5	10.4	9	18.8

Presence of a chronic medical problem may have some bearing on care seeking as shown in Table 6. Of the entire sample, women who reported a chronic medical problem requiring at least one physician visit per year tended to report that they received regular gynecological care (Kendall's tau b=-.17, $p < .05$). This finding may reflect an increased likelihood that women receiving treatment of a chronic medical problem would be given routine gynecological care by the same practitioner. Or, for the woman who has both a gynecologist, and an internist or family practice doctor, a habitual pattern of regular care seeking may be well established by her need for closer medical follow-up.

Perhaps more surprising than the relationship between chronic medical problems and gynecological care is the small number of women reporting presence of a chronic illness. Possibly the relative affluence of this sample may be cited as the reason for the good health of the women. If the findings of Naguib and Geiser (1968) are applicable, then women participating in social organizations are more likely to engage in preventive health activities. Such activities may either promote health directly or provide therapeutic intervention in acute illnesses before chronic conditions can become established.

As seen in Table 7, women who reported being on estrogen replacement therapy (ERT) also tended to report that they received regular gynecological care (Kendall's tau b=-.22, $p < .01$). This finding indicates that most sample

Table 6

Relationship of Chronic Illness and Gynecological Care

Presence of Chronic Medical Problem	Type of Care: Regular Care		Episodic Care		No Care		N
	N	%	N	%	N	%	
Chronical Medical Problems	33	84.6	3	7.7	3	7.7	39
No Medical Problem	33	70.2	5	10.6	9	19.1	47

Table 7

Relationship of Estrogen Therapy and Gynecological Care

Estrogen Replacement Therapy (ERT)	Type of Care: Regular Care		Episodic Care		No Care		N
	N	%	N	%	N	%	
Receiving ERT	28	90.3	1	3.2	2	6.5	31
Not Receiving ERT	39	69.6	7	12.5	10	17.9	54

women receiving ERT are receiving at least some gynecological evaluation. In fact, the majority of those women report receiving yearly care. This is a recommended interval of care seeking for those women using exogenous estrogens.

Primary Gynecological Care Giver

As shown in Table 8, the sample indicated that the gynecologist (33.7%) or family practice physician (31.5%) was the most likely person to provide gynecological care in the premenopausal period. In the postmenopausal client, the family practice doctor (35.8%) or internist (33.7%) was likely to give gynecological care. In this sample only 13.7% of postmenopausal respondents saw a gynecologist for postmenopausal care. Apparently, gynecologists are not the preferred clinician for gynecological care by the older women in this sample. This finding confirms the observation by Gold and Evrard (1979) that few office visits are made to gynecologists by postmenopausal women.

The following statements summarize the data presented in Table 9 regarding consistency of gynecological care giver:

1. Of the 31 women who utilized the services of a gynecologist before menopause, only 29% (N=9) continued to do so after cessation of menses. The majority shifted gynecological care to an internist (35.5%, N=11) or family practice doctor (22.6%, N=7).
2. Among the 15 respondents who received gynecological care from an internist in the premenopausal period, the majority (60%, N=9) continued to see an internist postmenopausally.

Table 8

Gynecological Care Provider for Pre and Postmenopausal Women

Type of Care Provider	Menstrual Status			
	Premenopausal		Postmenopausal	
	N	%	N	%
Gynecologist	31	33.7	13	13.7
Internist	15	16.3	32	33.7
General Practice	29	31.5	34	35.8
Other	3	3.3	2	2.1
No One	5	5.4	12	12.6
GYN & Internist	7	7.6	2	2.1
GP & Internist	2	2.2	--	----

Table 9

Changes in Patient Utilization of Health Care Providers

Premenopausal Providers	Postmenopausal Providers											
	Gynecologist		Internist		General Practice		Other		No One		GYN & Internist	
	N	%	N	%	N	%	N	%	N	%	N	%
Gynecologist	9	29	11	35.5	7	22.6	--	----	3	9.7	1	3.2
Internist*	1	6.7	9	60	3	20	2	13.3	--	----	--	----
General Practice*	1	3.4	6	20.7	20	69	--	----	2	6.9	--	----
Other	1	33.3	--	----	1	33.3	--	----	1	33.3	--	----
No One*	--	----	--	----	1	20	--	----	4	80	--	----
GYN & Internist	--	----	5	71.4	1	14.3	--	----	--	----	1	14.3
GP & Internist	1	50	--	----	--	----	--	----	1	50	--	----

*Note: One respondent did not report type of premenopausal care provider.

3. Of the 29 women who saw a general practitioner prior to menopause, the majority (69%, N=20) continued to receive care from that type of practitioner.

This study's findings on provider of gynecological care seem to conflict with information found in the literature. Lewis (1976) has suggested that women use an obstetrician-gynecologist on a continuing basis, and that an internist or general practitioner is used only for other medical needs. According to these data, the gynecologist does not render care to a majority of women, even women in their reproductive years.

Other researchers (Burkons & Wilson, 1975) have attempted to establish that the obstetrician-gynecologist is the primary physician for most women. Data from this study seem to suggest that among older women the internist or family practitioner is more likely to provide gynecological care than the reverse.

Summary

To summarize, this sample was relatively well educated and of higher income status. Nearly half of the respondents reported having gynecological surgery. The greatest number of women reported seeking regular gynecological care both pre and postmenopausally. The majority of women reporting no gynecological care in the postmenopausal period reported seeking episodic care or care for some specific problem during their reproductive years. There did not appear to be

any relationship between demographic variables and type of postmenopausal care seeking. The only attitudinal variable which seemed to be pertinent for this sample was "I don't think I need female care after the change of life." The variables of reported use of exogenous estrogen, and presence of a chronic medical problem were positively related to receiving regular gynecological care. The gynecologist or family practitioner were most likely to render gynecological care in the premenopausal period while postmenopausal women were more likely to see a family practitioner or internist for female care.

CHAPTER 4

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter includes a brief synopsis of the study followed by conclusions derived from the data. Implications for nursing practice are then posited. Limitations of the study and recommendations for future studies conclude the chapter.

Summary

The population of postmenopausal women in this country is substantial. And, according to projections by the U.S. Census Bureau, an increasing proportion of this country's population in the future will be comprised of postmenopausal women. Despite loss of reproductive capacity, this group of women will continue to need preventive gynecological care. Yet, there is evidence that suggests the older woman is not likely to seek such care.

The purpose of this descriptive correlational study was twofold. First, it attempted to ascertain if utilization of ambulatory gynecological services changed with cessation of menses. Second, it attempted to determine barriers to gynecological care seeking among postmenopausal women. Components of the health belief model were used as the theoretical framework. A convenience sample of 95 women, aged 55-70, was drawn from six fraternal or social organizations.

Respondents were surveyed at an organization function using a self-administered questionnaire. The questionnaire contained items concerning age, education, income, and number of years since last menses. They were also questioned about use of exogenous estrogens, history of gynecological surgery, and presence of chronic medical problems. Respondents were asked to indicate type of gynecological care seeking and type of gynecological care provider for both pre and postmenopausal periods. Those women who reported no gynecological care were asked to indicate agreement or disagreement with a list of barriers to care.

Conclusions

Several conclusions can be drawn from the findings of this study. First, the type of gynecological care sought by respondents remained relatively consistent despite changes in menstrual status, with the greatest number of women reporting gynecological care on a regular basis. However, more women were not receiving care in the postmenopausal period when compared to their reproductive years. Second, the variables of age, income, and education appeared to be unrelated to type of postmenopausal care seeking. Women who reported use of exogenous estrogen therapy or presence of a chronic medical problem were most likely to be receiving some form of ambulatory gynecological care. Third, the twelve respondents not receiving care did not indicate strong agreement with any of the attitudinal variables regarding barriers to care suggested by the literature.

Only one attitudinal variable, "I don't think I need female care after the change of life," received any amount of respondent agreement.

The final conclusion reached by this study was that among respondents the majority reported receiving gynecological care from a gynecologist (33.5%) or family practice physician (31.5%) in the premenopausal period. After menopause a majority of those respondents formerly receiving care from a gynecologist shifted care to an internist or family practice physician.

Implications for Nursing Practice

The findings of this study present three major implications for the practitioner:

1. If type of care seeking philosophy is relatively constant, then women need to be acquainted early in their lives with the benefits of preventive gynecological care. This would involve discussing normal gynecological changes associated secondary to aging with younger clients, while emphasizing continuing care needs.
2. As the largest number of postmenopausal women not seeking care indicated that they did not believe that they needed female care after the change of life, then more education should be made available to older women. Such education could focus upon current recommendations and controversies, thus allowing for a more informed care seeking decision.

3. If a majority of postmenopausal women seek care from nongynecological practitioners, efforts to reach and teach this population of older women should be directed toward physician practices in general or internal medicine. Based upon the findings of this study, the services of a women's health care nurse practitioner could be utilized in such a setting.

Limitations

Choice of sample and setting were major limitations of this study. The investigator selected sample women who attended social or fraternal organizations. One study on preventive screening for cervical cancer showed that membership in at least one such organization was positively correlated to health screening participation (Naguib and Geiser, 1968). Therefore this study, which sought to determine barriers to care seeking, may have missed the larger cohort of women who were not seeking care. In addition, the sample of this study group was skewed toward the higher income and educational brackets. A sample comprised of postmenopausal women living in lower income neighborhoods might produce data very different from the present sample.

Another limitation is the research questionnaire. First, the survey tool had only face validity based upon the literature. No reliabilities were obtained. Second, respondents were asked to choose between options which may not have been mutually exclusive. Respondents were

requested to select the one option best describing their care seeking behavior. Some women may have selected the statement, "I have had female care in the last two years because of some problems or concerns," although they were receiving regular care as well. In the estimation of those respondents, the problems or concerns may have been more important than the fact of receiving regular care. Thus, the options for the question which asked about current gynecological care may not have been mutually exclusive.

Recommendations for Further Study

Based upon the findings and limitations of this study, the following recommendations are made:

1. The survey questionnaire needs further refinement, and establishment of validity and reliability.
2. If the study were to be replicated, a more diverse sample should be surveyed, or attempts should be made not to use fraternal or social organizations as settings.
3. The majority of this sample did not hold the same values regarding attitudinal variables as suggested by the literature. Therefore, a study on this subject conducted at the factor isolating level of research may be useful.

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APPENDIX A

Letter of Informed Consent

OREGON HEALTH SCIENCES UNIVERSITY
SCHOOL OF NURSING

This booklet invites you to participate in a study about women between the ages of 55 and 70. Doctors and nurses are increasingly interested in the health care needs of adult women, and this is a study about women who have passed through the "change of life." The official title of this study is: Ambulatory Gynecological Care Services: A Survey of Pre and Postmenopausal Utilization. The principal researcher is Jane Harrison-Hohner, R.N., B.S. Dr. Mary Ann Curry, R.N., D.N.S., is the advisor for this study.

To participate you need only fill out this questionnaire booklet which will take about 10 minutes. If you wish to stop at any point in the questionnaire, you are free to do so. If you do not wish to participate, the booklet may be returned without being marked.

So that you may be assured of complete confidentiality please do not sign your name or use any identifying marks. Your answers will be pooled with those of other women in determining the results of the study.

Your anonymous marking of answers in the booklet is considered your agreement to participate. Your participation is considered finished when you pass in your booklet.

If you have further questions, Mrs. Hohner will be glad to answer them for you now, or you may reach her at the following address if you have questions at a later date.

Thank you for your consideration.

[redacted]

Mrs. Jane Harrison-Hohner
c/o Dr. Mary Ann Curry
Department of Family Nursing
3181 S. W. Sam Jackson Park Road
Portland, OR 97201

APPENDIX B

Survey Questionnaire

(1) DATE OF BIRTH_____

(2) DATE OF LAST MENSTRUAL PERIOD (MONTH AND YEAR)_____

(3) PLEASE CIRCLE THE LAST YEAR OF SCHOOL YOU COMPLETED.

0 1 2 3 4 5 6 7 8
9 10 12
13 14 15 16
17 18 19 20

(4) PLEASE CIRCLE THE CORRECT RESPONSE THAT INDICATES YOUR INCOME LAST YEAR BEFORE TAXES.

0-$4,999	$15,000-$19,999	$30,000 OR GREATER
$5,000-$9,999	$20,000-$24,999	
$10,000-$14,999	$25,000-$29,999	

(5) ARE YOU CURRENTLY TAKING FEMALE HORMONE REPLACEMENT PILLS OR CREAMS SUCH AS PREMARIN? (PLEASE CIRCLE CORRECT RESPONSE.)

YES NO

(6) HAVE YOU HAD ANY OF YOUR FEMALE ORGANS--SUCH AS WOMB, OVARIES, TUBES--SURGICALLY REMOVED? (PLEASE CIRCLE CORRECT RESPONSE.)

YES NO

(7) ARE YOU CURRENTLY SEEING A DOCTOR REGULARY (AT LEAST ONCE A YEAR) FOR A CHRONIC MEDICAL PROBLEM SUCH AS DIABETES, HEART DISEASE, BLOOD CLOTS, ETC. (PLEASE CIRCLE CORRECT RESPONSE.)

YES NO

(8) THE FOLLOWING QUESTIONS ARE CONCERNED WITH THE YEARS BEFORE YOU WENT THROUGH THE CHANGE OF LIFE. PLEASE UNDERLINE THE ONE ANSWER THAT BEST DESCRIBES YOUR FEMALE CARE PRIOR TO EXPERIENCING THE MENOPAUSE.

-- I GOT CARE ON A REGULAR BASIS, EVERY YEAR OR SO, EVEN WHEN I WAS NOT HAVING PROBLEMS.

-- ONLY WHEN I HAD A PARTICULAR NEED (SUCH AS HEAVY BLEEDING, PREGNANCY, INFECTION OF THE FEMALE PARTS, NEED FOR FAMILY PLANNING, ETC.).

-- NEVER HAD FEMALE EXAMS OR CARE THAT I AM AWARE OF.

(9) NOW PLEASE ANSWER A SIMILAR SET OF QUESTIONS ABOUT FEMALE CARE YOU MAY HAVE RECEIVED IN THE LAST TWO YEARS. PLEASE UNDERLINE YOUR ONE BEST RESPONSE.

-- I GET FEMALE CARE SUCH AS PAP SMEARS AND PELVIC (INTERNAL) EXAMS AT LEAST ONCE A YEAR.

-- I HAVE HAD FEMALE CARE IN THE LAST TWO YEARS BECAUSE OF SOME PROBLEMS OR CONCERNS (E.G., UNUSUAL BLEEDING, LOSS OF URINE WITH SNEEZING OR EXERCISE, WORRY ABOUT DISEASE OF THE FEMALE ORGANS).

-- I HAVEN'T HAD A FEMALE EXAM OR CARE SINCE MY CHANGE OF LIFE.

(10) WHOM DID YOU SEE FOR YOUR FEMALE CARE BEFORE YOUR CHANGE OF LIFE? (PLEASE CIRCLE YOUR RESPONSE.)

GYNECOLOGIST

INTERNIST

FAMILY PRACTICE OR GENERAL PRACTICE DOCTOR

OTHER (PLEASE SPECIFY)_____

NO ONE

(11) WHOM DO YOU CURRENTLY SEE FOR FEMALE CARE? (PLEASE CIRCLE)

GYNECOLOGIST

INTERNIST

FAMILY PRACTICE OR GENERAL PRACTICE DOCTOR

OTHER (PLEASE DESCRIBE)_____

NO ONE

(12) IF YOU ANSWERED "NO ONE" TO THE QUESTION ABOVE, PLEASE ANSWER THE FOLLOWING QUESTIONS. READ EACH QUESTION THEN CIRCLE THE ANSWER WHICH BEST DESCRIBES YOUR FEELINGS. FOR EXAMPLE:

THE RAIN IN OREGON IS DEPRESSING.

STRONGLY AGREE AGREE (DISAGREE) STRONGLY DISAGREE

I DON'T THINK I NEED FEMALE CARE AFTER THE CHANGE OF LIFE.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

I CAN'T AFFORD IT.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

I AM AFRAID OF WHAT MIGHT BE FOUND.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

I AM UNCOMFORTABLE TALKING WITH MY DOCTOR ABOUT FEMALE CARE.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

I DON'T HAVE THE TIME.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

FEMALE EXAMS ARE TOO UNCOMFORTABLE FOR ME.

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE

OTHER (PLEASE SPECIFY)_____

(13) WHICH OF THE ABOVE REASONS WAS MOST IMPORTANT? (PLEASE UNDERLINE IT.)

AN ABSTRACT OF THE THESIS OF

Jane A. Harrison-Hohner

For the MASTER OF NURSING

Date of Receiving this Degree: June 10, 1983

Title: AMBULATORY GYNECOLOGICAL CARE SERVICES: A STUDY OF PRE AND POSTMENOPAUSAL UTILIZATION

Approved: [redacted]
Mary Ann Curry, R.N., D.N. Sc., Thesis Advisor

The purpose of this descriptive correlational study was twofold. First, it attempted to ascertain if utilization of ambulatory gynecological services changed with cessation of menses. Second, it attempted to determine barriers to gynecological care seeking among postmenopausal women.

A convenience sample of 95 women, aged 55-70, was drawn from six fraternal or social organizations. Respondents were surveyed using a self-administered questionnaire designed by the investigator which contained items concerning age, education, income, presence of a chronic medical problem, use of exogenous estrogen, and history of gynecological surgery. Respondents were asked to indicate type of gynecological care seeking and type of gynecological care provider for both pre and postmenopausal periods. Those women who reported no gynecological care were asked to

indicate agreement or disagreement with a list of barriers to care posited by the literature.

The research data was analyzed using descriptive and inferential statistics. It was found that the type of gynecological care sought by respondents remained relatively consistent despite changes in menstrual status, with the greatest number of women reporting gynecological care received upon a regular basis. There did not appear to be relationships between variables of age, income, education, and type of postmenopausal care seeking. Women who reported use of exogenous estrogen or presence of a chronic health problem were most likely to be receiving some form of care. The twelve respondents not receiving care did not indicate strong agreement with any of the attitudinal barriers to care suggested by the literature. Among respondents the majority reported receiving gynecological care from a gynecologist or family practice physician in the premenopausal period. After menopause, a majority of respondents shifted care to an internist or family practice doctor.

Limitations of this study were discussed. Implications for the field of nursing were suggested and recommendations for further research were made.