Published in final edited form as:
J Prim Care Community Health. 2013 July 1; 4(3): 216–219. doi:10.1177/2150131912465314.

Primary Care Physicians' Concerns May Affect Adolescents' Access to Intrauterine Contraception

Susan E Rubin[1], **Giselle Campos**[1], and **Susan Markens**[2,3]

[1]Albert Einstein College of Medicine/Montefiore Medical Center, Bronx NY, USA

[2]Lehman College, CUNY, Bronx NY, USA

[3]Graduate Center, CUNY, New York, NY, USA

Abstract

Purpose—Although the intrauterine device (IUD) may be safely used in adolescents, few US adolescents use IUDs. Increasing IUD use in adolescents can decrease pregnancy rates. Primary care providers' clinical practices many be one of the many barriers to increasing adolescents access to IUDs. We explored primary care physicians' (PCPs) approaches to contraception counseling with adolescents, focusing on their views about who would be appropriate IUD candidates.

Methods—Phone interviews were conducted with 28 urban family physicians, pediatricians, and obstetrician-gynecologists. Using standard qualitative techniques, we developed coding template and applied codes.

Results—Most respondents have a patient-centered general contraceptive counseling approach. However, when considering IUDs many PCPs describe more paternalistic counseling. For example, although many respondents believe adolescents' primary concern is pregnancy prevention, many PCPs prioritize sexually transmitted infection (STI) prevention and thus would not offer an IUD. Attributes PCPs associate with an appropriate IUD candidate include responsibility, reliability, maturity, and monogamy.

Conclusion—Our findings suggest that when considering IUDs for adolescents some PCPs' subjective assessment of adolescent sexual behavior, attitudes about STI risk factors and use of overly restrictive IUD eligibility criteria impede adolescent's IUD access. Education around best practices may be insufficient to counterbalance attitudes concerning adolescent sexuality and STI risk; there is also a need to identify and discuss PCPs potential biases or assumptions affecting contraception counseling.

Keywords

contraception counseling; birth control; intrauterine device; intrauterine contraception; adolescents; primary care; qualitative research

Corresponding Author: Susan E Rubin, Department of Family and Social Medicine, Albert Einstein College of Medicine, 1300 Morris Park Avenue, Mazer 410, Bronx, NY 10461, USA. surubin@montefiore.org.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Background

Although the US adolescent pregnancy rate is at a historic low,[1] it remains significantly higher than European countries and Canada. Increased utilization of user independent contraceptives such as the intrauterine device (IUD) can decrease adolescent pregnancy rates.[2] IUDs are safe and effective for adolescents and nulliparous women. Professional guidelines support IUDs as a first-line contraceptive for adolescents,[3-5] yet only approximately 4% of contracepting US adolescents use IUDs.[6] Adolescents' low use of IUDs is multifactorial and is partly because of primary care physicians' (PCPs) lack of counseling about or offering IUDs.[7,8]

Contraception counseling in general involves discussion of multiple effective, appropriate options. Traditionally, PCPs took a paternalistic counseling approach, which emphasized provider-directed decision making. When using this type of clinical approach, PCPs determined which contraceptive would meet the patient's best interest and the patient was offered limited option. Currently, there is emphasis on patient-centered counseling with shared patient–provider decision making, resulting in greater patient autonomy and choice over selection of contraceptive method.

In this research letter, we describe PCPs' approaches to contraception counseling with adolescents, specifically focusing on their views about appropriate IUD candidates. These data were collected as part of a larger study exploring urban PCPs perspectives on the barriers and enablers to intrauterine and implantable contraception counseling and/or provision to adolescents.[9]

Methods

In-depth phone interviews (N = 28) were conducted with family physicians, pediatricians, and obstetrician-gynecologists who care for female adolescents, provide at minimum 30% outpatient clinical time, and practice at 1 of 2 large medical centers in the Bronx or Brooklyn, New York, geographic areas with disproportionately high adolescent pregnancy rates.

Using purposeful stratified sampling of clinical sites, we randomly recruited individual providers within sites. SER (first author) conducted phone interviews until reaching saturation for each provider type. Interviews were recorded and transcribed.

The analysis team consisted of a family physician clinical researcher (SER), an experienced clinical research coordinator (GC), and a qualitative sociologist with reproductive health expertise (SM). As described in detail elsewhere,[9] the team used standard qualitative techniques to develop a coding template and apply codes. This study was approved by the Albert Einstein College of Medicine Institutional Review Board.

Results

Sixty-one PCPs were invited to participate. Interviews were conducted with 9 family physicians, 10 pediatricians, and 9 obstetrician-gynecologists, representing 19 distinct practice sites. Table 1 shows respondent characteristics. Nineteen PCPs counsel adolescents about IUD, few do it frequently. Thirteen have ever inserted IUDs for adolescents.

During general contraceptive counseling with adolescents, most respondents describe a patient-centered approach. They assess the patient's situation and tailor counseling. For instance, when counseling adolescents Peds HH* "First [tries] to figure out what [an adolescent's] sexual history is like and what she expects her sexual history to be and what

she wants and what she can handle." This approach results in relative patient autonomy for method selection.

However, when discussing IUDs specifically many respondents describe more paternalistic counseling. Although many respondents believe adolescents' primary concern is pregnancy prevention, we found many PCPs prioritize sexually transmitted infection (STI) prevention. For instance, ObGyn TT "always [tells adolescents] a pregnancy unfortunately is unwanted but it won't kill you most of the time." PCP prioritization of STI prevention reflects a genuine desire to protect adolescents' health, which is shaped by PCPs concern about STI risk behavior as it pertains to IUD use. For example, FP BB is reluctant to offer adolescents IUDs because an adolescent with an IUD "might not think enough about STI protection if she was very confident that she wouldn't be able to get pregnant. She might not use condoms." This prioritization is also shaped by PCPs assessments of adolescent sexual behavior, particularly issues around monogamy. For ObGyn BB, if an adolescent is "very promiscuous that might make me think twice about an IUD. I know it's probably not based on any evidence, but I just think that they would be more at risk of obtaining an STD than someone who wasn't."

Attributes PCPs associate with an appropriate IUD candidate include responsibility, reliability, maturity, and monogamy. Representative of this is Peds TT, who thinks an IUD candidate should be "mature in their awareness and their sense of the consequences of their sexual activity and their awareness of the need for condoms." An adolescent who meets a PCP's criteria engenders confidence that she will not put herself at increased STI risk even with an IUD in place. If adolescents do not meet these criteria they are viewed as inappropriate candidates. Yet these criteria or attributes are often subjective and vary by provider. FP SS identified an IUD candidate as "patients who have had a baby, patients where the child's father is involved with the child." Meanwhile, for ObGyn NN "a young woman who is in the middle of high school and has future plans to attend college and is really trying not to achieve a pregnancy right now" is an appropriate IUD candidate.

Discussion

Overall, respondents describe patient-centered general contraception counseling and shared contraception method decision making. Yet when considering IUDs specifically, PCPs often revert to more paternalistic counseling and use restrictive criteria when assessing whether an adolescent is an appropriate candidate. These criteria are inconsistent with professional guidelines[3-5] and with the developmental stage of most adolescents. Few adolescents meet most respondents' IUD eligibility standards. Thus, adolescents' autonomy in contraceptive decision making and their access to the most effective reversible contraceptive[2,3] is limited. Interestingly, even some PCPs who are knowledgeable about current IUD guidelines still harbor some discomfort recommending IUDs for adolescents. More research is needed with a larger sample to ascertain the prevalence and effect of all these attitudes by PCP type and clinical setting.

Although PCPs relative reluctance to recommend IUDs is grounded in concern about increasing STI risk, there are no data correlating adolescent IUD use with increased risk or rate of STIs. While there is a transient increased relative risk of pelvic inflammatory disease during the first 3 weeks postinsertion, afterward pelvic inflammatory disease risk returns to baseline.[10] IUD use does not increase risk of infertility[5] and IUD continuity rates are much higher than that with the oral contraceptive pill, patch, ring, or injectable contraception.[5]

*Note: All respondents' initials have been changed to protect their privacy.

A key intervention to address the persistent public health issue of adolescent pregnancy is increasing contraception access,[11] especially access to the most effective methods. By balancing patient autonomy and provider-directed guidance, PCPs can empower adolescents with knowledge and enable them to make fully informed reproductive health care decision. Yet our findings suggest that PCPs subjective assessment of adolescent sexual behavior may limit IUD counseling and provision. Education around best practices may be insufficient to counterbalance attitudes concerning adolescent sexuality and STI risk. There is also a need to identify and discuss PCPs' potential biases or assumptions that may influence their contraception counseling.

Acknowledgments

We acknowledge the primary care physicians who participated in this study; without their time commitment this study would not have been possible.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This project is funded through NIH NICHD K23HD067247-01 (Susan E. Rubin) and the CTSA Grant UL1 RR025750, KL2 RR025749 and TL1 RR025748 from the NCRR, a component of the NIH, and NIH Roadmap for Medical Research.

Author Biographies

Susan E Rubin, MD, MPH, a family physician and clinical researcher, is an Assistant Professor in the Department of Family and Social Medicine at Montefiore Medical Center/ Albert Einstein College of Medicine. Her research focuses on provision of reproductive health care in primary care.

Giselle Campos, BA, currently a nursing student at CUNY Hunter College, was a Research Coordinator in the Research Division of the Department of Family and Social Medicine at Albert Einstein College of Medicine.

Susan Markens, PhD, is an Assistant Professor in the Sociology Department at Lehman College, CUNY whose research interests focus on women's reproductive health.

References

1. Ventura SJ, Curtin SC, Abma JC, Henshaw SK. Estimated pregnancy rates and rate of pregnancy outcomes for the United States, 1990-2008. Natl Vital Stat Rep. 2012; 60(7):1–21. [PubMed: 22970648]
2. Winner B, Peipert JF, Zhao Q, et al. Effectiveness of long-acting reversible contraception. N Engl J Med. 2012; 366:1998–2007. [PubMed: 22621627]
3. American College of Obstetricians and Gynecologists. Long-Acting Reversible Contraception: Implants and Intrauterine Devices. Jul. 2011 Practice Bulletin No. 121
4. Centers for Disease Control and Prevention. U.S. medical eligibility criteria for contraceptive use, 2010. MMWR Early Release. 2010; 59:88.
5. American College of Obstetricians and Gynecologists. Adolescents and long-acting reversible contraception: implants and intrauterine devices. Obstet Gynecol. 2012; 120:983–988. Committee Opinion 539. [PubMed: 22996129]
6. Finer LB, Jerman J, Kavanaugh ML. Changes in use of long-acting contraceptive methods in the United States, 2007-2009. Fertil Steril. 2012; 98:893–897. [PubMed: 22795639]
7. Rubin SE, Fletcher J, Stein T, Segall-Gutierrez P, Gold M. Determinants of intrauterine contraception provision among US family physicians: a national survey of knowledge, attitudes and practice. Contraception. 2011; 83:472–478. [PubMed: 21477692]

8. Rubin SE, Fletcher J, Stein T, Gold M, Segall-Gutierrez P. Underuse of the IUD in contraceptive care and training. Fam Med. 2010; 42:387–388. [PubMed: 20526899]

9. Rubin SE, Davis K, McKee MD. New York City physicians' views of providing long-acting reversible contraception to adolescents. Ann Fam Med. In press.

10. Grimes DA, Schulz KF. Antibiotic prophylaxis for intrauterine contraceptive device insertion. Cochrane Database Syst Rev. 2008; (3)

11. Elders MJ. Contraceptive availability to adolescents: do American values violate our most vulnerable? Clin Pharmacol Ther. 2008; 84:741–745. [PubMed: 18800038]

Table 1

Characteristics of Participating Primary Care Physicians.

	Physician Type							
	Family Practice (N = 9)		Pediatrics (N = 10)		Obstetrics/ Gynecology (N = 9)		Total (N = 28)	
	n	Percentage	n	Percentage	n	Percentage	n	Percentage
Gender								
Female	7	77.8	7	70.0	7	77.8	21	75
Intrauterine contraception education during residency …								
Learned about counseling	7	77.8	1	11.1	8	88.9	16	59.3
Learned about insertion	7	77.8	0	0.0	8	88.9	15	55.6
Performed insertion	7	77.8	0	0.0	5	55.6	12	44.4
Current clinical practice with intrauterine contraception and adolescents …								
Theoretically would counsel/mention	9	100.0	6	66.7	9	100.0	24	88.9
Actually has counseled/mentioned	8	88.9	2	22.2	9	100.0	19	70.4
Has inserted for adolescents	6	66.7	0	0.0	7	77.8	13	48.1