

Doctors' experience of the contraceptive consultation: a qualitative study in Australia

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ABSTRACT

Background Contraception is a field in which good doctor–patient communication is crucial and core to shared decision making. Despite the centrality of contraception to primary health care in Australia, little is known about how doctors manage the contraceptive consultation. In particular, little is known about how doctors discuss sexual issues related to contraception.

Methods Fifteen contraceptive providers participated in qualitative interviews averaging 45 min. Interviews were audio recorded, transcribed verbatim, and analysed using an inductive thematic approach.

Results We found doctors were aware that they had to modify their illness-based ‘scripts’ in consultations about contraception, and said it was challenging always to adhere to a shared model of decision making. Prescribing behaviour reflected personal preferences in relation to some forms of contraception, and doctors were enthusiastic about the levonorgestrel-releasing intrauterine system. Doctors identified gaps in training in relation to sexuality and reported feeling tentative in raising sexual issues, even within contraceptive consultations.

Conclusions A range of factors—including tendencies to use illness scripts, personal preferences, and discomfort with communications about sexuality—appear to influence doctors’ approaches to contraceptive management. Medical training that enables doctors to move out of an illness-treating framework and to improve their understanding of and comfort in discussing sexuality issues will improve their management of healthy women seeking contraception.

INTRODUCTION

Contraception is a core part of primary health care. In Australia, contraception is used by 95% of women exposed to the risk of unplanned pregnancy,¹ and is a

Key message points

- Doctors tend to resort to an ‘illness script’ in contraceptive consultations, rather than shared decision making, even though the patient is not ill.
- Our 15 Sydney-based doctors all had expertise in sexual health and contraception, yet few felt competent or comfortable discussing sexuality.
- Sexuality education including communication techniques should be included in postgraduate training in reproductive health.

primary reason for visiting a doctor. Primary care in Australia is delivered on a fee-for-service basis. Some clinics such as sexual health (ie, sexually transmissible infection (STI)) clinics and hospital-based gynaecology clinics, are free. The national health insurance system, Medicare, reimburses patients for a proportion of the standard fee for a general practitioner (GP) (or, under certain conditions, specialist) consultation. Patients with low incomes, such as students, the unemployed, and disabled people and aged pensioners, have access to a Health Care Card that reduces both consultation fees and the price of prescription medicines. Many services ‘bulk bill’, that is, bill Medicare direct, for low-income patients (and some do so for all patients). Thus the system has both state-funded elements as in the UK and many European countries, and private elements as in the USA and Germany. Standard hormonal contraceptives are obtainable under a government subsidised pricing system, the Pharmaceutical Benefits Scheme. Health

Care Cards entitle financially disadvantaged women to lower prices and, at their treating doctor's discretion, free consultations. Access issues tend to be limited to geographically isolated¹⁻³ and marginalised women.⁴⁻⁷ However, use of long-acting reversible contraceptives such as implants, injectables, and intrauterine devices (IUDs) is low, indicating that women may not be being offered a full choice of methods.^{1 8 9}

Few studies have explored how women make contraceptive choices in Australia, how the contraception consultation is managed, and how doctors' training, knowledge and attitudes influence what methods are recommended. In a survey of Australian obstetricians and gynaecologists regarding their management of women requesting an IUD, lack of knowledge of the evidence made some unwilling to recommend copper IUDs.¹⁰ A study in Europe found that women relied on their gynaecologist or GP as the primary source of information and advice on contraception, but also used other information sources, including women's magazines, family and friends, and family planning centres.¹¹

Although all discussions of contraception are necessarily related to sexuality, a UK-based study found that health care professionals rarely brought up the topic of sex, because of personal discomfort, lack of time or knowledge, and concerns over causing offence.¹² Consultations about contraception are often separated from those about sexual health or sexual function,¹³ even though a contraceptive consultation might be incomplete without discussion of the potential for particular methods to interfere with sexual practice or enjoyment. Despite doctors often being the first port of call for information about sexuality, other studies have found that doctors are generally under-equipped to manage consultations about sexual function.¹⁴

In recent decades the doctor–patient relationship has ostensibly progressed from a paternalistic model to that of shared decision making.¹⁵ Shared decision making involves an interaction between the doctor and patient such that a consensus is built about a treatment plan.¹⁶⁻¹⁸ The desire for shared decision making may be particularly strong with regard to contraception, with one study suggesting that women are significantly more likely to want autonomous decision making about birth control than about their general health care.¹⁹ Contraception offers unique challenges to the routine 'illness script' for the doctor–patient interaction, as the routine script leaves little opportunity for patient participation. This 'illness script' contains information about the doctor's understanding of a disease including knowledge about predisposing factors, signs, symptoms, management and its amelioration based on both knowledge and experience.²⁰ A different sort of script is required for contraception consultations when dealing with healthy women.

Given the importance of effective doctor–patient interactions and shared decision making in the field of contraception, we sought to explore doctors' perceptions of how their knowledge and attitudes towards different contraceptives influenced their contraceptive management, and to investigate their perception of how discussions around sexuality fitted into the contraceptive consultation.

METHODS

Design

We piloted a semi-structured interview schedule with three contraceptive providers (see [Box 1](#) for questions). The interviewer allowed conversation to flow naturally and relied on the questions only if the relevant topics did not arise during the natural course of the discussion. No concerns arose during the pilot interviews, so they were included in the final analysis. A further 12 doctors were recruited. Participants were expert doctors whose current practice included a focus on contraception. A letter introducing the study was followed up with a phone call to secure participation. Participants were offered \$A30 reimbursement for any expenses incurred. Interviews were conducted by MK, a psychologist and researcher in her early 30s, at the doctor's place of work.

Box 1 Interview discussion schedule

- ▶ Tell me about your current role/position.
- ▶ Tell me what you learnt in your training in relation to contraception.
- ▶ Do you feel your training helped with understanding sexuality more broadly (eg, problems, experiences, sexual health, STIs [sexually transmitted infections])?
- ▶ What do you consider to be the advantages and disadvantages of particular contraceptive methods? (*Prompt for contraceptive methods not mentioned*)
- ▶ What do you think are the key issues for women seeking contraception or discontinuing or changing method?
- ▶ What characteristics of the woman make you tend to recommend a particular method?
- ▶ How do you find out about sexual function in your consultations?
- ▶ Do you think contraceptive methods influence sexual functioning?
- ▶ Do you think women are well informed about contraception before they come to see you?
- ▶ Do you think there are enough contraceptives on the market to cater for the various needs of all your clients? If not, could you think of a new method to invent?
- ▶ How do you see the role of pharmaceutical representatives?
- ▶ Who do you mostly see seeking contraception? Why?

Interviews averaged 45 min and were audio recorded, then transcribed verbatim by a professional transcriber. Transcripts were de-identified and pseudonyms given to doctors.

Data analysis

The researchers (KI and MK) independently conducted an inductive thematic analysis following the phases outlined by Braun and Clarke.²¹ They immersed themselves in the data by repeatedly listening to the interview recordings and re-reading the transcripts. They then systematically separately coded the transcripts line by line to identify patterns in the data and then compared coding taxonomies. NVivo 9 research software was used to assist with highlighting and organising codes, and to combine coding to ensure identical coding was not duplicated and unique coding was captured. The researchers searched for themes by grouping relevant codes together and collapsing overlapping ideas. Data were interpreted within a framework of awareness of the social roles doctors play.

RESULTS AND DISCUSSION

We recruited 15 contraceptive providers (12 women and 3 men) in New South Wales (NSW), Australia. Doctors were aged 30–40 (4), 40–50 (6) or 50–60 (5) and were working in: family planning (4), sexual health (4), specialist women's reproductive health (4), general practice (3), a university clinic (3), and a youth service (2). Five doctors worked in two fields. Doctors' practices were located in central Sydney (6), suburban Sydney (7), and regional NSW (2). We deliberately recruited doctors experienced in contraceptive provision.

We identified four main themes in the data:

1. Approach to managing a condition that is not an illness
2. Doctors' preferences for contraceptive methods
3. Contraceptive counselling: the process of excluding methods
4. Sexuality and the contraception consultation.

Approach to managing a condition that is not an illness

Doctors working solely in women's health recognised that they were usually working with healthy people and this was different from treating people who were ill.

“One of the things that stands out about women's health is that you're working with mostly well people and you're helping empower women I guess to take a bit more control over things in their lives... When you're working with very sick people, it's a totally different model. ...with well people it's not like the doctor is the boss.” (Dr Fisher)

However, for many working in dual roles it was clear that their medical training and the work they were immersed in outside their contraceptive role was

primarily concerned with illness, so the scripts they used when discussing contraception tended to lapse into those for managing illness. One doctor thought this tension stemmed from doctors' medical training and socialisation.

“I always get the feeling that [we're] biased towards looking for disease and infection rather than contraception. I think [we] don't find [it] quite as interesting because it's treating the well rather than the unwell.” (Dr Bruce)

Doctors' preferences for contraceptive methods

Doctors had clear preferences for particular contraceptives, and these preferences influenced their prescribing. Doctors used information, authority and empowerment to influence their clients. The patient-doctor relationship was described metaphorically as a 'market',²² with clients the consumers and customers. Many of those interviewed advocated strongly for the use of the LNG-IUS (the Mirena levonorgestrel-releasing intrauterine system), as it was long-acting, reversible, did not require ongoing user adherence, and brought with it non-contraceptive benefits such as lighter menstruation, less pain, and over time—for some women—no periods at all.

“So when the Mirena came along it became the Rolls Royce of the IUD contraception.” (Dr Deakin)

It seemed to be the doctors' choice for contraception:

“Fantastic! Mirena's the best intervention since antibiotics...it's wonderful 'cause it sorts out periods and, you know, a really great contracepti[ve]-we put in a lot here and I would advocate it. I'm on the second one myself so I think it's the doctor's choice for contraception and menstrual control. So yeah, big fan of Mirena.” (Dr Cook)

“I think, if I had a womb, I'd rather a Mirena in it than a copper coil.” (Dr Curtin)

Despite such enthusiasm, it was clear that some apprehension still existed about the LNG-IUS. One doctor feared that it would one day receive bad press, as the Dalkon Shield had in the 1980s.

“I still have a fear a little bit that we're going to get someone who's going to go on television and say that her life was ruined by an IUD like Mirena. ...I hope that never happens again.” (Dr Chifley)

Doctors were also very positive about the pill and it remained the first-line prescription choice.

“And the pill has revolutionised, you know, the Western world and women's role in it.” (Dr Fadden)

“I would probably start off with combined pill as my baseline thought process. I'd think, 'Is this suitable for this person?' And obviously that includes do they want it and what do they think about it. But...first of

all are there any medical reasons and also are there any lifestyle reasons, any side effects that they're concerned about?" (Dr Curtin)

However, scepticism was expressed about newer pills with components such as 'natural' oestrogens, promising clearer skin and fewer unwanted side effects. Doctors were concerned over equity issues and ongoing affordability when young women were prescribed newer more expensive pills. They also did not perceive the newer pills to be superior despite their higher price.

"I just about never, ever, ever start anybody on one of the more expensive pills. And I probably do have a bit of an issue with GPs that actually will start kids who are on Health Care Cards on things like Yaz and Yasmin. And I think people are led to believe that the newest thing or the most expensive is the best, and I just don't think that's very thoughtful, in the long run." (Dr Forde)

Many doctors did not consider fertility awareness based methods and withdrawal (coitus interruptus) as effective forms of contraception.

"I don't think of withdrawal as a form of contraception. ...I remember somebody telling me it could still populate Honduras, the number of sperm in the pre-ejaculate." (Dr Bruce)

However, a few doctors said that when used correctly, they could be very effective and certainly better than no method at all.

"And I must admit, if you've got absolutely nothing there, you should be encouraged to use withdrawal, rather than think that it's all hopeless and you might as well just have sex, you know, penis and vagina sex, and just do the whole thing. ...I think that's much better than scaring people." (Dr Forde)

Contraceptive counselling: the process of excluding methods

Doctors expressed conflicting viewpoints of their role as prescriber or as guide empowering individual choice, often switching between multiple roles as educator, counsellor or treating clinician. Sometimes they openly encouraged clients to use methods they saw as appropriate in accordance with their medical experiences or attitudes or indeed personal experiences of use of contraception. There seemed to be some tension between the approach of telling patients about all options and encouraging informed choice, and the reality of clinical consultations with more directive counselling. Many doctors used mental shortcuts to come up with a contraceptive match in a limited time. These included consideration of the individual's culture, beliefs, fears, age, reproductive stage, gynaecological health, and medical history. Some doctors spoke of using a more intuitive approach and paying attention to their client's cues.

Many of the participants recognised a tension between employing an evidence-based approach while still allowing the client power in decision making. When what the client articulated did not fit with the evidence base, some doctors decided not to address this with the client, but rather just offer another option which better suited her needs.

"It's the same for any method of contraception. If you tell me that you think it's a problem, I'll believe you. There is enough choice... And my personal disbelief of their objection is nothing to do with them. And I don't share it with them. I don't ever try and talk a person into a method... If you tell me that...the method...makes your hair turn green, I'll say, not a problem. Let's find another one. I won't engage with you in your magical thinking." (Dr Page)

For some doctors, contraceptive consultations started with excluding unsuitable methods. There was some acknowledgement that contraception was very individual and what was perfect for one woman might be intolerable for another.

Sexuality and the contraceptive consultation

When discussing the relationship between contraception and sexuality, doctors highlighted gaps in their training; many had sought further training in sexual counselling or had developed skills on the job, while others felt they had never acquired good skills in this area.

"Yeah, I think the training is not really that broad, generally, and certainly I don't think I'm well equipped to deal with sexual problems... I'm better equipped to deal with kind of sexual infections, but not so much relationship issues." (Dr Watson)

Personal discomfort prevented some from asking about sexual function or relationships. Some had concerns about whether that was a part of their role and how such questions might be received by clients, potentially making them uncomfortable.

"It's not a thing, I must admit... I think again that's possibly the problem being a male, actually. And I think women are reluctant to bring it up... But these [impacts on sex life] are not things that usually I would even talk about. They're very rare." (Dr Chifley)

These concerns were expressed by female as well as male doctors, and doctors consistently reported that contraception and sexuality were treated separately within medical practice.

"There's contraception doctors that are women's health, that are very much focused on contraception and women's rights. There's STD doctors that are just focused on sex and I think the two don't go well together. You know, Family Planning don't know much about HIV. The HIV doctors don't really want to know much about contraception. People don't ask

enough about the circumstances of sex in either camp... And I think the two are separate and they shouldn't be because they're integral." (Dr Fadden)

Although doctors saw that contraception had both positive and negative impacts on women's sex lives, few saw a clear link between contraception and libido, regarding female sexual response as multifactorial.

"I just think that link is pretty tenuous...there's so many other things that influence libido in women that I think contraception's just a very small factor." (Dr Fadden)

"I don't know. I think that I do sometimes see people who might describe changed sexual desire or changed ability to lubricate, or reduced capacity for endurance, which then might temporarily relate to types of contraception. I think it's often difficult to unpick what's the contraception, what's the changed dynamic of their relationship." (Dr Curtin)

Indeed, a few of those interviewed were uncomfortable with the question and skirted around the topic or asked how others had answered it. Doctors also tended to shift back into a risk–benefit framework, sometimes acknowledging that contraception did affect sex life but deeming it a necessary evil in a risk–benefit analysis.

"On the whole, the benefits actually outweigh the disadvantages... There's just the general thing about contraception, overall, in terms of fewer complications from pregnancies, from unplanned pregnancies, including things like the complications of termination, ectopic pregnancies, miscarriages... Contraception is really effective, you know, sort of broad public health measure." (Dr Forde)

One interviewee wondered whether doctors perhaps downplayed any impacts on sexuality because of the limited evidence connecting the two, and emphasised that the doctor's role was to find a successful contraceptive match.

CONCLUSIONS AND IMPLICATIONS

This qualitative study provides rich, in-depth knowledge about the approaches taken by 15 doctors' to contraceptive management, and illuminates some of the complexities and challenges in this process. Consistent with the findings of Henderson *et al*,²³ the doctors recognised some tension between the shared approach—informing patients of options and allowing autonomous decision making—and the reality of clinical consultations which sometimes involved more directive counselling. Our findings suggest doctors in part encourage methods according to their own preferences and their understanding of the latest evidence in the field, and this can sometimes merge back into a paternalistic rather than a shared model of care. Another pressure which adds to this tendency is the time pressure in a typical GP clinic consultation,

which may discourage discussion of a range of contraceptive options. This is important since women with an understanding of their chosen contraceptive and an established pill-taking routine are more likely to adhere to their method.^{24 25}

Undergraduate training in sexual and reproductive health as part of a medical degree is very variable in Australia, and dependent on each individual university. Each medical school needs to meet generic competencies (Australian Medical Council <http://www.amc.org.au>), but these do not specify particular competencies in sexual and reproductive health. Many Australian universities run postgraduate (generally Masters level) courses that include modules on STIs, sexual function, contraception and related topics.

The Royal Australian New Zealand College of Obstetrics and Gynaecology (<http://www.ranzcog.edu.au>) trains gynaecologists to work in public and private practice, but there is no equivalent to the UK model of a subspecialty in Sexual and Reproductive Health. The Royal Australian College of Physicians (<http://www.racp.edu.au>) has a 3-year training programme resulting in recognition as a specialist sexual health physician; this training includes reproductive health.

Family planning organisations in all Australia states and territories offer short courses including clinical attachments in sexual and reproductive health for doctors and other health care professionals. These are widely recognised as best practice and the standard pathway for GPs to gain skills. They also offer specific training in IUD and contraceptive implant insertion and removal. GPs can also undertake 6-month 'special skills posts' in family planning organisations as part of their training.

Most of the respondents to this study had done training in addition to their medical degrees; some had or were currently studying for specialist training as sexual health physicians or specialist GPs. Nonetheless, the doctors reported feeling less than comfortable and competent when discussing issues of sexuality and sexual function, a finding that has also been noted in health professionals in the UK¹² and Switzerland.¹³ Internationally, the lack of training of doctors in sexuality and more broadly in sexual health has been recognised,²⁶ but this is the first Australian study to document the professional discomfort among a group of doctors who are experts in sexual health and women's health. Sexuality education needs to be better incorporated into undergraduate medicine and postgraduate training for practitioners specialising in women's reproductive health, including encouraging the use of communication aids that can be useful.²⁷ Although contemporary medical training emphasises communication skills, specific training in discussing sex explicitly during contraception and sexuality consultations is needed at both undergraduate and postgraduate level. Many medical students who attended high school in Australia have received education that

includes sexual and reproductive health, and in tertiary education sexual and reproductive health is assumed knowledge. However, discussing sexuality and the body openly and honestly breaches normal social taboos, and many students, particularly those from outside Australia, may have limited knowledge and skill in this area and need practicing in allowing men and women to discuss these topics with each other in a professional manner.

In addition to the piecemeal system of training, another reason for the gulf between contraceptive care and sexual health is structural. Sexual health clinics, which are free and do not require patients to produce a Medicare card, are not generally funded to provide contraception, and indeed low-risk people who are exclusively heterosexually active are not routinely seen at many sexual health clinics. While family planning clinics provide integrated contraceptive and sexual health services, they are limited in number and not universally accessible to all women. GPs provide primary care including the bulk of contraceptive and STI care,²⁸ but levels of training and skills are variable.

The division in services between STIs and reproductive health is reflected in policy initiatives. There is no integrated national sexual and reproductive health policy.^{29 30} STI and HIV policy is handled under 'infectious diseases' by departments that also work on blood-borne viruses, but are separate from responses to sexual assault, childbirth services, or women's health in general. Each state in Australia has its own strategic plans, so funding models differ, but generally there is no model for publicly funded integrated sexual and reproductive health care. In recent years, however, the Australasian Sexual Health Alliance has been promoting conversation between disciplines and sectors.

This study did not attempt to survey doctors and achieve representative results. Rather we wanted to get a feel for the dominant discourse among contraceptive service providers that would inform a larger study on women's experiences of contraceptive use. As we deliberately targeted expert doctors, it is likely that other doctors with less exposure to and experience of women's reproductive health care may be less well informed and may have had different attitudes and opinions. There is also the possibility that doctors concerned with self-presentation described their clinical experiences and approaches in ideal terms. But given those interviewed provided quite balanced accounts, we feel this did not dominate in the findings.

We found that doctors sought to communicate their knowledge of the evidence in a way that directed each woman to the best choice for her as perceived by the doctor. Despite being an expert group of practitioners, respondents identified themselves as having limited confidence in dealing with issues of sexual

function and this remains an area that requires further attention. Apart from improvements in the provision of information to women and discussion of options, further research could seek ways to improve the ability of GPs to deliver contraceptive services—for example: interpreting our findings and those of other researchers in the context of research on doctor–patient communication in general; evaluation of provider training interventions within the context of implementation research, using for example the evaluation framework suggested by Michie *et al*;³¹ and collation and analysis of models of international integrated sexual and reproductive health services in developed and developing countries to learn from their successes, failures, and barriers to implementation.

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