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The general practitioner contraceptive appointment. More than just a script?

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Abstract

Objective: To determine the secondary health benefits when women attend a general practitioner (GP) appointment for a prescription of the oral contraceptive pill (OCP).

Design: An online survey of GPs working in the Australian Capital Territory in Australia.

Setting: Primary care

Participants: 104 GPs responded. Participants participated through a link in a local medical publication, phone calls to practice managers and emails sent to general practitioners. A link to the survey tool was provided.

Main outcome measures: Proportion of consultations that addressed a secondary health issue, in addition to prescribing of the OCP. Secondary outcomes were an audit of management activities and qualitative feedback about the consultation.

Results: 96% of participants stated they had diagnosed a secondary health issue when prescribing the OCP. The major themes emerging from consultations in qualitative date were the complexity of consultations, the wider social and medical situation, discussions about switching to long-acting contraceptives and the consultation providing opportunistic healthcare.

Conclusions: The majority of consultations to issue a prescription for the OCP involved management of a secondary health issue. If women did not see a general practitioner for their prescription, then some secondary health issues might be missed..

Introduction

The oral contraceptive pill (OCP) remains an important global tool for women to control their reproductive health. It is estimated that 9% of the world's female population of reproductive age currently use the oral contraceptive pill as their main method of family planning [1].

In Australia, the OCP remains the principle method for contraception with around 50-80% of women using it as their main method [2]. However, the OCP is also used for other purposes including menstrual regulation, period pain, acne management, and to address underlying gynaecological issues such as endometriosis, and underlying medical issues such as bleeding disorders when management of menstrual cycles can prevent otherwise life-threatening haemorrhage [3].

There are specific indications and contraindications to safely prescribe the OCP, and failure to comply with these can result in potentially catastrophic outcomes. It is also important to check for compliance and ensure poor compliance has not led to unplanned pregnancy. Prescribing the OCP also provides an opportunity to provide other preventative health advice. This can include advice on prevention of sexually transmitted infection (STI) and general lifestyle advice on alcohol consumption, smoking, weight, family planning and mental health [4]. This preventive advice is a crucial aspect of holistic care, not simply a fortunate additional service. In Australia, the OCP is only available on prescription. This provides health care practitioners an opportunity to educate women on the types of contraception available and provide advice regarding use, compliance and evaluate sexual health requirements [2].

There has been global discussion that prescribing the OCP might be safely performed in nonmedical settings or commercial premises such as pharmacies. However, there has been limited research on how such a policy change might reduce the safety and preventative health benefits of prescribing within a medical setting such as a general practice. There have been no Australian studies on this issue.

Our hypothesis was that the prescription of the OCP in a medical setting would be associated with important secondary health benefits in 20% of consultations. These benefits could include management of other areas of health such as STI or mental health management [2].

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Table 1. Management at a consultation where the oral contraceptive pill is prescribed

	N(%)
A secondary health issue managed during the consultation	100(96%)
Excluded pregnancy	24(23%)
Excluded urine infection	19(18%)
Excluded chlamydia or gonorrhoea	68(65%)
Excluded candida or vaginitis swabs	23(22%)
Reviewed other health issues and ordered a blood test	11(11%)
Reviewed other health issues and ordered an imaging study	3(3%)
Checked if CST was required	60(58%)
Provided counselling for sexual health	103(99%)
Provided counselling for psychological conditions	75(72%)
Provided counselling for other contraceptive options	104(100%)
Discussed switching to long acting reversible contraception	101(97%)
Exclude contraindications to hormonal pill	102(98%)

This study's aim was to determine the proportion of consultations where a secondary health issue was addressed during a consultation where the OCP was prescribed in a general practice setting. The secondary aim was to explore management performed during the consultation and secure qualitative feedback.

Methodology

Type of study

Due to COVID-19 social distancing restrictions, an online survey was undertaken of general practitioners working in Australian Capital Territory (ACT) region of Australia to audit the outcomes of consultations where the OCP was prescribed.

Recruitment

GPs were invited to participate through a link in a local medical publication, phone calls to practice managers and emails sent to general practitioners. An electronic link to the survey audit tool was provided.

Ethics and consent

Institutional ethics approval was obtained from the Australia National University Science & Medical Delegated Ethical Review Committee (Human Ethics protocol 2019/595). Consent of the GP to participate occurred when the participant selected the "I agree" section of the participant information sheet on the first page of the survey audit.

The survey

Upon clicking on the link, participants entered the Apollo site (ANU Polling Online, version 3.03 2018) hosted by Australian National University, dedicated for the survey study. Data was collected via drop down boxes with yes/no responses. There was also a section for free hand typing of comments at the end of the survey for qualitative analysis. Data collection was anonymous. The GP was asked to enter data based on their practice in a recent consultation where they prescribed the OCP.

Data included demographics of the survey cohort, management that occurred during consultation, consultation outcomes and an opportunity for qualitative comment. Data was stored on the ANU Apollo system in an encrypted format.

Statistical analysis

Our hypothesis was that 20% of consultations would address a secondary health issue. In order to detect this with 95% confidence a sample of 100 responses was required. Descriptive statistics were applied. Continuous variables were presented as mean and standard deviation or as median and interquartile range depending on whether they are normative or non-normative. Discrete data were presented as number and percentage. The primary outcome is the percentage of consultations where a secondary health issue was addressed.

Results

Overall, 104 participants responded to the survey, with almost half (48%) working in an inner-city region, and the remaining 32% and 17% working in an outer city or rural location, respectively. Majority of respondents were female practitioners (82%). Most practitioners were aged 40-60 years (45%). A further 44% were younger practitioners under 40 years of age. Only 10% were over 60 years of age.

Overall, 96% (N=100) of general practitioners indicated that a secondary health issue was addressed during the consultation where the OCP was prescribed (Table 1). Secondary health issues addressed included counselling for sexual health (99%), counselling for psychological conditions (72%), screening for chlamydia or gonorrhoea (65%) and a CST (58%). Other management that was performed included pregnancy testing (23%), screening for candida or vaginitis (22%), urine infection MSU or dipstick (18%), blood test (11%) and imaging studies (3%). In addition, counselling specific to long-acting reversible contraception (LARC) (97%) as an alternative to OCP was undertaken (Table 1).

General practitioners collected considerable history and examination before prescribing the OCP. Most general practitioners asked about the patient's age (100%), smoking status (100%), other medical (100%), current medications (99%), allergies (99%), and excluded contraindications for prescribing the pill such as migraine, family history of blood clotting disorders (98%). Most practitioners also enquired about the patient's cervical screening history (98%), risk of STI and sexual behaviour (94%), current relationship history (90%), previous pregnancies (79%), psychological health (71%), alcohol consumption (64%) and employment history (58%) (Table 2). Majority of general practitioners performed clinical examinations including measuring blood pressure (99%), heart rate (91%), and weight, height or BMI (81%) (Table 2).

GPs also indicated that in some consultations the OCP was prescribed for non-contraceptive reasons. The non-contraceptive indications included menstrual cycle management (29%), dysmenorrhoea (20%) and skin care (11%). These secondary issues were also addressed during the consultation when relevant

Qualitative results

In the qualitative section of the audit survey, six major and two minor themes were identified using thematic saturation.

Complexity of consultations

The major theme to emerge was the complexity of prescribing the OCP and the need to identify what additional history, examination and investigations were required to manage each unique situation. The consensus was that there was no simple consultation format or proforma that could be applied to the OCP consultation. The complexities depended upon the patient's age, comorbidities and social circumstances.

"Everything depends upon is this a new patient? A 16-year-old or 49 year old?"

Table 2. History, examination and discussion performed at a consultation when the OCP is prescribed

History issues reviewed at consultation	Response
Check the patients age	104 (100%)
Check smoking status of patient	104 (100%)
Check alcohol consumption of patient	67 (64%)
Check the patients use of illicit drugs	45 (43%)
Check the patients list of medications	103 (99%)
Check the allergies of the patient	103 (99%)
Examinations performed	
Blood pressure	103 (99%)
Heart rate	95 (91%)
Weight, height, or BMI	84 (81%)
Abdominal assessment	14 (13%)
Cardiac assessment	19 (18%)
Gynaecologic assessment on the patient	23 (22%)
Breast examination	14 (13%)
Urine analysis	12 (12%)
Respiratory assessment	8 (8%)
Mental state examination or psychological assessment	49 (47%)
Issues discussed	
Discuss the patients current relationship history	94 (90%)
Discuss any of the patients other medical conditions	104 (100%)
Discuss the patients sexual behaviour and risk of STI	98 (94%)
Discuss the patients cervical screening history	102 (98%)
Discuss the bowel health of the patient	23 (22%)
Discuss the bladder health of the patient	35 (34%)
Discuss the employment status/history of the patient	60 (58%)
Discuss if the patient has had any previous pregnancies	82 (79%)
Discuss if the patient has had any previous abortions	50 (48%)
Discuss the psychological health of the patient	74 (71%)

"This depends on the age of the patient, history given length of time I have, length of time the patient is known to me and also if this is a continuing prescription"

Many of the comments reflected the diverse consultation requirements that an OCP prescription might demand of clinicians and the individualisation required to ensure the patient's risks and concerns were assessed.

The wider social and medical situation

The second major theme was the need to discuss social and medical history with the patient to establish the correct form of contraception for their particular situation and ensure other health risks were identified.

"An assessment of mood is vital as progesterone may impact on mood and also a review of side effects as this may lead to a change in pill or type of contraception"

"Also discuss plans for future pregnancy and provide information on pre-contraception planning, genetic testing etc"

Switching to long acting contraceptives

The third major theme was the need to consider whether long acting methods of contraception were more appropriate for the patient's personal situation. Many GPs preferring long acting reversible contraception (LARC) methods, especially in women seeking long-term contraception or those with other symptoms such as dyspareunia or heavy bleeding.

"I always discuss whether a long acting contraceptive may better suit needs. Depends whether patient just needs contraception or whether they also need cycle control and have other problems"

"Increasingly I prescribe long acting contraceptives unless they need secondary benefits of the pill. Pill good in teenagers"

Opportunistic healthcare

Many doctors mentioned how a woman presenting for an OCP script provided the perfect opportunity for screening for sexually transmitted infections (STIs), mental health issues and social pathology, and for monitoring blood pressure (BP) or weight or performing cervical screening tests (CST), or reviewing lifestyle issues.

"Request for OCP is an opportunity to provide whole person assessment, preventative health, education and relationship building, sexual, reproductive and psychological health are a core part of the consultation. Screening for family violence, parenting, reproductive life plan is also core."

"An appointment for repeat OCP script is an ideal time for screening to assess need for STI check, CST check, take BP, discuss lifestyle and to discuss LARCs. Also to discuss fertility with patients and family planning. I really enjoy these appointments actually".

Diagnosis of mental health and other medical concerns

Another dominant theme was the issue of women presenting for the OCP who then mentioned other medical concerns such as mental health symptoms and stress or who enquired about pregnancy planning, relationship concerns and more serious family violence issues.

"Often they come in for the pill but then have a long list of other issues including mental health and stress and other health problems such as asthma that also need review. Very rare to just issue a script for contraception. Always other things addressed"

"Often the woman presents with one thing and you end up counselling about other things like pregnancy planning, relationship concerns, mental health, asthma and all manner of other issues. I never perform just a script for the pill consult."

It's never just a script for the pill

Many doctors also felt there was so such thing as just a script for GPs, especially when it came to the OCP

"There is rarely any such thing as "just a script" for GPs"
"Never just give the pill"

Minor themes included addressing the rising rates of STI's in the ACT and the chief medical officer asking everyone to consider screening for syphilis, gonorrhoea, and chlamydia when unprotected intercourse occurs and discussing how the pill prescription provided an ideal opportunity to do this and also the need to constantly re-evaluate for potential contraindications or side effects.

Discussion and conclusion

The key finding of the study was that 96% of GPs addressed a secondary health issue at a consultation to prescribe the OCP. This was considerably higher than our predicted rate of 20%. The issues addressed represented important health issues including screening for sexually transmitted, urinary, and vaginal infections, diagnosing, or planning a future pregnancy, addressing mental health and family violence issues, and initiating important investigations including cervical screening, blood tests and imaging for other health issues. In addition, consultations involved assessing and reinforcing compliance, and excluding contraindications. The high rate of secondary health issues addressed, that each would justify an independent consultation, means that any cost benefit analysis of introducing prescribing in other

health settings needs to consider the financial and health burden of disease, and the cost of missing the management of secondary health issues that are routinely addressed during the general practitioner OCP consultation.

Studies indicate that Australian women want information about contraception options, side effects and demand autonomy in the contraceptive decision-making process [5]. Many women use the OCP as they lack knowledge of or are misinformed about other contraceptive options [2]. However, 96% of respondents stated they discussed the use of LARC in an OCP appointment and commented that LARCs are now emerging as a first line option for women who want long-term contraception or have cycle management concerns. However, the OCP remained useful in younger patients and those who required the additional benefits specific to OCP.

Australia has a high rate of OCP use compared to other countries. One reason advocated for this high rate of usage has been the revised WHO guidelines in 2000 that modified the restrictive criteria around hypertension and smoking as contraindications for women taking the oral contraceptive pill [6]. However, we observed that general practitioners constantly reassess women with these risk factors to determine if OCP remains an appropriate choice of contraception. Many participants reported that they measured blood pressure, heart rate, height, weight, or BMI and collected a smoking history.

Contraception is not a static 'one off' decision nor a one-size fits all approach. Many women change their contraceptive methods throughout their reproductive lives, this leads to a level of complexity when prescribing the OCP [7]. Women have different contraceptive needs based on their age, medical history, pregnancy history, family planning, comorbidities, and stage of life that influence the contraceptive consult. This complexity was reflected in the dominant theme from qualitative analysis that the OCP consultation was complex and involved individualisation to the woman's needs and circumstances.

Women are more likely to visit the doctor then men, and this increase in consultations is partly due to contraception presentations [3]. Discussion about sexual health is more than just contraception, it is important to make sure contraceptive appointments address the wider needs of women's sexual health and include discussions on topics like treatment and screening for sexually transmitted infections, sexual dysfunction, planning a pregnancy or support with unplanned pregnancy. Women want these discussions to be performed in a confidential non-judgmental manner [4]. We found that most general practitioners introduced these conversations opportunistically as part of quality holistic preventive medical care during OCP consultations.

Another theme was the desire of practitioners to inform women of longer acting contraception (LARC) options. Australia has low rates of uptake of LARC compared to other western countries, the exception being in regional areas [8,9]. Our results suggest general practitioners may be trying to change community uptake by investigating barriers to LARC during OCP consultations. Prior research suggests that many women lack knowledge of LARC [10,11]. Personalised education about contraceptive options and side effects, misconceptions about LARC, may change uptake rates [2,11].

The OCP consultation provided an opportunity to assess mental health. This is important as hormones can independently impact on mood, and mental health pathology is common [5]. Utilising the OCP consultation as an opportunity to evaluate mental health provides dual benefits to the patient.

This study had some strengths. Firstly, the survey tool was easy to complete, did not consume a large amount of the general practitioner's time and avoided loss to follow up as data was collected after the event. It also was a cost-effective way to secure a general picture of the activities undertaken during a consultation to prescribe the OCP. The limitations are that a retrospective audit is less accurate than prospective data collection. The survey was online, and doctors were not formally interviewed in person due to COVID-19. This meant that respondents did not have an opportunity to clarify any ambiguity in questions. Data also relied on participants to self-report the care they provided, which could be over or underestimated. For future studies, a prospective audit of patient files or general practitioner interviews immediately following consultations might provide more accurate data.

Future research should also evaluate whether policy changes in prescribing locations or providers will result in clinical and financial benefits or harm. This research could assist in performing a cost-benefit analysis of prescribing in various locations, as our data suggest than more happens at a consultation to prescribe the OCP than simply issue of the prescription. This additional clinical input should be considered in any future policy decisions.

In summary, our research indicates that attending a general practitioner for a repeat prescription for the OCP is associated with concurrent addressing of secondary issues in sexual, reproductive, mental, and general health.

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