

Practical Approaches to Prescribing Contraception in the Office Setting

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Many adolescents will not seek contraceptive services until well after their first sexual intercourse [1]. Most adolescents do not seek contraceptive services until they have been sexually active for 6 months, yet 50% of adolescents will conceive within these first 6 months of unprotected intercourse [2,3]. In other words, many sexually active adolescents will be not seek care until it is too late. Initial access to care becomes crucial for preventing unintended adolescent pregnancy [4].

Early (12–14 years) and often middle (15–17 years) adolescents, are concrete thinkers; their inability to think abstractly limits their ability to make decisions and choices for future benefit. The use of all types of contraceptives requires some advance planning. This may become a barrier in delivering care to early and middle adolescents. To plan in advance requires acknowledging that sexual activity may occur in the near future. Many adolescents describe being swept away and not having planned intercourse.

Concrete thinkers also may have difficulty acknowledging the possibility of pregnancy. For example, early adolescents may admit that they are sexually active and comprehend the fact that sexual activity may produce a pregnancy, but they may be unable to acknowledge that they could become pregnant through unprotected intercourse. Understanding of personal vulnerability requires knowledge that an action taken now could produce a consequence in the future. Prevention of pregnancy also requires decisions and choices now to prevent an unforeseen event in the future.

Even older adolescents with a growing ability for abstract thinking may have ambivalence about the rightness or wrongness of their decision to be sexually

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active. Sometimes, this ambivalence translates into poor contraceptive practices. Planning a contraceptive method implies that they have made an active choice to be sexually active [5].

Barriers to care

The unique developmental tasks of adolescence may pose barriers to care for contraceptive services. Encouraging abstinence (both primary and secondary) while providing for contraceptive needs can be a difficult balance to achieve. There are also other barriers to care for the adolescent that must be overcome. For many adolescents, physical access to care is difficult. Teens may not know where services are provided and how to find services at lower cost. Clinics or offices without after-school appointments limit care. More school systems are imposing penalties for absences, even those excused for a medical visit. Clinic/office locations inconvenient to public transportation also limit care. The early to middle adolescent may not be driving and may have to depend upon a parent for transportation.

Language may be a barrier in an increasingly multicultural society. There may be cultural barriers that make access to care especially difficult for first-generation adolescents and their immigrant parents.

Concerns about confidentiality may stop some teens from seeking reproductive health services. Many studies have demonstrated that confidential treatment encourages teens to seek contraceptive services earlier after sexual debut [10]. Confidential care should encourage family communication while acknowledging that many adolescents would not seek care if it were not confidential [11,12]. If confidentiality is not discussed early with the parents and teen, fear of anger from parents toward the provider may interfere with provision of services.

Many adolescents feel that they cannot discuss issues of sexuality with their parents [9]. Although confidential care should be available to all adolescents for sexual health needs, not knowing how to discuss issues of sexuality with a parent also can be a barrier to care. Many teens want to discuss their sexuality with parents, but both parents and teens are equipped poorly to begin the conversation. Embarrassment, fear of punishment, or fear of disappointing parents are all barriers. Being an askable parent is not a trait that comes automatically with the addition of a new child to the family. Parents will bring to this experience their own feeling about their sexuality, especially sexual decisions that they made during their own adolescence.

Paying for the services may pose another challenge, especially if the teen is insured by a third party payer provided through a parent. Managed care and third party payers add an additional level of concerns about confidentiality [6]. Confidentiality becomes an especially difficult issue for adolescents covered by managed care plans where the parents are the primary insured individuals. Some teens may be covered by health insurance provided by a noncustodial parent in the event of divorce. These situations present a challenge for both the teen and the

care provider. Adolescents may not be aware of lower cost sources of care including school-based clinics, organizations such as Planned Parenthood, and family planning services available through their county health department. Those with Medicaid coverage may not realize that confidential family planning services are available.

Teens also may be reluctant to bring questions and concerns about sexual health to their pediatric health care providers. Some offices may be very child-friendly but not welcoming for adolescents and young adults. Some of the same barriers experienced with parents may be present again with the pediatrician as a parental authority figure. Physicians are also constrained by time, training, or ambivalence about providing contraceptives for teens. Spending time alone with the teen during each routine physical exam places additional stress on an already tight schedule in most offices [7]. Some pediatric care providers are not comfortable with providing pelvic exams in the office and are not aware that a pelvic exam is not essential before contraceptives are prescribed. Screening for sexually transmitted infection (STI) may be performed with new nucleic acid amplification-based technologies from a first voided urine sample.

Often teens have misconceptions regarding the efficacy and safety of contraceptive methods. There are many misconceptions about the safety of hormonal contraception among teenagers. Unfounded fears often include weight gain, acne, future infertility, and risk of cancer. The health benefits of hormonal contraception are underestimated, and the risks overestimated. Incorrect information often is perpetuated by the teen's peer group. These unfounded fears also may be shared by parents, especially concerns that hormonal contraception is dangerous for the younger adolescent. Parents often worry that hormonal contraceptive methods prescribed for medical indications will increase the possibility of sexual activity in their teen even though this has been proven not to be true.

Fear of a pelvic exam may stop some teens from requesting contraceptive services. There is much misinformation among adolescents about this procedure and fear of the examination itself. Most teens are not aware that hormonal methods of contraception may be prescribed without a pelvic exam [8].

A history of childhood sexual abuse or sexual assault also plays a role in adolescent sexual decision making. Several studies have noted that an earlier onset of sexual activity may be especially problematic with the early adolescent whose abstract thinking and advance planning skills may be limited. Sexual assault is common among adolescent girls and is often not identified by the girl herself as assault. The fear and shame associated with the trauma may prevent the girl from seeking reproductive health care services.

Practical pointers of counseling

In an ideal setting, all children would have easy access to a known, trusted, and approachable clinician. That clinician would have an effective and trusting partnership with the parents that began before adolescence, and issues of com-

munication and confidentiality would be a routine part of anticipatory guidance. This formula would provide the best sexual health care for the adolescent. Unfortunately, as families are more mobile, care providers change frequently with a change in insurance status, and a growing number of adolescents are uninsured or underinsured, this ideal setting may be more the exception than the rule.

The best counseling for good sexual decision making and effective contraceptive use begins before the onset of sexual activity. Young adolescents should have access to accurate information about the risks of adolescent pregnancy, STIs, and strategies to reduce both, including abstinence. This involves a multidisciplinary approach with family, medical provider, school, and faith community.

Given the typical adolescent delay in seeking contraceptive services, effective contraceptive strategies need to be introduced before the onset of sexual activity. Teens need to be provided information regarding contraceptive methods during routine well adolescent exams. Effective strategies in the pediatric office can include written take-home material in waiting rooms, exam rooms, and restrooms. The material should be attractive and reading level appropriate. Posters, booklets, and other materials can be placed in restrooms where teens may read them in private. Providing early adolescents and their parents information together may encourage conversations at home. Explaining guidelines for confidential treatment of adolescent sexual health concerns is much easier when done before the need arises.

Teens also can be encouraged to share the information with peers who may be sexually active. Provide teens with several copies of information about the safety and efficacy of contraceptives and encourage them to leave them behind at school, movie theaters, malls, or on the bus. Adolescents often look to their peers for sexual information and can be encouraged to be a source of accurate information. Virginal teens can help dispel myths regarding the safety of contraception and help share information about access to care from school-based clinics, Planned Parenthood, and public health department clinics. Physicians who are reluctant to spend valuable counseling time in the office with those teens who are not sexually active should remember that they may be equipping an informal peer counselor [13].

The next step in effective counseling is availability. Barriers to availability can be addressed on a community level with school-based clinics, support of public health clinics, and effective sexuality education in the school that includes accurate contraceptive information. Health care providers still are viewed as community resources and may have a positive impact on community decisions if they take the time to become involved. Resources are available from the American College of Obstetricians and Gynecologists (ACOG) to assist in community education. The Adolescent Sexuality Tool Kit from ACOG contains helpful resources for practitioners to use in the office and community (www.acog.org).

In the office setting, barriers to care also need to be addressed. There are many ways that the office/clinic environment can be modified to encourage effective counseling. An environment that is welcoming to the adolescent may include a waiting space or area for teens. Publications of interest to teens including reading

material about contraception may be provided. Some offices have found after-school appointments helpful. Office/clinic support staff who enjoy adolescents, who have a good understanding of the world of the adolescent, and who are trained in effective counseling strategies may increase compliance. Support staff should be nonjudgmental in their interactions with teens. All clinicians should be self-aware about their attitudes and judgments that can be communicated unintentionally to the teen seeking contraceptive services. Phone support availability for questions and problems has been found to be helpful [14]. Communication by E-mail also can be helpful when done properly.

Effective contraceptive use by the adolescent begins with anticipatory guidance from the care provider about common traps that may lead the adolescent to discontinue use or use a method incorrectly [15].

The teen should be actively involved in the choice of contraceptive method. For the average healthy teen, a hormonal method coupled with condom use is often the best choice. It is helpful, however, to talk through the process of choosing a method to allow the teen to be an active participant. The teen's active involvement in the selection process will help foster a sense of ownership of the method. There are various materials available to assist in the process. Most patients will retain only a small percentage of information provided during an office visit [16]. Written material to take home often is used, although some teens will be reluctant to take home written materials for fear of loss of confidentiality. There are a growing number of Web sites (www.aware.com among others) providing accurate and age-appropriate information for teens about contraceptive choices. Many of these sites are interactive, and some even allow questions about sexuality and contraception to be posted and answered by experts in the field. Adolescent patients all learn differently. Written materials may be helpful for some; audio or visual teaching tapes may help others. Seeing and holding a package of pills or a condom is valuable for some teens. The availability of pharmaceutical samples has been demonstrated to be an important tool in increasing compliance [17].

Teenagers often overestimate the dangers of oral contraceptives. This fear may lead to discontinuation when minor adverse effects develop [18]. It is important that the rarity of serious adverse effects be addressed. It is also important to mention the myths of pill use, such as fears of infertility or cancer. The common adjustment adverse effects, such as mild headaches, breakthrough bleeding, and occasional bloating should be discussed, so they will not be frightening to patients. It is especially helpful to advise teens starting oral contraceptives that they should contact the provider before making the decision to discontinue their pills. It is important to discuss the possibility of an occasional amenorrheic cycle with oral contraceptives. The absence of a withdrawal period frightens many teens, often leading to discontinuation of the method. On the other hand, teens should be instructed to come in for a pregnancy test if they do miss a period, because use of contraceptives can be imperfect. Sometimes teens will experience breakthrough bleeding and decide that they should stop their pills to allow a period. Both situations can result in unintended pregnancies [19].

Prescribing practices need to take cost of the method into account to increase compliance. Discussing the cost of the method and how the teen will pay for the prescription is important. Adolescents are less knowledgeable than most adults about costs, the use of insurance prescription coverage, and the availability of lower cost contraceptives from the health department or agencies. Many teenagers have never filled a prescription and may have no idea what to do with the small piece of paper they are given in the office. This presents a valuable teaching opportunity to explain how prescriptions are filled, how they are paid for, and the importance of planning ahead. Providing the patient with a sample package of pills, patches, or a vaginal ring just in case they cannot get to the pharmacy is often helpful. Day one of cycle starts or quick starts of cyclic oral contraceptives may be more practical than Sunday starts [20]. Most clinics and providers are not available on Sundays if a prescription needs refilling; not all pharmacies and most agencies are not open for dispensing or questions on weekends.

Increasing compliance with condom use requires careful instruction in proper use but also requires negotiation skills with a partner, and the adolescent may not possess these skills. It may be helpful to practice a dialog between the teen and her partner. There are several commercial booklets available to allow teens to practice these conversations. Younger adolescents at high risk for STIs or pregnancy may not be able to learn these skills; sometimes it can be helpful to encourage the adolescent to blame her care provider for the need to use condoms. "If you don't want to use condoms, my doctor/nurse said that you would have to come and talk to them" may be a helpful statement for the adolescent to learn.

Many adolescents find the daily dosing of oral contraceptives difficult, and this can result in breakthrough bleeding. The common teachings of "take your pill at bedtime" or "take your pill when you brush your teeth at bedtime" are not effective in adolescents who often have different weekend and weekday schedules. Placing a reminder note on the bathroom mirror will not work if the teen's parents are not aware of her contraceptive use. One solution that often works is encouraging the teen to wear an inexpensive sports watch with the alarm set for the daily time the pill needs to be taken. If the teen will keep her pills in her purse or backpack, she can be reminded by the alarm on the watch to stay on schedule with her pills. Using a different delivery system, such as a vaginal contraceptive ring or a contraceptive transdermal patch, may also help with these compliance problems.

There are clinical situations that present special opportunities for counseling to increase contraceptive compliance. The teen who presents for pregnancy testing and has a negative pregnancy test will be relieved; this can be an important moment to re-evaluate her contraceptive method, her compliance, and adverse effects of the method. Teens taking oral contraceptives can be reminded of proper pill use in the face of a missed withdrawal bleed, breakthrough bleeding, or missed pills. Pregnancy testing is often done on a walk-in basis by clinic support staff. These individuals should have training to recognize these teachable moments and take advantage of that negative pregnancy test and a teen who is often receptive to teaching at that moment of relief.

Abortion counseling (both before and after the procedure) is another opportunity to discuss prevention of future unintended pregnancies. This should be provided by the clinic providing the termination services, but this does not always happen. Contraceptive counseling should begin at the time diagnosis of the unintended pregnancy, which is often in the primary clinician's office. It should be a part of all postabortal follow-up visits. Spontaneous abortion is also frequent in the adolescent population. This may be the first contact of the adolescent girl with the health care system, and compliance with follow-up visits may be poor. This contact is an opportunity that should not be missed.

Adolescents are very likely to resume sexual activity soon after delivery of a baby. The third trimester of pregnancy is an optimal time to discuss postpartum contraceptives with the pregnant adolescent. This should be discussed again before discharge from the hospital. No teen should leave the hospital without a clear plan for prevention of unintended pregnancy.

Parental involvement/confidentiality

In the perfect world, parents, schools, and health care professionals would work together to provide information about pregnancy and STI prevention as a part of sexuality education before sexual debut. Unfortunately, this does not happen often. In fact, some adolescents feel that they cannot discuss issues of contraception with their parents. Many sexually active teens worry about anger, disappointment, or shame from their parents [21]. These concerns may interfere with their ability to obtain and use effective contraception [22]. This has led most states to enact legislation or health care policy to allow teens to receive confidential family planning services.

Allowing teens to give their own consent for health care and counseling services relating to pregnancy prevention/diagnosis/treatment, STI diagnosis/treatment, and termination of pregnancy is permitted in most states. Individual states have enacted legislation to restrict teen access to some services, especially abortion services, without parental consent. Each state has different legal requirements for adolescents to provide informed consent, and it is the responsibility of each practitioner to have a clear understanding of the laws and requirements of the state in which he or she practices. ACOG and the American Academy of Pediatrics have position papers in favor of teen access to confidential family planning services [23].

Although laws vary from state to state, there are several legal and ethical principles that apply in all jurisdictions. Traditionally, parents make all decisions about the lives of their minor children, including health care decisions and informed consent, and are responsible financially for their children's health care. The courts have recognized, however, that there are circumstances where requiring parental consent for treatment would interfere with the ability of the adolescent to obtain necessary medical treatment. In general, these circumstances involve family abuse or sensitive subjects (related to sexual activity or substance

abuse). Emancipated minors are able to provide their own consent for medical treatment; generally, emancipated minors are those who are married, living separate from parents without financial support, or in the military.

Consent for sensitive services, especially contraceptive-, pregnancy-, and STI-related care, is different for each legal jurisdiction and generally determined on the state level. It is important that each clinician be familiar with the policies and laws of the state in which he or she practices. At present, provision of abortion services to adolescents is the most controversial. When parental notification is required by the state, there is usually a provision for judicial bypass, where the court may authorize the adolescent to give her own consent [24–26].

For the adolescent to provide her own consent, the basic principles of informed consent must be met. Specifically, the patient must understand the diagnosis, risks, and benefits of treatment, alternative choices, and risks of not undergoing the recommended treatment. In some states, it is up to the clinician to determine the degree of understanding of the adolescent. Studies have shown that most adolescents are capable of giving informed consent for medical decisions [27]. In clinical settings where parents are responsible for informed consent (eg, before surgical procedures), there is still benefit in involving the adolescent in the process. This may increase compliance by the adolescent and is good preparation for adulthood [28,29].

Confidentiality of written and verbal communication between the clinician and the patient also is protected under the law. This extends to the adolescent in situations where they are able to provide their own informed consent for care. Exceptions to this rule would include reportable abuse, serious danger of self-harm or harm to others, and certain reportable STIs. The clinician has an ethical obligation to disclose that information to the patient at the onset of care.

The clinician must learn to walk a fine line between encouraging productive parental involvement and making sure that teens receive the reproductive health care they need. Anticipatory guidance for parents should include a discussion of adolescent confidentiality, preferably before a crisis develops. Clinicians should discuss the subject of confidentiality with parents and teens and assist in developing a good working relationship between the teen, parent, and clinician. Clinicians should support good teen–parent communication about all subjects, including those related to sexuality.

In summary, providing teens with age appropriate contraceptive services requires a clinician who has a good understanding the many facets of the life of the teen that will impact their contraceptive choices and compliance. The clinician should strive to foster good parent–teen communication, while at the same time maintaining confidentiality. A good understanding of home, school, and community environments will facilitate pregnancy prevention. All interactions with teens need to be approached with a good understanding of the pertinent developmental issues and an understanding of various education strategies to increase compliance. A team approach between family, school, community, and health care professional will give each adolescent the best chance for healthy sexual decision making.

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