Meeting Women's Requests for Intrauterine Device and Contraceptive Implant Discontinuation: An Exploratory Survey of Physicians

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Abstract

Long acting reversible contraceptives (LARC), including intrauterine devices (IUDs) and contraceptive implants, can support an individual in meeting their reproductive goals by allowing them to prevent pregnancy effectively. These devices can also limit an individual's control over reproduction because they generally require an in-person visit to a health care provider for removal. Returning for another visit may be logistically challenging for many individuals who may need to arrange for transportation, childcare, or take time off from work. Effectively negotiating with a provider to request removal may be additionally challenging for medically underserved and disenfranchised people who may not feel empowered to do so. The objective of this study was to assess providers' willingness to honor patients' requests for IUD and contraceptive implant removal on the day of the request. A survey was conducted in which clinicians were presented with scenarios of women requesting IUD or implant removal. Clinicians were asked what they were most likely to do. A total of 105 clinicians were surveyed. The responses of 60 clinicians who inserted IUDs and 57 who provided the contraceptive implant were included in the analysis. When asked about same-day removal of an IUD or implant from a dissatisfied patient who requested removal, 40% stated they would remove the implant, and 57% stated they would remove the IUD on the day of the request. Findings from this study suggest many clinicians would be unwilling or unable to accommodate a patient's request for device removal at the time of their visit. This delay or refusal represents a significant barrier for patients and has implications for reproductive autonomy that should be further explored.

Keywords

intrauterine device, implant, reproductive justice, discontinuation, contraceptive coercion

Introduction

The term *reproductive justice* was invented in 1994 by black women who recognized that the women's rights movement did not adequately defend the rights of women of color, indigenous people, and transgender people. The SisterSong Women of Color Reproductive Justice Collaborative is a national membership organization that was formed from 16 organizations representing women of color in 1997.[1] SisterSong defines reproductive justice as "the human right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities.[1] Reproductive justice is a framework that examines the intersectionality of social institutions, economics, the environment, and culture on an individual's reproductive life.[2] The reproductive justice framework acknowledges that multiple factors affect an individual's ability to control their own reproductive experience, including their interactions with the health care system.[2]

Contraceptive coercion occurs when an individual promotes or discourages pregnancy by controlling another person's contraceptive behavior.[3,4] Contraceptive coercion typically occurs between 2 individuals in a personal relationship and involves behavior intended to maintain power and control in a relationship.[3] In a broader, historical context, organizations and governments have introduced coercive policies and practices related to contraception and reproduction, typically targeted at disadvantaged groups.[5] These policies and practices vary widely from involuntary sterilization in the 1970s to incentivizing the use of specific contraceptive methods in the 1990s.[6] In the 1990s, legislators in 13 states introduced measures to provide women receiving public assistance with financial incentives to obtain the contraceptive implant Norplant.[7] Such policies and practices can also fall under the category of contraceptive coercion.

Studies demonstrate long acting reversible contraception (LARC), including contraceptive implants and intrauterine devices (IUDs), have robust efficacy, safety, and cost-effectiveness.[8] Initial enthusiasm for IUDs and contraceptive implants brought many to herald LARC as "top-tier" or "first-line" contraceptives that should be presented to every individual as the optimum method.[8,9] LARC can support an individual in meeting their reproductive goals by allowing them to prevent pregnancy effectively.[10] These devices can also limit an individual's control over reproduction because they generally require an in-person visit to a health care provider for removal.[11] Most women who choose to regain fertility must have access to medical care and a provider who is willing to remove the device. Although some women choose to remove their own IUD, many are not counseled about this option or do not feel comfortable doing so.[5,6] Health researchers and advocates now caution that enthusiasm for LARC should be tempered with individualizing care based on an individual patient's preferences and resisting the differential promotion of LARC methods among certain groups of individuals.[12]

In 2 recent qualitative studies, patients describe provider preference for LARC methods in which providers communicated either explicitly or implicitly that the patients should not remove their IUD despite the patients' request to do so.[13,14] Given the effectiveness of LARC at pregnancy prevention, a tension can

exist between the long-targeted public health goal of reducing unintended pregnancy on a population level and an individual's personal preferences for a particular contraceptive method. With a reproductive justice lens, contraceptive counseling practices should empower each individual to make the best decision for themselves in their circumstances. Using 2 hypothetical scenarios, this study describes whether clinicians were willing to remove IUDs and implants at the request of a patient or if they delayed or refused removal.

Delaying removal of a LARC or refusing to remove a device altogether are different clinician responses to a patient's request for removal. However, both represent barriers to patient-centered care. The American College of Obstetricians and Gynecologists (ACOG) has advocated for insertion of an IUD or implant at the time the patient decides that they want to use this contraceptive method as long as one is reasonably certain a patient is not pregnant. ACOG cites 2-visit IUD insertion protocols, where a patient makes a request at the first visit and returns at a later time to have the IUD inserted, as a barrier to care. Recent studies demonstrated that only 54% of women returned to have an IUD inserted when a 2-visit protocol was used.[15] Another study found only 32% of individuals returned to have an IUD inserted citing time needed for an additional visit and transportation as 2 of the main reasons they did not return.[16] While removal procedures may add 5 to 10 minutes to a patient's visit and require access to certain instruments and equipment (speculum and ring forceps for IUD removal, scalpel, local anesthetic, needle, syringe, and forceps for contraceptive implant removal), if clinicians advocate for contraceptive counseling and insertion of an IUD or implant at a single visit, clinicians should also be willing to remove a device on the same day as the request to discontinue the device.

Methods

A prospective survey was administered to a convenience sample of providers across a variety of medical specialties, at various levels of training, to explore how providers would respond to 2 hypothetical scenarios describing patients who requested removal of an IUD or contraceptive implant. Clinicians attending 3 conferences (Internal Medicine Grand Rounds, Obstetrics and Gynecology Research Day, and a family medicine conference) in Honolulu, Hawai'i were asked to complete an online survey between April and June 2016. Conference attendees included resident, faculty, community physicians (MD or DO), and advanced practice clinicians (APRN, CNM, PA). Clinicians were provided with a link to the online survey printed on a sheet of paper posted at the registration desk when they entered the conference room. Clinicians could complete the survey on a smartphone, tablet, or laptop. It is estimated that approximately 170 clinicians attended the 3 conferences. All participants provided informed consent before completing the online survey and could opt out of any of the questions. No incentives were offered for survey completion.

Participants provided demographic information (age, gender, specialty, years in practice) and information about contraceptive provision in their practice. Clinician responses were included in the analysis if the clinicians were currently inserting IUDs or implants. Clinicians were asked 2 questions about contraceptive service provision, "How many patients do you counsel a month about birth control?" and which best applies to you, (1) I do not counsel patients about the IUD as a form of birth control, (2) I counsel patients about IUDs and refer them to another provider for placement, or (3) I counsel patients about IUDs and place the IUD myself. For questions about IUD discontinuation, clinicians who responded, "I counsel patients about IUDs and place the IUD myself" were included in the analysis because these clinicians would have the experience, training, and supplies to remove devices. Clinicians were asked similar questions about the contraceptive implant, and those who answered that they did not insert the contraceptive implant themselves were excluded.

Two separate hypothetical scenarios on IUD and implant discontinuation with responses that used a Likert scale (see below) were included. The survey was pilot tested with 5 clinicians for readability before administering the survey to a convenience sample. The first scenario stated, "*Name* is a 29-year-old Gravida 1 Para 1 who has been using a hormonal IUD (Levonorgestrel IUD) for the last 2 years. She states that she has become dissatisfied with the IUD. *Name* will not provide specific reasons why she doesn't like the IUD, only stating that she wants it removed. She tells you that she does not want to become pregnant in the next 2 years. After providing counseling about the normal side effects, risks, and benefits of the IUD, what are you most likely to do?" Note: Gravida 1 Para 1 indicates that the patient had been pregnant once and gave birth once. The second scenario stated, "*Name* is a 17-year-old Gravida 0 [has not been pregnant previously] who has been using a hormonal implant (Nexplanon) for the last 6 months. She states that she has become dissatisfied with the implant. *Name* will not provide specific reasons why she doesn't like the implant stating that she wants it removed. She tells you that she does not want to become pregnant in the next 2 years. After providing counseling about the normal side effects, risks, and benefits of the contraceptive implant, what are you most likely to do?" Participants selected 1 of the following options: (1) I would not remove the IUD/implant, (2) I would not remove the IUD/implant on that day. I would have her return for another visit if she still wants it removed, (3) I would remove the IUD/implant on that day only if she agrees to use another method, or (4) I would remove the IUD/implant.

Reliability and validity testing was not conducted. The survey was administered with Qualtrics Version 2016 (Qualtrics, Provo, Utah). Though Qualtrics can ensure that only unique IP addresses are allowed to take a survey, this feature was not enabled because the reliability of the wireless internet service at all locations was not consistent. Respondents had to restart a survey if they were disconnected because of a poor wireless internet connection. If 2 different surveys came from the same

IP address with a similar date and time stamp, the survey in which the respondent answered more questions was included in the analysis. For example, if 1 survey had responses to the first 3 questions and a second survey from the same IP address with a similar date and time stamp had answers to all questions, only the second survey was included in the analysis. Descriptive analysis was performed using SPSS Version 25.0 (IBM, Chicago, IL). In this exploratory survey, *P* values were reported, though, given the limited sample, statistical testing for associations was not an objective of this study. This study received institutional review board exemption (University of Hawai'i Committee on Human Studies 21833).

Results

Approximately 170 conference attendees were notified of the study though the exact number of conference attendees was unknown. Of the 105 clinicians who completed the survey, the 60 who reported that they inserted IUDs and the 57 who reported that they inserted the contraceptive implant were included in the analysis. Fifty-five inserted both IUDs and implants, 5 inserted only IUDs, and 2 inserted only implants. The demographics of the study population are presented in Table 1 and Table 2. Roughly a quarter of participants who reported inserting IUDs or implants were obstetrician gynecologists (27% IUDs, 25% implants), and a quarter were family medicine physicians (25% IUDs, 26% implants). One person who identified as an advanced practice clinician inserted IUDs (2%). However, nearly half of the respondents did not report their specialty (47% IUD, 49% implant). Of the clinicians who inserted IUDs, 98% reported that they also prescribed or provided injectable contraception (depo medroxyprogesterone acetate) and combined hormonal contraceptives. Among those who inserted contraceptive implants, 98% also provided the other contraceptive methods.

Of note, some respondents inserted both IUDs and implants, so the demographics of 55 individuals are presented in both Table 1 and Table 2. However, respondents were presented with 2 separate scenarios regarding LARC discontinuation, so answers to questions about IUD or implant discontinuation are not duplicated. When asked if they would remove an IUD from a patient dissatisfied with the IUD following clinician counseling about the normal side effects, risks, and benefits of the IUD, 57% stated they would remove the IUD on that day, 37% stated they would not remove the IUD that day and would have the patient return for another visit for removal, and 12% reported

Table 1. Demographics of Survey Participants by Response Regarding Intrauterine Device (IUD) Discontinuation

		IUD response			
	n (%)	I would not remove the IUD that day and would have her return for another visit. n (%)	I would remove it on the day only if she agrees to use another method. n (%)	I would remove the IUD. n (%)	*P* value
Total	60 (100)	22 (37)	7 (12)	31 (57)	
Sex					
Male	18 (30)	6 (33)	3 (17)	9 (50)	.81
Female	41 (68)	16 (39)	4 (10)	21 (51)	
No response	1 (2)	0 (0)	0 (0)	1 (100)	
Age (Years)					
30 or younger	13 (22)	5 (39)	1 (8)	7 (54)	.80
31–40	18 (30)	6 (33)	1 (6)	11 (61)	
41–50	15 (25)	4 (36)	3 (27)	4 (36)	
51 or older	11 (18)	4 (36)	3 (27)	4 (36)	
No response	3 (5)	1 (33)	0 (0)	2 (67)	
Years in Practice					
Currently in residency	23 (38)	9 (39)	2 (9)	12 (52)	.50
Completed residency in the last 10 years	8 (13)	2 (25)	0 (0)	6 (75)	
Completed residency ≥ than 11 years ago	29 (48)	11 (38)	5 (17)	13 (45)	
Number of Patients You Counsel Per Month About Birth Control					
Less than 1 per month	2 (3)	1 (50)	0 (0)	1 (50)	.24
1 to 5 per month	14 (23)	8 (57)	0 (0)	6 (43)	
6 to 10 per month	7 (12)	4 (57)	1 (14)	2 (29)	
More than 10 per month	37 (62)	9 (24)	6 (16)	22 (71)	

Table 2. Demographics of Survey Respondents by Response Regarding Contraceptive Implant Discontinuation						
			Implant response			
	n (%)	I would not remove the implant. n (%)	I would not remove the implant that day and would have her return for another visit. n (%)	I would remove it on the day only if she agrees to use another method. n (%)	I would remove the implant. n (%)	*P* value
Total	57	1 (2)	31 (54)	2 (4)	23 (40)	
Sex						
Male	16 (28)	1 (6)	8 (50)	1 (6)	6 (38)	.59
Female	40 (70)	0 (0)	23 (58)	1 (3)	16 (40)	
No response	1 (2)	0 (0)	0 (0)	0 (0)	1 (100)	
Age (Years)						
30 or younger	13 (23)	0 (0)	7 (54)	0 (0)	6 (46)	1.00
31–40	18 (32)	0 (0)	7 (39)	2 (11)	9 (50)	
41–50	13 (23)	0 (0.)	8 (62)	0 (0)	5 (39)	
51 or older	9 (16)	1 (11)	8 (89)	0 (0)	0 (0)	
No response	4 (7)	0 (0)	1 (25)	0 (0)	3 (75)	
Years in Practice						
Currently in residency	24 (42)	0 (0)	12 (50)	1 (4)	11 (46)	.59
Completed residency in the last 10 years	8 (14)	0 (0)	3 (38)	0 (0)	5 (63)	
Completed residency ≥ 11 years ago	25 (44)	1 (4)	16 (64)	1 (4)	7 (28)	
Number of Patients You Counsel Per Month About Birth Control						
Less than 1 per month	3 (5)	0 (0)	2 (67)	0 (0)	1 (33)	.87
1 to 5 per month	14 (25)	0 (0)	8 (57)	0 (0)	6 (43)	
6 to 10 per month	6 (11)	0 (0)	3 (50)	1 (17)	2 (33)	
More than 10 per month	34 (60)	1 (3)	18 (53)	1 (3)	14 (41)	

they would remove the device only if the patient agreed to use another method (Table 1). When asked if they would remove an implant from a patient who was dissatisfied with the implant following physician counseling about the normal side effects, risks, and benefits of the implant, 40% would remove the implant that day, 54% would have the patient return for another visit for removal, and 4% would remove the device only if the patient agreed to use another method. One individual (2%) stated they would not remove the implant for the patient in the scenario.

Discussion

This study suggests a substantial proportion of women who wish to discontinue an IUD or implant would not be able to have the device removed on the day they requested. Given the exploratory nature of this survey, providers were not asked why they would delay removal; thus, conclusions cannot be drawn about their motivations. The motivation for delaying removal is important, however, especially considering how this survey reflects upon reproductive autonomy and contraceptive coercion. Therefore, further research in this area is warranted. There are many possible explanations for delaying IUD or implant removal. Implant removal can be straightforward and quick or time-consuming, and it is not always possible to predict how long it will take to remove a contraceptive implant in any particular patient. IUD removal typically takes 5 minutes or less and is less likely to be difficult or complicated. Inclusion of only providers who inserted IUDs or implants would suggest that these providers have the necessary equipment for IUD or implant removal in their clinical space. A significant number of individuals did not report their specialty making this data less reliable, so we were unable to determine if non-obstetrician gynecologists were more or less likely to have patients return on a different day for removal.

Subjective criteria may play a role. Providers may have found it difficult to reconcile the hypothetical patient's stated desire to not become pregnant with their request to remove a highly effective contraceptive method and may have sought to delay removal as a means to deter removal. Other studies have described how provider enthusiasm for the IUD could result in impaired reproductive autonomy for patients.[7,8] A qualitative study of patients requesting IUD removal noted that providers communicated a preference, either explicitly or implicitly, for

IUD continuation.[8] In a mixed-methods study where family planning visits at different clinical sites were audio-recorded, a small number of counseling visits were viewed as "inappropriate" where women appeared to be pressured to choose an IUD, and their concerns about the method were dismissed, or their preferences were challenged.[14]

LARC methods were described as "first-line" contraceptives because they were framed as "forgettable," meaning little effort beyond insertion was required on the part of the user to maintain high efficacy for many years. These qualities made IUDs and implants particularly useful for "high-risk" populations who are disproportionately affected by unintended pregnancy and could have difficulty ensuring access to and compliance with methods that require more frequent refills or visits to a health care provider. However, patient reproductive autonomy can be impaired when provider efforts shift away from ensuring access for all individuals and shift toward insistence of LARC for high-risk populations.[12]

The interaction of race, ethnicity, and socioeconomic status can impact contraceptive recommendations.[14,17-19] Though these factors were not explored in the current study, future studies should probe how these factors affect provider recommendations and what can be done to improve health care provider's ability to meet patients' requests for contraceptive discontinuation at the time of their request. In other studies, IUDs were differentially recommended to racial minority women compared to white women.[17] If race can affect contraceptive recommendations, it is not unreasonable to hypothesize that it could also affect provider willingness to accommodate requests for discontinuation, and this should be more thoroughly explored.

Regardless of the motivations of each respondent, findings from this study have implications for reproductive autonomy. A patient's request for LARC removal may be delayed by the clinician for simple logistic reasons such as a provider not being able to accommodate an extra 5 to 10 minutes with the patient at that particular visit or having to attend to another patient with an urgent concern. However, regardless of the rationale, when this occurs, the patient experiences a delay in discontinuing a method of contraception they no longer want, resulting in the patient leaving the office with a contraceptive device implanted in their body that they no longer wish to be there. Patients routinely change insurance types or lose their insurance altogether, which can be a barrier to returning to care. Patients may have to arrange for time off from work or find childcare to attend a visit with a health care provider. Some offices do not allow parents to bring young children into an examination room when they have a pelvic examination or a procedure performed. Returning for another visit may be particularly difficult for the medically underserved who may not feel empowered to negotiate with a provider and request removal at the same visit, even though they realize they face challenges in returning for an additional visit. ACOG has stated that 2-visit IUD insertion protocols are a barrier to contraceptive access. Advocating instead for insertion of an IUD or contraceptive implant at the time of the request as long one is reasonably certain a patient is not pregnant.[8,15,20] If health care providers advocate for contraceptive counseling and insertion of an IUD or implant during a single visit, they should also be willing to remove a device on the same day that it is requested.[10]

The proportion of providers who reported they would not remove the device at all is very small but indicates some patients may experience significant barriers in discontinuing a LARC method. Providers who would only remove the device if the individual agreed to use another method also represent a problematic group as they were willing and able to remove a device on the day the patient requested, but only when the hypothetical patient limited their reproductive decisions.

This study's findings are exploratory given the small number of clinicians surveyed, and larger studies are necessary to infer associations. Only a small sample of clinicians in Hawai'i was surveyed; therefore, results may not be generalizable to a national sample. However, these descriptive analyses provide insight into some of the barriers individuals face when requesting the removal of contraceptive devices, and this could be the springboard for further studies in this area.

When a person chooses an IUD or implant, they relinquish the ability to self-discontinue the contraceptive method and must rely on healthcare providers to respect their reproductive decisions. If they encounter a particular health care provider who delays or refuses contraceptive device removal, a patient must explore other options for removal. Patients can find another provider or health care center, but this can be more or less difficult for any particular patient based on some of the potential structural barriers previously identified. Patients describe a hesitancy to use IUDs and implants because of the inability to self-discontinue and frustration when providers are reluctant to remove the device.[4,8] The findings of this study draw attention to the possibility of compromised autonomy in discontinuing IUDs and implants and the need for awareness of a reproductive justice framework when a patient requests discontinuation of contraception.

Conflict of Interest

None of the authors identify a conflict of interest.

Disclosure Statement

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