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"I wish they could hold on a little longer": physicians' experiences with requests for early IUD removal☆,☆☆

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Abstract

Objective: This study describes the perceptions and experiences of family physicians when women request early intrauterine device (IUD) removal.
Study design: This qualitative study included semistructured individual interviews with 12 physicians who encountered patients seeking early IUD removal. We identified eligible participants via chart review. We analyzed interviews using deductive and inductive techniques to identify content and themes.
Results: Physicians consistently referred to IUDs as the "best" or their "favorite" method, and several joked that they tried to "sell" the IUD during contraceptive counseling. Most reported having mixed or negative feelings when patients opted to remove the IUD. Most encouraged their patients to continue the IUD, hoping to delay removal until symptoms resolved so that removal was not needed. Some physicians reported feeling guilty or as if they had "failed" when a patient wanted the IUD removed. Many providers reported a conflict between valuing patient autonomy and feeling that early removal was not in the patient's best interest.
Conclusions: Physicians have complex and contradictory feelings about early IUD removal. While most providers acknowledged the need for patient autonomy, they still reported encouraging IUD continuation based on their own opinion about the IUD.
Implications: While IUDs are highly effective and well-liked contraceptives, providers' responses to IUD removal requests have implications for both reproductive autonomy as well as the doctor–patient relationship. More work is needed to ensure that providers remove a patient's IUD when requested.

Keywords: Qualitative; Family medicine center; Intrauterine device; Discontinuation

1. Introduction

Long-acting reversible contraception (LARC) includes the intrauterine device (IUD) and the contraceptive implant, the most effective reversible contraceptives [1]. Changes in eligibility criteria [2] have increased the number of patients who can use LARC, and LARC has received attention from public health organizations for its potential to decrease undesired pregnancy, abortion, health care costs and teen birth [3–6]. National and local policy changes have increased accessibility and affordability of LARC as well as increased provision within primary care settings [7–13].

While provider enthusiasm for the IUD may lead to greater access to this method, it may also present a barrier to IUD removal. A small proportion of LARC users (10%–20%) discontinue use in the first year [14,15], and unlike with other contraceptives, these patients usually need a visit with their provider to discontinue the method. In a previous study, we interviewed patients about their experiences discussing early[1] IUD removal with their physicians. Patients reported that their physicians often preferred them to continue the IUD even when the patients preferred

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[1] For the purposes of the patient study, we defined "early" IUD removal as removal within 9 months of insertion. That said, the use of the word "early" can be problematic when used to describe discontinuation of a contraceptive method, as it can imply that there is a correct amount of time to use a certain method, which is not true. However, we use this term as a shorthand in order to identify women who were likely to be considered by their providers to be requesting removal sooner than expected.

removing the device [16]. Since most patients cannot, or prefer not to, remove an IUD themselves [17], physician attitudes and reluctance to remove the device have potential implications for reproductive autonomy. Several authors and researchers have raised concerns about the relationship between LARC and reproductive autonomy [18–21], and difficulty accessing removal is another way in which LARC users could face unintentional reproductive coercion. Other previous studies have also documented patients' experiences with provider reluctance to provide LARC removal [22,23], but no previous study has investigated providers' perspectives about LARC removal. This study examines family physicians' perspectives on early IUD removal.

2. Materials and methods

2.1. Sample and recruitment

We recruited Family Medicine attending and resident physicians from two primary care clinics in the Bronx, NY. We excluded the nurse practitioners and obstetrician-gynecologists who also provide IUD care in these health centers in order to recruit a more homogenous sample. We identified providers by chart review, and providers were eligible if they had a patient aged 15–44 years who had a visit to discuss IUD removal within 9 months of insertion during the period of chart review. We excluded providers who were research collaborators for this study or the previous patient study. We also excluded contraceptive implant removal discussions because, while the IUD removal procedure is easily performed by most providers during a routine visit, an implant removal procedure at our centers generally requires a referral to a smaller group of specially trained providers.

Because "early" IUD discontinuation has been defined as anywhere between 6 months and just short of the Food and Drug Administration-approved duration of the device [3,15,24], we chose the time frame of 9 months to target interactions that were more likely to be considered "early" by providers, while also allowing us to recruit adequate numbers of participants within the duration of the study. Only removal requests considered "elective," or not medically indicated, were eligible for inclusion.

2.2. Data collection

We developed the semistructured interview guide based in part on results from the previous patient study [16], and pilot tested the guide with one physician for clarity and duration. Along with demographics, it included questions about attitudes and counseling about IUDs, patients' reasons for IUD removal, and experiences with and feelings about early removal visits. One member of the research team (AB), with a background in public health and prior training and experience in qualitative interviewing, recruited all participants by e-mail and conducted all interviews in person. Interviews lasted between 45 and 75 min and were recorded and then transcribed. Although no participants had worked directly with the interviewer, all participants knew her to be a member of the reproductive health research team, which is invested in providing patient-centered family planning and contraceptive care. Participants received a $25 gift card for their time. The Albert Einstein College of Medicine Institutional Review Board approved this study.

2.3. Analysis

We first developed the coding scheme collaboratively by reviewing the initial transcripts, then modified the coding scheme through an iterative process until we judged it to be comprehensive [25,26]. We initially identified 21 codes organized into four domains of inquiry: providers' attitudes toward the IUD, patients' reasons for removal, providers' response to removal requests and providers' feelings about IUD removal. At this point, two members of the research team (JA, AB) coded each transcript with the assistance of NVivo10 analytic software [27]. We conducted a rolling analysis of the data as they were collected, and memoing served to reflect on the data and identify thematic saturation. We resolved discrepancies through discussion until consensus was reached. The study team met frequently to review interviews, discuss emerging themes and modify the codebook as needed. We organized the data around five domains — the four domains mentioned above, within which themes arose, as well as an additional domain (weighing autonomy and reproductive goals) which arose inductively from the data. When no new data were found to support disconfirming or alternative conclusions related to the 5 thematic domains, we felt that we had reached data saturation in the analytic process, and conducted two confirmatory interviews. We present quotes illustrative of these themes with identifying information masked and shortened for clarity, but otherwise verbatim.

3. Results

Of 807 charts that we reviewed, we identified 61 eligible visits with 35 providers. Of these providers, we excluded 5 who were not family physicians and 7 who were either part of the research team or had been involved with the prior patient study. We informed all 23 remaining providers about the study; one provider declined, and we contacted the rest individually to schedule interviews, which we conducted until thematic saturation, which occurred after 12 interviews. Demographic characteristics of participants are included in Table 1.

3.1. Attitudes toward the IUD

Physicians in this study were overwhelmingly positive about the IUD.

> Isn't it something like 99% effective … it's like huge, so I use that in my advertising to women. And it's not something that they have to think about taking every day. So probably those are the top two reasons why I tell people it's awesome. (Provider 1).

Table 1
Participant characteristics (n=12)

Demographics	n (%)
Stage of career	
Current resident	4 (33)
Early career (1–5 years)	3 (25)
Mid-career (6–20 years)	3 (25)
Later career (21–35 years)	2 (17)
Gender	
Female	9 (75)
Male	3 (25)
IUD experience last 12 months	
Insertions, mean (range)	20.25 (0–70)
Removals, mean (range)	3.8 (0–12)
Proportion of clinical care that is women's reproductive health[a]	
<20%	1 (9)
20%–40%	8 (66)
>40%	2 (17)

[a] Percentages do not sum to 100% due to missing data for one participant.

Providers frequently reported trying to "sell" the IUD during contraceptive counseling, often in a half-joking context, and at times reported struggling not to pressure their patients to use it.

> I usually say, "Have you heard of the IUD?" And I will usually — I′m smiling right now because I don't try to influence women's decisions, but I do try. Like I don't want me to be the person making the decision, but I do want to guide them to make a good decision for them. But I usually say it's my favorite method… And I usually say that it's our most effective method and it's very easy to put in. (Provider 3).

3.2. Patients' reasons for removal

Providers reported that the most frequent reasons patients requested IUD removal were pain, bleeding, or discharge, and focused mostly on the inconvenience of these symptoms in their descriptions.

> I think that of the women who have had [persistent bleeding or spotting], I think it's more annoying than anything else. I don't think it's because they're worried they're bleeding out or they're worried that something's not working. (Provider 3).

> And I mean in terms of the spotting, women just say, "I feel gross. I can't have sex with my husband. I'm always bleeding, I always have to have a pad on, it gets annoying and uncomfortable." (Provider 10).

Sometimes, patients requested IUD removal for symptoms that providers did not think were related to the IUD.

> So I've had some folks who will come back, complaining that they need to take the [copper] IUD out because it's affecting their hormones… Something I'm like, "That's impossible because there's no hormone in the one that I gave you." (Provider 6).

3.3. Providers' response to removal requests

When patients requested IUD removal, most providers reported that their main goal was to help patients figure out how to continue the IUD. Often, providers hoped to delay removal for at least 3–6 months after insertion, with the hope that symptoms would improve.

> I think if it's really early on my general response is to say, you know… "Let's give it a couple more months and see how you do." I think that tends to be my typical response to any concerns. (Provider 7).

Often, providers centered the IUD removal discussion around why the IUD was a good method of contraception for the patient, particularly in comparison to other methods.

> I've definitely had some folks who come in saying, "I want this thing out."…Then I can ask, "Is [removal] worth it to you given all the things that we felt really made the IUD a really great choice? Is this something that you can tolerate for another couple of months to give it a chance for your body to adjust or not?" And that's usually the turning point…So, it's a negotiation. (Provider 6).

Providers often offered patients reassurance and suggestions for symptom management in order to help the patient continue the IUD. Providers indicated that their patients were often "okay with" or "open to" the provider's continuation plan even if continuing the IUD was not the patient's first choice.

> I think I probably do try to encourage women to bear with it for a little bit, if they're otherwise satisfied with the method…it's annoying but it's not like something that's hurting them. I think the reassurance matters a lot to them, and…all of them have been willing to wait some more time. (Provider 3).

When in a few instances the providers agreed with the decision to remove the IUD, it was because patients had severe symptoms that were clearly secondary to the IUD and had already attempted to treat those symptoms or waited for symptoms to resolve.

> The heavy spotting patient I was totally on board [with IUD removal]. We'd given it a shot. It seemed clearly…related to the IUD.…And we had done everything we could to try to stop it. And she was invested in keeping it in, it just didn't work. (Provider 4).

Most providers reported removing an IUD even when they did not feel it was best for the patient.

> But I guess in the instance where the patient really wants it removed, and I don't think that the reason is—I don't want to say the right reason, she's allowed to have whatever reason she wants—but if it seems to me that the symptoms that she's attributing to the IUD are not actually being caused by the IUD, and she's really adamant that we take it out, I guess it's probably clear to her that I don't really agree with her. But it's my job to do what she wants me to do in that case. (Provider 10).

3.4. Providers' feelings about IUD removal

Providers reported overall negative feelings about early IUD removal.

> So to me [early IUD removal is] a tragedy 'cause it's a really good thing to put in, and if you can get through those first few months, you're golden. (Provider 5).

> I never want to have anyone remove their IUD unless they want to have a planned pregnancy and they're ready for it. Every other case, I feel like they should keep it in if they can, obviously. (Provider 9).

For some, device cost affected how they felt about early IUD removal, though these providers reported that it was not a factor in how they counseled patients.

> There's one person who had [the IUD] in for three months or so, took it out…and then went back and said, "I want the IUD back." I think that's when I was just [thinking] like, "Oh my God, that's nearly $2,000 just like that." It was just sort of like, "Okay, I have to really just stick to the script"…but here in my head I'm just like, "Dear God, do you have any idea what you just did?" (Provider 6).

Providers often blamed insufficient pre-insertion counseling by other staff when patients decided to have the IUD removed for typical side effects such as cramping and bleeding.

> It's like [patients say], "Oh my God, I've got this thing and like now I'm just spotting all the time." Like, "Yeah, your provider should have told you that you were going to be spotting for a really long time." (Provider 1).

For some providers, negative feelings about IUD removal were associated with guilt and a sense of failure if the IUD did not work for the patient.

> It [feels personal] because I feel like I have not sold—and certainly not convinced—but I have talked to them about this method and I have talked up how great it is, so that if they come back really unhappy I do feel like a little bit like it's my fault. (Provider 3).

3.5. Weighing autonomy and reproductive goals

Most providers remarked about wanting to respect patients' decisions and autonomy with regard to IUD removal.

> In terms of just like everyone's right to control their body…I feel like that's implicit in the agreement when you put it in, that it'll come out whenever the person wants it to. (Provider 11).

> You know, I could see that she was really emotional about [wanting the IUD removed] and to a certain extent, whether I agree with it or not, this is her body and she has every right to get rid of it. So I didn't push that hard. It was just sort of trying to figure out where was she, and where could I meet her psychologically, emotionally, intellectually on this. Because I think pushing where you're not wanted is not okay with reproductive health. (Provider 6).

However, despite discussing the importance of patient autonomy, providers often reported encouraging IUD continuation if they thought it was in the best interest of the patient, particularly when they felt IUD removal conflicted with the patient's reproductive goals.

> Like if I feel that they have expressed to me that they don't want to get pregnant, that coming into clinic for multiple visits is not feasible for them, that there are good reasons why they don't want other medications, and that other methods have failed them in the past, then I probably will be a little bit more pushy about trying to have them bear with the IUD and see whether or not some of the side effects improve. (Provider 3).

Some providers reported feeling conflicted when trying to respect patient autonomy if they felt that IUD continuation was in the best interest of their patients.

> I need to be really sensitive to the fact that if they're telling me to take it out, and there is a power [im]balance there…. And so I definitely like wanted to try to meet her needs, but I do remember being frustrated, because I felt like her symptoms were most likely not because of the IUD and she wasn't really interested in hearing that. (Provider 3).

> I think [early IUD removal is] disappointing to me, and I wish they could hold on a little bit longer. But that's my wish and I don't put my wishes on people. (Provider 5).

4. Discussion

This study follows a previous study that investigated patients' experiences discussing IUD removal with their providers, including times when providers resisted IUD removal [16]. The results from this provider study confirm much of what was found in the patient study: that providers preferred IUD continuation and often encouraged patients to continue with the IUD if they thought it was in the patient's best interest. This study also demonstrated that physicians bring some biases to the IUD removal discussion. In particular, providers reported being more likely to agree with IUD removal when they felt it was a "good" reason, or when they felt that the patient had already tried hard enough to continue the IUD.

Comparison to the previous study suggests possible areas of miscommunication between providers and patients. First, while the patient study found that fear regarding symptoms was a common reason to seek early removal, providers in the present study seemed unaware of patient fears, and were more likely to focus on inconvenience or discomfort associated with symptoms. Second, while providers often counseled patients to wait longer for symptoms to resolve, our previous study found that most patients had already waited for symptoms to improve before making the appointment to discuss IUD removal. Third, providers seemed comfortable clearly indicating their own preference for IUD continuation, putting the onus on patients to indicate if they wanted to remove the device against their provider's recommendation. This does not take into account that many patients are not comfortable disagreeing with their doctors, and may keep the IUD for longer than they want if their provider resists removal.

As this study was conducted in New York City, IUD removal may have fewer consequences than in other settings, due to easier access to all contraception, including LARC, as well as to abortion services. The participants in this study were familiar with the interviewer and research team, which may have affected their responses; if so, it is likely that this would have biased their responses toward being more patient-centered. As participation was voluntary, the providers

who agreed to participate may be different in some way from those who did not.

While we use the term "early" throughout this paper to identify patients considering IUD removal sooner than their providers expected, there is no "correct" duration of use for any contraceptive. However, there seems to be an expectation among providers of a long duration of use of LARC that is not expected with other reversible contraceptives; this may be due to the high up-front cost, the focus on continuation rates in some studies, the typically temporary nature of the most common side effects, or perhaps the name "long-acting" reversible contraception itself. However, none of these things necessitate a particular duration of use, and provider bias about duration of use can hinder access to IUD removal, and as a result, impact reproductive autonomy.

The physicians in this study felt conflicted about early IUD removal, and their competing priorities can be described in terms of medical ethics: what they personally feel is best for the patient (beneficence) versus their desire to support patients' choice in their reproductive health care (autonomy) [28]. This struggle is a common dynamic in many areas of medicine and is therefore understandable. However, reproductive health care decisions are generally decisions of clinical equipoise, and not situations of health risk. Reframing the concept of "early" removal, such that a certain duration of use of LARC is not expected, may help address providers' concerns about IUD removal that occurs sooner than they anticipated. While the majority of IUD users are satisfied and keep the IUD, decreasing barriers to IUD insertions also requires that patients maintain access to IUD removal when desired.

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