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Adolescents demanding a good contraceptive: a study with standardized patients in general practices

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Abstract

To assess how Flemish general practitioners (GPs) are handling the first contraception consultation, we used standardized patients (SPs) as the best method to assess the performance of GPs in daily practice.

Thirty GPs got a visit from one of the three SPs. Based on a validated checklist, the SPs scored the performance of GPs and they registered the circumstances and the duration of the consultation. Twenty-eight consultations were analyzed.

General practitioners scored moderately on the content level of the consultation. Rarely, GPs asked about attitude regarding safe sex, took gynecological history or discussed contraindications. None of the GPs took a personal history to exclude pregnancy. The SPs received enough information about correct pill use, but there was minimal discussion on factors associated with pill intake and interactions with other medications. Few GPs (6/28) gave a prescription corresponding to the Flemish guidelines. The others were influenced by the pharmaceutical representatives. The girls felt, however, very satisfied with the consultation with the GPs.
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1. Introduction

Oral contraceptives are the second most prescribed medicines by general practitioners (GPs) in Belgium [1,2]. Gynecologists and GPs are responsible for 33.8% and 59.2%, respectively, of the total budget spent on prescriptions for combined oral contraceptives. Therefore, the role of the GP as a health care provider for adolescents seeking contraceptives is crucial.

In the UK 74% of the contraceptive consultations take place in general practice; the others in community Family Planning Clinics [3]. Nevertheless, Donovan et al. [2] found that the barrier to consult a GP in the UK was too high for adolescents [3]. The adolescents had anxieties that the consultations were not completely confidential. However, other studies found that adolescents are not so reluctant to consult their GP [4–7] and may even be highly satisfied with their GP [8]. In Flanders (Dutch-speaking Belgium), adolescents preferred the GP (77%) over the school doctor (5%) or gynecologist (18%) for a consultation about contraception [6].

During the consultation, the GP has and should use the opportunity to counsel and to give correct information about the different possibilities for contraception [9].

A good dialogue with parents of adolescents, especially the mother, increases the likelihood of correct use of contraceptives and safe sex. The doctor should also give information on emergency contraception and discuss side effects and misconceptions about the pill, being the most frequent reasons to stop the pill [10–13].

A high-quality contraception consultation with an adolescent is a challenge for every GP and requires adequate knowledge and communication skills for adolescents. Therefore, in 2002, we developed a validated evidence-based guidelines for correct use of oral contraceptives [14].

Many studies deal with the attitude of patients and health care providers on consultations, but there is little information on what GPs actually tell their patients. There is evidence that with regard to assessment of what occurs

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during a consultation, direct methods are to be preferred above indirect methods, as they are more valid [15].

Rethans et al. [16–18] found that the use of clinical notes to audit doctor's performance in Dutch general practice is invalid. Only 32% of all actions undertaken had been recorded. Also, Norman et al. [19] concluded that only 9% to 42% of the basic acts performed in a consultation were written in the file [17–19].

The purpose of this study was to assess the GPs' performance with a first-time request for oral contraception by adolescents and to evaluate the experience of the adolescents with the consultation.

2. Methods

For assessing actual practice performance, the method of unannounced standardized or simulated patients (SPs) was chosen [20]. The term "simulated patients" is more appropriate for medical education, because the authenticity of role play is important. For research, the emphasis is on standardized and consistent role play. There is fair evidence that this method is valid, reliable, feasible and acceptable [21].

The study was carried out 9 months after the publication of the guideline [14] and was approved by the Ethical Committee of the Flemish College of General Practitioners.

2.1. Selection of the GPs

One hundred GPs were stratified by gender and by location of practice in the five provinces and were randomly selected from a list of all registered GPs in Flanders ($n=6$, 244). All GPs received a letter informing them about the study and offering them the opportunity to refuse participation in the study. Fourteen GPs refused to participate. Of the remaining 86, for budgetary reasons, we selected 30 GPs, all located in places within reach of public transportation.

2.2. The case

A clinical scenario was agreed upon by a panel of authors and researchers. This is the 'case' which is currently presented in Box 1. Three students were recruited and trained to perform as SPs presenting to the GP with the scenario.

Box 1
Case description. An 18-year-old teenager requests oral contraception for the first time. The girl moved into the neighborhood and she is looking for a new GP. Her parents may not know she uses a contraceptive. She wants to have the pill, because she has a new boy friend. She already uses a condom. Family history is positive for breast cancer. Personal and gynecological history are negative.

Table 1
Profile of the doctors ($n=28$)

Age (years)	<30	6
	30–39	7
	40–49	11
	50–59	4
Gender	Male	14
	Female	14
Practice	Solo	16
	Partner	1
	Group	11

2.3. Checklist development

A checklist of 48 items, all related to the key messages of the guideline, was developed to assess the GP's consultation [14]. The checklist was drawn up by the panel of researchers and enhanced during the training with the SPs. All items contained a short explanatory note on how to score in order to make scoring more precise. The scoring system was based on "one point per item performed". This resulted in a frequency of items for the total group of GPs and individual scores per GP per consultation. We did not assign different weights to different aspects.

2.4. Training of SPs

Training of the three students focused on how to use the scenario, to present as SPs and to fill in the checklist afterwards. The SPs' checklist scores during training were compared with the score of a panel of three observers, who scored the same consultation. They achieved an accuracy of 90% of the trainer score during the session. In a rehearsal session, a few weeks later, organized at the university, their visits were registered on a minidisc, and their checklist scores were compared with those of two trainers (gold standard). The kappa values were respectively 0.83 (95% CI 0.67–0.99) (JM, JV) and 0.86 (95% CI 0.72–1.0) (KM).

2.5. Preparation for the practice visits

To reduce the likelihood of detection of SPs, we developed for the SPs a profile of each of the practices. We provided addresses, phone numbers and information on practice organizations. The SPs were provided with real local addresses in the vicinity of the visited practices. Before the actual visits, the SPs sometimes checked the location. The SPs used their own names and mobile phone numbers.

2.6. Practice visits

Before the first visit, all SPs conducted a pilot visit as a training exercise in real practice to check all preparations made beforehand.

Three months after having received the invitational letter, the 30 selected GPs were visited by the SPs. During the project period, the SPs contacted the practice organizations themselves, made appointments or went to "open consultations" depending on the practice organization. The

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