

ORIGINAL ARTICLES

Coil or intrauterine device? Patient preferences for contraceptive terminology

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Abstract

Objective. To discover what terminology women prefer to use when referring to contraceptive methods and to investigate the understanding of and ideas associated with contraceptive names.

Design. A self-administered questionnaire was answered by 191 new patients at family planning clinics (FPCs). Women were asked if they understood the terms used by the fpa (Family Planning Association), if they knew of any alternatives and, if so, which they preferred.

Setting. Selected FPCs across the city of Manchester.

Results. Patients preferred to use familiar terms, e.g. pill, mini-pill, coil and morning-after pill. There was no difference in preference when the results were compared by age or educational level. A greater proportion of non-Caucasians than Caucasians preferred the precise (fpa) terms. Although precise terms were not widely known or understood, when used they were associated with more information than were the familiar terms.

Conclusion. All FPC staff should evaluate the language used by individual patients and, where appropriate, introduce precise terminology to help patients to make informed, appropriate choices.

Key message points

- Colloquial names for contraceptive methods were associated with more misunderstanding and negative images than were the terms used in the family planning leaflets.
- This difference was independent of the patients' level of education.
- Many respondents did not know the meaning of the 'correct terminology'.
- We recommend that precise terms should be introduced during a consultation for contraception, with clarification of their meaning.

Introduction

The ideal clinical consultation has been widely written about, particularly the style, structure and content.^{1–5} In contraception and sexual health consultations, vocabulary and embarrassment may inhibit patient understanding.⁶ The need to choose words appropriate for the user is highlighted by the Plain English Campaign.⁷ There is an emphasis on avoiding jargon, which they define as language only understood by a particular group of people. Specialist language has developed to facilitate interaction between members of subgroups in society and serves an important purpose. However, medical jargon is often meaningless to patients and may result in confusion.

We noticed that patients were using different terminology for contraceptive methods than were clinic staff and were not always familiar with the correct terms as stated in fpa (Family Planning Association) leaflets.

Patients appeared to have strong negative and positive perceptions of individual methods. When a word is used, both parties may presume that they understand the term and are talking about the same thing, when in fact they are not and have interpreted the term differently, e.g. missed abortion, incompetent cervix and inadequate cervical smear test result. It is therefore important to clarify that terms are being used correctly.

It has been suggested that jargon may be used subconsciously as a control mechanism.^{2,8–10} When doctors focus on their own agenda (fact finding) they are in direct control. As the style of consultation becomes increasingly patient-centred, the doctor loses power and authority. Different groups in society have their own needs and preferences in medical consultations. One study¹¹ highlighted the difficulties that non-professional Asian women have in accessing and using contraception including communication problems but also lack of pre-existing knowledge and low levels of personal autonomy. It found that these women related to family planning terminology differently to clinic staff and did not understand some common words such as coil or cap. In a study from Leicester in Gujarati speakers¹² when ad hoc interpreters are used, between 25% and 52% of words were translated incorrectly. Technical words were translated incorrectly more often than were simple words.

Method

During the period May–June 2002, a questionnaire was given to all new female patients attending five family planning clinics (FPCs) to find out their preferences for contraceptive terminology. FPCs with relatively high attendance figures were selected from across the city, from each of the three primary care trusts, to provide a good cross-section of population for age, educational level and ethnic groups. Only new patients to the FPC were included, to try to eliminate any influence from previous contact with family planning-trained staff. The questionnaire was self-administered, with help from a companion if necessary, while patients waited to see the nurse or doctor, and placed anonymously in a box in the reception area.

A pilot study of 50 patients was carried out initially to identify any ambiguities with the questionnaire. Questions about eight of the most common contraceptive methods were included, namely the condom, combined oral contraceptive pill, progestogen-only pill, intrauterine device, diaphragm, contraceptive injection, implant and emergency contraception. Women were asked if they knew any alternative names for these methods and, if so, which name they preferred and why. A further question asked them to identify sources of information they used to find out about contraception.

In the pilot there were a variety of answers given for

four terms in particular (i.e. combined oral contraceptive pill, progestogen-only pill, intrauterine device and emergency contraception) so we decided to concentrate on these methods. To determine whether blank answers were because the patients did not understand the question, or due to true indifference, an option to tick a box if not sure of the method was included in the final version. In order to discover if alternative names for the same contraception have different associations (either positive or negative), respondents were asked what two different terms for the same method made them think of. For this exercise we used coil compared to intrauterine device, and mini-pill compared to progestogen-only pill. Ethics approval for the study was received from the North Manchester Local Research Ethics Committee.

Statistical analysis

The results were collated in Excel and analysed using SPSS Version 9. Analysis was subdivided according to age, educational level and ethnic group. Categorical data were compared using a two-sided Fisher's exact test because of the small sample size. The standard significance level of 0.05 was used for all statistical comparisons.

Results

During the main study, 222 copies of the questionnaire were given out and 191 were completed giving a response rate of 86%. The ages of the patients ranged from 15 to 51 years with 62% in the 20–29 years age range. Ten (5%) people did not reply to this question. One-third (33%) of the respondents indicated that they had received higher education, 11% had studied to A-level standard and 23% had received a basic level of education. The remaining 33% respondents did not answer or misunderstood this question. Those respondents that answered White British, White Other and Irish were classified as Caucasian. All other answers were counted as non-Caucasian. The ethnic mix of the sample was 75% Caucasian and 25% non-Caucasian. Nine (4.7%) people did not answer this question.

Understanding

This question asked for alternative names for combined oral contraceptive pill, progestogen-only pill, emergency contraception and intrauterine device and which name, if any, was preferred (Figure 1). We found that 45% of respondents for progestogen-only pill and 45% for intrauterine device ticked the box indicating they were not sure what the method was. However, only 17% of respondents for combined contraceptive pill and 11% for emergency contraception were not sure of the method.

In addition, the answers were categorised as misunderstood if the patients had not ticked that they did not understand, but clearly gave an incorrect term such as 'cap'. It should be noted that for the progestogen-only pill this was difficult to determine as a large proportion gave the name 'pill' and are shown as 'Ambiguous' in Figure 1.

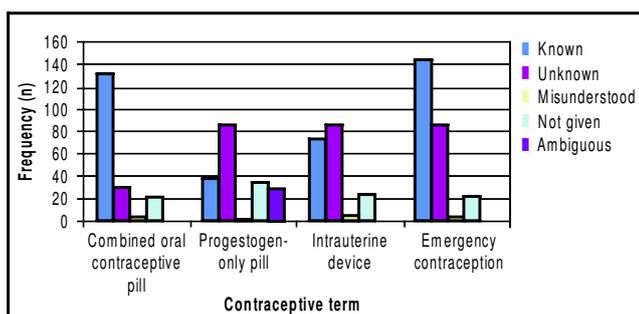


Figure 1 Summary of the understanding of the contraceptive terms given on the questionnaire

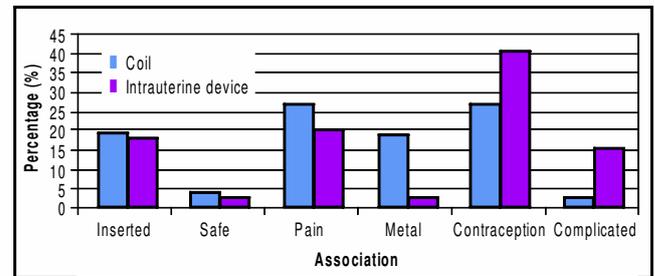


Figure 2 Comparison of the associations linked to the names coil and intrauterine device

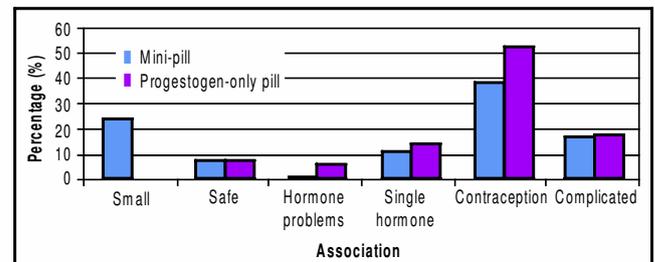


Figure 3 Comparison of the associations linked to the names mini-pill and progestogen-only pill

Associations

The four terms investigated for their associations were coil, intrauterine device, mini-pill and progestogen-only pill. In answer to the question 'What do the following words make you think of?' we found that the most common response was 'contraception' or words explaining how the method was used and who it was suitable for: coil 38/139 (27%), intrauterine device 29/74 (39%), mini-pill 38/99 (38%) and progestogen-only pill 41/77 (53%). The number of respondents for each question varied.

Of the responses about the terms coil and intrauterine device, 38/139 (27%) and 14/74 (19%), respectively, associated them with pain and bleeding. For the coil 26/139 (19%) of the comments were to do with its physical shape and composition, including 'metal', 'spring' and 'snake'. Only 2/74 (3%) of the responses for the intrauterine device linked it to metal or wires. Equal proportions for the terms coil and IUD, 27/139 (19%) and 13/74 (18%), respectively, thought about it being inserted into the body (Figures 2 and 3).

Many people did not reply to these questions. The colloquial terms, coil 52/191 (27%) and mini-pill 92/191 (48%), were left blank by fewer people than the precise terms, intrauterine device 117/191 (61%) and progestogen-only pill 114/191 (60%).

Terminology

In response to the question 'Which name do you prefer?' the majority of respondents preferred to use the colloquial term for all four of the contraceptive methods on the questionnaire and several alternative names were given. These were grouped together into those recommended by

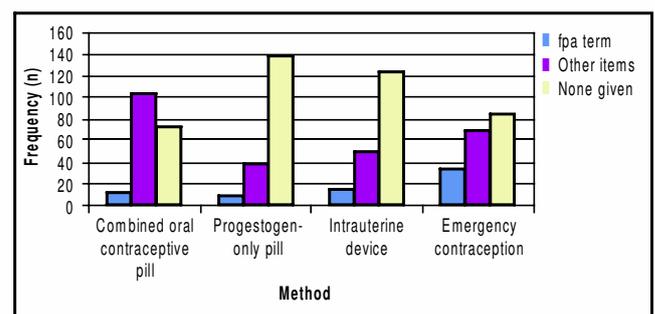


Figure 4 Summary of preferred terms for the various contraceptive methods

Table 1 Information sources that patients preferred to use to find out about contraception

Information source	Responses (n)
Chatting with friends or relatives	123
Leaflet	105
Explanation/demonstration by nurse	101
Magazine	84
Explanation/demonstration by doctor	61
TV	38
Internet	18
Telephone helplines	11
Other (job, school sex education)	4

the fpa, others (colloquial names) and no preference (Figure 4).

The frequencies of preferred terms for the combined oral contraceptive pill were: pill 90/191 (47%), no preference 74/191 (39%), contraceptive pill 11/191 (6%), combined oral contraceptive pill 8/191 (4%), combined pill 4/191 (2%), brand names and mini-pill both 2/191 (1%).

The frequencies of preferred terms for the progestogen-only pill were: no preference 140/191 (73%), pill 26/191 (14%), mini-pill 15/191 (8%) and progestogen-only pill 10/191 (5%).

The frequencies of the preferred terms for the intrauterine device were: no preference 125/191 (65%), coil 48/191 (25%), intrauterine device 15/191 (8%) and loop, condom and 'sterilet' each 1/191 (0.52%).

The preferred terms for emergency contraception were: no preference 85/191 (45%), morning-after pill 69/191 (36%), emergency contraception 35/191 (18%), loop, condom and 'sterilet' each 1/191 (0.52%).

There was no statistically significant difference in the preference when the results were compared for age or level of education received. However, there was a significant difference according to ethnic group for the terms used to describe the combined oral contraceptive pill ($p = 0.0052$) and the progestogen-only pill ($p = 0.035$). A far greater proportion (93%) of the Caucasian group compared to the non-Caucasian group (38%) preferred the 'other name' (colloquial names) rather than the term 'combined oral contraceptive pill'.

Information sources

We asked the question 'What helps you to understand contraception better?'. The sources of information that the patients preferred to use to find out about contraception are shown in Table 1. Respondents were allowed to give as many sources as they wished. The most popular choice was to chat with their friends or family (123 responses), followed by information in the form of a leaflet (105). A visit to the nurse was the third most frequent response.

Discussion

This study demonstrated quite clearly that the patients in the sample preferred to use the terms they were familiar with when referring to contraception, the most popular terms being the pill, the mini-pill, the coil and the morning-after pill. A large number of women also indicated that they had no preferred term.

However, it was further demonstrated that the commonly used terms had associations that were incorrect and may be misleading. For example, almost 20% of the comments about the coil linked it to metal and springs; far fewer similar assumptions were made for the term intrauterine device. The mini-pill was often associated with something small, possibly a smaller version of the combined pill or lower dose of hormones. In comparison, the name progestogen-only pill was not associated with size. This implies that although the terms intrauterine device and progestogen-only pill were less widely recognised, when employed they conveyed accurate information to patients. It is therefore possible to suggest that contrary to what this sample of patients have indicated they prefer, a better service would be provided for them if clinic staff and other educators encouraged them to use more precise terminology.

There was a statistically significant difference in the proportions of preferred terms from the different ethnic groups. A far greater proportion of the Caucasian group preferred the common names for the combined oral contraceptive pill, e.g. the pill, when compared to the non-Caucasian group. This may be because people from ethnic groups who do not speak English as their first language may not use colloquial terms in their everyday life, and so find the precise terms easier to accept.

At present, the precise terms are perceived to some extent as medical jargon by the public, as demonstrated by the considerable number of respondents who said they did not know or understand them. Therefore to avoid alienating patients, the use of these terms must be accompanied by full explanations using simple language, perhaps using the common term at the same time to clarify that they are one and the same thing. All clinic staff should be aware of this, and both kinds of terms could be incorporated into written material.

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