

Contraceptive Care by Family Physicians and General Practitioners in Japan: Attitudes and Practices

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Background and Objectives: Japan has one of the highest rates of unintended pregnancies among developed countries. Family physicians and general practitioners (FPs/GPs) have unique opportunities to provide family planning. The purpose of this research was to elucidate the attitudes and practices about contraceptive care by FPs/GPs in Japan. **Methods:** In this cross-sectional study, we distributed to physician members of the Japanese Academy of Family Medicine a survey that addressed their educational experiences with contraceptive care, frequency of contraceptive care in their practices, attitudes toward providing it, and attitudes toward providing medical students and residents with contraception education. **Results:** A total of 265 physicians responded (response rate 77.2%). Many physicians reported receiving limited education about contraception, and 75% reported offering no contraceptive care in practice. While 60% of participants reported a desire to provide information about contraception, one of four physicians reported no interest. About 90% of the physicians indicated that medical students should have contraception education. Eighty percent reported that residents should receive such education. **Conclusions:** Most FPs/GPs in Japan have received limited education about contraception. Few provide it currently, but 60% are willing to do so. Further investigation is needed to fully understand barriers to Japanese FPs/GPs providing contraceptive care.

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Unintended pregnancy is one of the world's most important women's health issues. The World Health Organization reported that nearly 40% of all pregnancies are unintended, and around 6 out of 10 of such unwanted pregnancies resulted in an induced abortion.¹

Japan has one of the highest rates of unintended pregnancies among developed countries.² Goto et al³ investigated the current state of pregnancies among 421 married women in Japan and discovered that 46.2% of the participants reported experiences of unintended pregnancy, and 39.5% of such pregnancies resulted in abortions. Further, more than half the participants who experienced unintended pregnancies reported no contraception use. The Goto study illustrates the importance of contraceptive care as a women's health issue in Japan.

Japanese family medicine is still in an early stage of development despite its founding roots 20 years ago.⁴ The family medicine constituency in Japan includes first-generation, self-taught family medicine pioneers, second-generation family medicine residency-trained

family physicians, and general practitioners by function who were largely trained in general internal medicine or subspecialties. This would resemble the early 1970s situation in the United States, though without board certification. A debate continues about whether family physicians should provide obstetric and gynecological care, and there are few family physicians and general practitioners (FPs/GPs) providing delivery care in Japan. It is also unusual for FPs/GPs to address gynecological care. Nonetheless, Japanese women only seek care from OB-GYN physicians when they become pregnant or have overt gynecological problems. Japanese FPs/GPs, on the other hand, have many opportunities to discuss family planning with their patients during general medical visits.⁵

Surprisingly, there is no research investigating Japanese FPs/GPs' views and practices with regard to contraceptive care in Japan. The purpose of the research reported here was to elucidate the attitudes and practices about contraceptive care for reproductive-aged women by FPs/GPs in Japan. Such data could inform curriculum reform, both in undergraduate and graduate medical education, and help equip Japan's future family physicians with the clinical tools they need to provide family planning.

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Methods

In this survey research, we distributed a structured questionnaire to physicians who were registered members of the Japanese Academy of Family Medicine (JAFM). This academy was established in 1986 and has provided leadership in establishing family medicine in Japan.⁶ Since there is no official board certification in family medicine in Japan, membership in the JAFM is voluntary and based on self-interest in joining. The academy had membership of 460 during the time this research was conducted, and most members were practicing FPs/GPs, including Japanese teachers of family medicine. The membership also included medical students, residents, and paramedical staff who were interested in family medicine. We excluded nonphysician members, medical students, physicians not in active practice, and those who had resigned from the JAFM during the time of the research.

Participants were asked to complete a questionnaire with items addressing: (1) their experiences in contraception education during medical school or residency training, (2) the frequency of providing contraceptive care in their practice, (3) respondents' attitudes about providing contraceptive care, and (4) their perceptions of the need for contraception education for medical students and residents. The instrument was distributed with a cover letter requesting their participation. A reminder was sent to nonrespondents twice at 2-week intervals. A fourth mailing included a final request and a second copy of the instrument.

Data were analyzed using SPSS (Statistical Package for Social Sciences, SPSS Japan). Simple statistics were calculated for the demographics data. Statistical significance of continuous measures was tested by two-tailed Student *t* test, and categorical data were tested by the chi-square test where appropriate.

Results

Of 460 members in the JAFM during the study period, we excluded 74 nonphysician and medical student members. Completed surveys were returned by 291 of the 386 physicians to whom we distributed the instruments. Sixteen letters were returned because of unknown addresses. We dropped from the analysis as ineligible 23 physicians who reported that they were retired or resigned from the academy. Thus, 268 of 347 eligible physicians (response rate 77.2%) were included in the analysis. The demographics of the participants are shown in Table 1. Most were men (85.8%) with a mean age of nearly 40 years. Most had received specialty training as internists (45%) and more than 25% had studied abroad. Many reported seeing reproductive-aged women (the average number was 11 reproductive women/week) in their offices.

Respondents' experiences in contraception education during medical school or residency training are depicted

in Table 2. Many participants reported educational experiences about condoms (72.4%), intrauterine devices (66.8%), and the oral contraceptive pill (OCP) (63.8%). Few reported receiving education about spermicide (22.4%) or about and the inefficiency of douching (6.7%) and withdrawal (25.0%).

Regarding the frequency of providing contraceptive care in their practice (Table 3), most participants reported not providing contraception education to their patients. About three of four physicians reported that they provide no contraceptive care in their practice.

Their willingness to provide contraceptive care is shown in Table 4. Only 60% of the participants reported wishing to provide contraceptive care in their practices.

Table 1

Participant Demographics

| n=268 | Mean | Range |
|--|-------|---------|
| Age (years) | 40.1 | (25-73) |
| Years after graduation from medical school | 14.4 | (1-26) |
| | n | (%) |
| Gender | | |
| Male | 230 | (85.8) |
| Residency training | | |
| Rotation | 188 | (70.1) |
| Fixed | 67 | (25.0) |
| Other | 12 | (4.5) |
| No response | 1 | (0.4) |
| Specialty (total responses=308)* | | |
| General internal medicine | 140 | (45.5) |
| Family medicine | 102 | (33.1) |
| Specialty in internal medicine | 19 | (6.2) |
| General medicine | 10 | (3.2) |
| Surgery | 8 | (2.6) |
| Pediatrics | 8 | (2.6) |
| Psychiatry | 6 | (1.9) |
| Orthopedics | 5 | (1.6) |
| Other | 10 | (3.2) |
| Experiences overseas (n=94)* | | |
| United States | 49 | (52.1) |
| United Kingdom | 12 | (12.8) |
| Canada | 4 | (4.3) |
| Other country | 10 | (10.6) |
| Country not reported | 16 | (17.0) |
| Experiences with outpatient training in: | | |
| Pediatrics | 160 | (59.7) |
| OB-GYN | 99 | (36.9) |
| Distribution of patients in practice (patients/week) | | |
| Average number of outpatients/week | 142.0 | (100) |
| Child (0-15 years) | 12.6 | (8.9) |
| Adolescence (16-19 years) | 9.9 | (7.0) |
| Adult (20-64 years) | 49.7 | (35.0) |
| Elderly (65 years and older) | 70.1 | (49.4) |
| Reproductive-aged women | 11.5 | (8.1) |

* Multiple responses were possible.

Table 2

Japanese FPs/GPs' Experiences in Contraception Education During Medical School or Residency Training

| n=268 | n | (%) |
|--|-----|--------|
| Condoms | 194 | (72.4) |
| Intrauterine device | 179 | (66.8) |
| Oral contraceptive pills | 171 | (63.8) |
| Vasectomy | 116 | (43.3) |
| Diaphragm | 113 | (42.2) |
| Inefficiency of withdrawal (ejaculation outside the vagina) | 67 | (25.0) |
| Using two forms of contraception (e.g., condom and spermicide) | 64 | (23.9) |
| Spermicide | 60 | (22.4) |
| Inefficiency of douching (e.g., vaginal washing by coke) | 18 | (6.7) |

FPs/GPs—family physicians and general practitioners

Of those, 60.4% expressed a desire to include condoms in their care recommendations, and 57.5% indicated a desire to provide care through use of OCPs, though 24% and 30% of the participants, respectively, reported no willingness to provide any of these types of care. Most respondents stated that medical students and residents should learn contraceptive care in medical school and/or residency training.

Physicians who exclusively reported their specialty as family physician (n=81) were compared for differences with physicians who exclusively reported their original specialty as general internal medicine (n=118). Physicians who reported more than one specialty were not compared. Family physicians received more education and provided more contraceptive care such as condoms and OCPs ($P<.05$), but there was no difference in their willingness to provide this care.

Discussion

Our study reveals that self-identified FPs/GPs in Japan have received little training about contraception during medical school or residency training, few physicians currently provide contraceptive care or education, and only 60% report a willingness to provide it at all.

Before World War II, all birth control methods other than condoms were prohibited by the Japanese government, a policy that yielded high rates of illegal abortions.⁷ Japan became one of the first countries to legalize induced abortion in 1948, though OCPs were not legalized until 1998.^{8,9} The reasons why OCPs were not approved for contraception for a long time are complicated. Japanese health authorities were concerned about the side effects of OCPs. There may have been a basis for this concern since some physicians actually prescribed middle-dose pills for contraception instead of low-dose pills. Further, many specialists were afraid that easy access to OCPs would increase the spread of sexually transmitted disease, including HIV infection. Others were concerned that OCPs might further decrease the birth rate in Japan, since it had been low in recent years. Finally, some believe obstetricians-gynecologists profited from performing abortions and thus opposed OCPs due to financial interests.¹⁰ These historical perspectives in which abortion became the default mechanism of family planning may help explain in part the low rates of medical student and resident education about contraception and the reluctance by Japanese family physicians to provide contraceptive care.

Our data suggest several reasons why many family physicians in Japan do not—and will not—provide contraceptive care in their practices. These include (1) lack

Table 3

Japanese FPs/GPs' Self-reports of Contraceptive Care in Their Clinical Practice

| n=268 | Never/ Almost Never | | Sometimes | | Often/ Always | | No Response | |
|----------------------------------|------------------------|--------|-----------|--------|------------------|-------|----------------|-------|
| | n | (%) | n | (%) | n | (%) | n | (%) |
| Vasectomy | 255 | (95.1) | 3 | (1.1) | 0 | (0.0) | 10 | (3.7) |
| Spermicide | 255 | (95.1) | 2 | (0.7) | 1 | (0.4) | 10 | (3.7) |
| Diaphragm | 254 | (94.8) | 4 | (1.5) | 0 | (0.0) | 10 | (3.7) |
| Inefficiency of douching | 251 | (93.7) | 5 | (1.9) | 3 | (1.1) | 9 | (3.4) |
| Intrauterine device | 249 | (92.9) | 10 | (3.7) | 2 | (0.7) | 7 | (2.6) |
| Using two forms of contraception | 241 | (90.0) | 12 | (4.5) | 6 | (2.2) | 9 | (3.4) |
| Oral contraceptive pills | 223 | (83.2) | 31 | (11.6) | 7 | (2.6) | 7 | (2.6) |
| Inefficiency of withdrawal | 222 | (82.8) | 26 | (9.7) | 12 | (4.5) | 8 | (3.0) |
| Condoms | 196 | (73.1) | 53 | (19.8) | 13 | (4.9) | 6 | (2.2) |

FPs/GPs—family physicians and general practitioners

of knowledge about the importance and effectiveness of contraceptive care, (2) lack of knowledge about how to provide such care, and (3) absence of a favorable attitude to provide this care.

Lack of Knowledge About the Importance and Effectiveness of Contraceptive Care

Respondents to our survey reported few experiences with contraception education in medical school and/or residency training, even though all medical schools provide contraception curricula in OB-GYN in Japan. Our study suggests, therefore, that many family physicians easily forget their medical school training about contraceptive care unless they provide such care in daily practice. It appears that such education also is not reinforced during residency training. In addition to education during medical school and/or residency training, continuing medical education (CME) courses are needed to provide up-to-date education about contraceptive care for practicing family physicians. Because there is no board certification of family physicians in Japan, there is no opportunity for Japan FPs/GPs to have reinforcement about contraceptive care. CME is not mandatory for FPs/GPs. CME and other media such as medical journals or family medicine mailing lists¹² could increase contraceptive care among Japanese FPs/GPs.

Lack of Knowledge About How to Provide Contraceptive Care

The lack of knowledge about hormonal regimens in general may explain why family physicians in Japan have not become familiar with OCPs after their approval in 1999. A typical participant response was "These issues seem to be for OB physicians. It is difficult for us to discuss contraception with patients in Japan." Such

an attitude can be seen in other developed countries as well. Bedford et al¹⁴ surveyed generalist physicians in the United Kingdom about their practices and attitudes about providing contraceptive care. They stated that family planning could be provided by someone other than themselves. This research suggests that family physicians without specific training in family planning might have difficulty discussing sex-related issues with their patients.

Interestingly, recommendations about education in family planning for postgraduate (residency) training, which will be required for all medical school graduates in Japan beginning in 2004,¹⁵ differ between the Ministry of Health, Labour, and Welfare (MHLW) and the Japan Society of Obstetrics and Gynecology (JSOG). The MHLW recommends that all residents should be able to provide family planning,¹⁶ though the JSOG recommends that they only need to understand it.¹⁷ The latter policy suggests that the JSOG does not recognize education about family planning as the responsibility of any specialty, including their own. We believe that residency training of family physicians should include skills in the provision of family planning so that graduating residents will be competent to provide this care.

Absence of a Favorable Attitude to Provide Contraceptive Care

Only about 60% of the study participants reported wishing to provide some contraceptive care, and one of four physicians reported they would not provide such care at all. Some respondents stated, "Contraceptive care is not our work. We have many public health nurses who can provide this care." In addition, many feel that Japanese women are afraid of OCPs' side effects. Finally, preventive care is isolated from mainstream medicine and is not covered by

medical insurance in Japan. That means Japanese FPs/GPs cannot receive pay even if they spend time providing preventive care such as contraception. These complicated factors might affect FPs/GPs' attitudes toward providing contraception care and should be explored in future research.

Limitations

A potential limitation of this study is selection bias. The participants are limited to physician

Table 4

Japanese FPs/GPs' Willingness to Provide Contraceptive Care in Their Practice

| | Willing | Currently | Would Not | No |
|----------------------------------|------------|-----------|------------|----------|
| | to Provide | Provide | Provide | Response |
| n=268 | n (%) | n (%) | n (%) | n (%) |
| Condoms | 162 (60.4) | 33 (12.3) | 64 (23.9) | 9 (3.4) |
| Oral contraceptive pills | 154 (57.5) | 23 (8.6) | 79 (29.5) | 12 (4.5) |
| Inefficiency of withdrawal | 135 (50.4) | 17 (6.3) | 98 (36.6) | 18 (6.7) |
| Using two forms of contraception | 118 (44.0) | 8 (3.0) | 120 (44.8) | 22 (8.2) |
| Inefficiency of douching | 108 (40.3) | 11 (4.1) | 129 (48.1) | 20 (7.5) |
| Intrauterine device | 90 (33.6) | 5 (1.9) | 151 (56.3) | 22 (8.2) |
| Vasectomy | 80 (29.9) | 3 (1.1) | 161 (60.1) | 24 (9.0) |
| Diaphragm | 76 (28.4) | 4 (1.5) | 165 (61.6) | 23 (8.6) |
| Spermicide | 70 (26.1) | 2 (0.7) | 173 (64.6) | 23 (8.6) |

FPs/GPs—family physicians and general practitioners

members of the JAFM, and the data might not reflect the current situation of all FPs/GPs in Japan.

Another limitation is that only the most interested and motivated physicians might have returned the survey. These results thus might overestimate supportive attitudes toward provision of contraceptive care. Nonetheless, while the JAFM membership might not be representative of all general practitioners who function as family physicians in Japan, its members do represent the doctors in Japan who are practically and philosophically supportive of family medicine as a discipline in Japan.

Conclusions

In summary, most self-identified FPs/GPs in Japan do not currently provide contraceptive care, apparently due to a lack of education and reinforcement of its importance during residency training. While up to 60% of Japanese FPs/GPs are willing to provide this care, about 25% are completely opposed. These data provide evidence that systematic training about contraception is needed for family physicians, even in a developed country like Japan. Educational interventions and greater skills among Japan's family physicians might help reduce Japanese women's reliance on abortions as a default birth control mechanism after unintended pregnancy. Further research on patient preferences, traditional separation of preventive medicine from mainstream medicine, and coverage for contraception counseling by the national medical insurance system are needed to fully understand the role that family physicians can take in the provision of contraceptive care in Japan.

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