Shared Decision Making and Contraceptive Counseling

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### Disclosures

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<th>Christine Dehlendorf, MD, MAS</th>
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<td><strong>Commercial Interest</strong></td>
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Objectives

- Discuss different models of counseling commonly used in family planning care, including shared decision making, and their strengths and weaknesses

- Describe patient preferences for contraceptive counseling

- Recognize potential role of provider bias in family planning care, and the role of SDM as one strategy to address this bias
Patient-centered care

“Patient-centered care is care that is respectful of and responsive to individual patient preferences, needs, and values.”

- Institute of Medicine

- Recognized by IOM as a dimension of quality

- Associated with improved outcomes
Communication is a key aspect of PCC

- Quality, patient-centered interpersonal communication is central to patient-centered care
  - Fosters positive, respectful, therapeutic relationships that enable patient to express needs and preferences
  - Ensures provision of appropriate education and counseling
What evidence is there that interpersonal communication matters?

• Interpersonal communication affects healthcare outcomes generally, including:
  ▪ Patient satisfaction
  ▪ Use of preventive care
  ▪ Medication adherence

Doyle et al, BMJ 2013
Evidence for impact of interpersonal communication in family planning

- Counseling influences method selection
- Quality of family planning counseling associated with use of contraception and satisfaction with method
- Client/patient-centered care is the right thing to do

Dehlendorf: AJOG, 2016
Rosenberg: Fam Plann Perspect, 1998
Forrest: Fam Plann Perspect, 1996
Harper: Patient Ed Counsel, 2010
How do we provide client-centered contraceptive care?

- Consumerist Counseling
- Directive Counseling
Consumerist counseling

• Informed Choice:
  ▪ Provides only objective information and does not participate in method/treatment selection itself

• Foreclosed:
  ▪ Only information on methods asked about by the patient are discussed

• Both prioritize autonomy
Problems with consumerist counseling

- **Informed Choice:**
  - Provider does not assist client/patient in understanding how preferences relate to method characteristics or tailor information to patients' needs

- **Foreclosed:**
  - Fails to ensure women are aware of and have accurate information about methods
Approaches to contraceptive decision making

- Consumerist Counseling
- Directive Counseling
Directive counseling

- Provides information and counseling designed to promote use of specific methods
- Rooted in the healthcare provider’s preferences, or assumptions about the client’s priorities
Move Towards More Directive Approaches

• General emphasis on/promotion of LARC methods in family planning field

• Examples:
  - Tiered effectiveness: Present methods in order of effectiveness
  - Motivational interviewing: Patient-centered approach to achieving behavior change
Directive Counseling in Action

- Language among providers of “success” or “failure” in counseling based on whether client selects a LARC method

- References by AAP and ACOG to LARC methods as “first line”

- Performance evaluations based on choice of LARC methods
Is directive counseling patient-centered?

- **Directive counseling** appropriate when there is one option that leads to better health outcomes
  - Smoking cessation
  - Diabetes control

- Providers can engage with patients’ preferences in a patient-centered manner, while having an agenda

- **Decision support** appropriate for preference-sensitive decisions, in which there is no one best option, with tradeoffs among different outcomes of each treatment
  - Early breast cancer treatment
  - Early prostate cancer treatment
What kind of decision is contraceptive choice?

- Women have strong and varied preferences for contraceptive features

- Relate to different assessments of potential outcomes, such as side effects

- Also relates to different assessments of the importance of avoiding an unintended pregnancy
How do women think about pregnancy?

- **Intentions**: Timing-based ideas about if/when to get pregnant, sometimes includes “wants”

- **Plans**: Decisions about when to get pregnant and formulation of actions

- **Desires**: Strength of inclination to get pregnant or avoid pregnancy

- **Feelings**: Emotional orientations towards pregnancy
A Multidimensional Concept

Plans ≠ Intentions ≠ Desires ≠ Feelings

• All different concepts
• Women may find all or only some meaningful
• Often appear inconsistent with each other
“I guess one of the reasons that I haven’t gotten an IUD yet is like, I don’t know, having one kid already and being in a long-term committed relationship, it takes the element of surprise out of when we would have our next kid, which I kind of want. I’m in that weird position. I just don’t want to put too much thought and planning into when I have my next kid.”
“Another pregnancy is definitely not the right path for me and I’m being very careful with birth control. But if I somehow ended up pregnant would I embrace it and think it’s for the best? Absolutely.”

“I don’t want more kids and was hoping to get my tubes tied. We can’t afford another one. But if it happened I’d still be happy. I’d be really excited. We’d rise to the occasion…nothing would really change.”
“Sometimes I probably want to get pregnant when I’m 22 or 27… or probably soon. Who knows? Probably when my daughter starts walking, maybe.”

“I already got a kid so you know I’m not opposed to having children. If it happens, it happens…. I’d prefer we don’t have children right now but if it happens, okay.”

Gomez et al. Young Couples Study 2016
But shouldn’t we get women to plan “for their own good”? 

• Is an unintended pregnancy a universally negative health outcome?

• Little data to support this assumption
  ▪ Many studies show no association with social or health outcomes
  ▪ Some studies show associations with low birth weight and preterm birth
  ▪ However, generally not well-designed and well-controlled
  ▪ Most examine only retrospective intentions

Concerns with directive counseling approaches

• Assuming women should want to use certain methods:
  ▪ Ignores variability in preferences, including around importance of avoiding unintended pregnancy
  ▪ Does not prioritize autonomy

• Pressure to use specific methods can be counterproductive
  ▪ Perceived pressure increases risk of method discontinuation

Dehlendorf, unpublished data
Kalmuss: Fam Plann Perspect, 1996
Pariani: Stud Fam Plann, 1991
Contraceptive decision making

- Consumerist Counseling
  - Promote patient autonomy
- Directive Counseling
  - Increase use of highly effective methods

Quality decision based on patient preferences
“A collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences….This process provides patients with the support they need to make the best individualized care decisions.”

- Informed Medical Decisions Foundation
- http://www.informedmedicaldecisions.org/what-is-shared-decision-making/
Shared decision-making in family planning

• Best method for an individual depends on her preferences
  ▪ E.g., women will weigh effectiveness differently relative to other characteristics

• Consistent with many women’s preferences for counseling

Dehlendorf: Contraception, 2013
Dehlendorf: unpublished data
Shared Decision Making in Family Planning

“I just think providers should be very informative about it and non-biased...maybe not try to persuade them to go one way or the other, but maybe try to find out about their background a little bit and what their relationships are like and maybe suggest what might work best for them but ultimately leave the decision up to the patient.”

Dehlendorf, Contraception, 2013
Shared decision-making in family planning

- Patients who report sharing their decision with their provider had higher satisfaction with decision making process
  - Compared to both patient- and provider-driven decisions
- May not be best for everyone, but provides starting point for counseling

Dehlendorf: Contraception, 2013
Dehlendorf: unpublished data
Shared Decision Making and Disparities in Family Planning Care
History of reproductive injustices

- Nonconsensual sterilization of poor women and women of color throughout the 1900s

- Legislative proposals in the 1990s to make receipt of welfare benefits contingent upon Norplant use

- 150 incarcerated women in California were coercively sterilized from 2006-2010
History of reproductive injustices

• **Stratified reproduction**
  - The fertility of some people is valued by those who dominate social discourse and the fertility of other people is not
  - Formal and informal policies to limit the reproduction of some or encourage the reproduction of others

• **Has implications for counseling**
  - Potential for increased sensitivity among women of color regarding directive counseling
Race and trust in family planning services

• 35% of Black women reported “medical and public health institutions use poor and minority people as guinea pigs to try out new birth control methods.”

• Greater than 40% of Blacks and Latinas think government promotes birth control to limit minorities

• Black women more likely to prefer a method over which they have control

Jackson, Contraception, 2015
Rocca, PSRH, 2015
Thorbun and Bogart, Women’s Health, 2005
“...biases may exist...often unconsciously, among people who strongly endorse egalitarian principles and truly believe that they are not prejudiced. There is considerable empirical evidence that even well-intentioned whites...who do not believe that they are prejudiced demonstrate unconscious implicit negative racial attitudes and stereotypes [which] significantly shape interpersonal interactions....Evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care.”
"...biases may exist...often unconsciously, among people who strongly endorse egalitarian principles and truly believe that they are not prejudiced. There is considerable empirical evidence that even well-intentioned whites...who do not believe that they are prejudiced demonstrate unconscious implicit negative racial attitudes and stereotypes [which] significantly shape interpersonal interactions....Evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care."
Provider bias

- Blacks less likely to be referred for catheterization and bypass surgery
- Patients of color less likely to receive pain meds in ER
- Physicians judge Black patients to be:
  - Less intelligent
  - Less likely to comply
  - More likely to abuse drugs
- Low SES also associated with being judged negatively
- Providers have less positive affect and are more dominant with patients of color

Pletcher: JAMA, 2008
Institute of Medicine: Unequal Treatment, 2003
Johnson: Am J Public Health, 2004
Provider bias in family planning

- 28% of black women reported being pressured to start one type of method when they preferred another.

- Low-income women of color more likely to report being advised to limit their childbearing than were middle-class white women.

- Blacks were more likely than whites to report having been pressured by a clinician to use contraception.

- 67% of black women reported race-based discrimination when receiving family planning care.

Becker: Perspect Sex Reprod Health, 2008
Thorburn: Women Health, 2005
Are Women of Color Counseled Differently?

- Family planning providers have lower levels of trust in their Black patients.
- Providers are more likely to agree to sterilize minority and poor women.
- Are there also disparities in counseling about the IUD?
  - RCT using videos of standardized patients presenting for contraceptive advice.
  - Shown to participants at national meetings of ACOG and AAFP.

Jackson, unpublished data
Harrison, Obstet Gynecol 1988
Dehlendorf, AJOG, 2010
The “Patients”
The “Patients”
IUD recommendations by race/ethnicity and SES

• Providers more likely to recommend IUD to low income women of color than to low income White women
  ▪ No racial/ethnic difference in recommendations among high income women

• Supports possible bias related to highly effective methods in poor women of color

Counseling and Family Planning Disparities

- Given historical context and documented disparities in counseling, essential to ensure that providers focus on individual preferences when caring for women of color.

- Shared decision making provides explicit framework for doing this, without swinging too far to other side.
Conclusion

• Clients and their preferences, in all their complexities, need to be acknowledged when providing family planning care

• Shared decision making is a valuable tool to ensure that providers prioritize the individual client and their needs