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"We have to be mythbusters": Clinician attitudes about the legitimacy of patient concerns and dissatisfaction with contraception

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ABSTRACT

Although women in the United States use birth control at high rates, they also discontinue it at high rates, often citing dissatisfaction and side effects. At the same time, research shows that clinicians often neglect to discuss or discursively downplay the importance of side effects in contraceptive counseling. Scholars have yet to consider how clinicians' beliefs about the legitimacy of patient concerns and dissatisfaction may undergird these patterns. This study uses in-depth interviews with reproductive healthcare providers (N = 24) to examine their attitudes about common complaints regarding hormonal birth control. I identify how their reliance on formal medical knowledge, including evidence-based models, can lead them to frame patients' experiences or concerns about side effects as "myths" or "misconceptions" to be corrected rather than legitimized. I also describe a pattern of providers portraying negative side effects as normal to contraception and therefore encouraging patients to "stick with" methods despite dissatisfaction. Finally, I explore how these themes manifest in racialized and classed discourses about patient populations. I discuss the potential cumulative impact of these attitudes – if providers do carry them into clinical practice, they can have the effect of minimizing patient concerns and dissatisfaction, while steering women towards more effective methods of contraception.

1. Introduction

Nearly all adult women in the United States have used a contraceptive method at some point in their lifetimes and over 85 percent have used a highly or moderately effective, reversible method, like the pill, shot, or intrauterine device (IUD) (Daniels et al., 2013). Women use birth control at high rates, but they also discontinue it at high rates, often due to dissatisfaction (Littlejohn, 2012).

Healthcare providers play a crucial role in contraception: they educate and counsel patients about different forms of birth control, write prescriptions and insert and remove contraceptive devices, and help patients manage adverse reactions. Though women frequently report dissatisfaction and side effects from contraception (Littlejohn, 2012, 2013), we know little about how healthcare providers think about the legitimacy of that dissatisfaction. I aim to fill that gap in this research using in-depth interviews with reproductive healthcare providers.

2. Background

Nearly half of contraceptive users have discontinued a method because of dissatisfaction (Moreau et al., 2007). Negative side effects drive much of the dissatisfaction with hormonal methods in particular (Moreau et al., 2007). Users of hormonal contraception commonly report side effects such as headaches, weight gain, mood changes, nausea, and breakthrough bleeding (Brunner Huber et al., 2006; Littlejohn, 2012; Westhoff et al., 2007). The experience of negative side effects is common, but not universal - many report temporary or no side effects from hormonal contraception and some report only positive side effects, like clearer skin and less painful periods (Haider and D'Souza, 2009). Non-hormonal methods of contraception can have negative side effects as well. For instance, condoms can inhibit sexual pleasure and spontaneity. However, in this paper I focus on prescription methods, most of which contain synthetic hormones.

Provider-prescribed methods, including all hormonal methods and the copper IUD, are more effective at preventing pregnancy than most non-prescription methods of contraception. Differences in efficacy are important to understand, because a major public health goal in the United States is to reduce unintended pregnancy (ODPHP, 2014). Women experience, on average, 1.3 contraceptive failures in their lifetimes (Trussell and Vaughan, 1999), meaning it is relatively common to get pregnant when you do not intend to, even while contracepting. Leading healthcare organizations aim to increase the use of the most effective methods of contraception among women at risk of unintended pregnancy (AAP, 2014; ACOG, 2012). For example, the World Health Organization (WHO) promotes tiered effectiveness

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contraceptive counseling, where healthcare providers present information about the most effective methods first and then, if needed, discuss remaining methods in descending order of effectiveness (WHO, 2007; see also Stanback et al., 2015). According to this model, the top two tiers of highly and moderately-effective birth control are largely composed of hormonal, prescription-based methods, like the implant or pill. (There are two exceptions: the copper IUD requires insertion by a provider, but does not contain hormones; the lactational amenorrhea method, based on consistent breastfeeding after a recent birth, is neither provider-administered nor hormonal). Importantly, long-acting reversible contraception (LARCs), which are often promoted as "first-line" options (AAP, 2014; ACOG, 2012), also require a provider for removal. By contrast, the bottom two tiers of less effective methods are composed completely of non-hormonal, non-prescription methods, like condoms, diaphragms, and withdrawal.

Not all medical providers and health advocates have embraced the enthusiastic promotion of tiered-effectiveness counseling and LARC methods. Critics point out counseling that focuses heavily on efficacy and provider-dependent methods can lead to clinical models that minimize patients' individual preferences and undermine reproductive autonomy, especially for disadvantaged women historically marginalized in reproductive medicine (Gomez et al., 2014; Gubrium et al., 2015).

Though efficacy is often primary in medical models of family planning, studies of women's contraceptive preferences illuminate the multiplicity of factors users weigh. For example, one survey of women seeking abortions found that for over 90 percent, no contraceptive method contains all of the features they rank as "extremely important" (Lessard et al., 2012). This is partly because users often desire features that conflict – for example, methods that are highly effective, easy to use, *and* have few or no side effects. Even though non-life-threatening consequences, like weight gain and mood swings, may be secondary from a medical standpoint, users may find these side effects to be intolerable and consequently switch or discontinue their methods (Littlejohn, 2013).

A central tension in addressing women's dissatisfaction with contraception is how to weigh evidence-based medicine with users' individual preferences, values, and experiences (Downey et al., 2017). Scholars have documented both the predominance and pitfalls of evidence-based medicine in the United States (Timmermans and Berg, 2010; Greenhalgh et al., 2014). In its ideal form, the evidence-based model decreases uncertainty and increases standardization by using the results of randomized controlled trials to guide clinical practice (Timmermans and Berg, 2010). In contraceptive counseling, this model manifests in debates over whether providers should discuss potential side effects, especially those for which there is no established, epidemiological link to the prescribed methods. For instance, users commonly cite nausea, weight gain, headaches, and mood changes in conjunction with hormonal contraceptives (Brunner Huber et al., 2006). None of those side effects have been causally linked to birth control in randomized controlled trials (Grimes and Schulz, 2011), though some evidence is inconclusive (Gallo et al., 2014). (There is one important exception: research has linked Depo-Provera or "the shot" to weight gain (Bahamondes et al., 2001)).

Some researchers suggest that warning patients about side effects that have not been established by randomized controlled trials can create a "nocebo effect." The *expectation* of these adverse side effects, they argue, can cause more users to experience them. Therefore, they advise clinicians to avoid mentioning side effects not verified by randomized controlled trials in contraceptive counseling (Grimes and Schulz, 2011). Others suggest that despite a possible "nocebo effect," providers should elicit patients' specific concerns, because many users are already worried about side effects (Dehlendorf et al., 2013). This viewpoint is based on research highlighting perspectives of family planning patients: women name the discussion of side effects as a high priority and feel providers often overlook or sometimes even suppress these topics (Dehlendorf et al., 2013).

Previous research has also documented how users value embodied experience – or evaluations of health based on direct experience and the everyday realities of life (Bell, 2009) – as an important source of information about contraception (Anderson et al., 2014; Brown et al., 2013; Dehlendorf et al., 2013; Lowe, 2005). For instance, one study of how women gather information about contraception demonstrates that most trust personal recommendations from friends and prefer to learn about a method from a woman who has used it herself (Anderson et al., 2014). Another finds that even in consultations with medical professionals, women value their providers' embodied knowledge, stemming from personal contraceptive use, over their formal medical expertise (Lowe, 2005). The author concludes that "despite its apparent 'medicalization', women consider contraception as distinct from 'medical matters', and that 'real' expertise over contraception stems from embodied rather than textual knowledge" (Lowe, 2005, 362). These informal information-gathering techniques that prioritize experiential knowledge conflict with the tenets of evidence-based medicine.

Recent research that combines patient surveys with audio-recordings of their contraceptive counseling visits provide a window into provider-patient interactions. For instance, when providers counsel patients about birth control, discussion of side effects is often limited and not presented as a significant part of the decision-making process (Dehlendorf et al., 2014). Moreover, that discussion primarily addresses medical risks and safety rather than side effects that can be salient to patients (Minnis et al., 2014). When side effects are discussed, providers portray positive side effects as highly likely and beneficial, while presenting negative side effects as less likely and producing minimal discomfort (Littlejohn and Kimport, 2017). These studies elucidate patterns of clinical interaction, but cannot provide insight into clinicians' attitudes and motivations for discursively downplaying the importance of negative side effects.

Extant literature explores women's dissatisfaction with birth control and their experiences of side effects and how these factors are (not) discussed in contraceptive counseling visits. However, less research examines how clinicians' beliefs may undergird their approaches to contraceptive counseling. In the present study, I analyze providers own words and perspectives to address this gap. I identify how their reliance on formal medical knowledge, including evidence-based models, can lead them to frame patients' experiences or concerns about side effects as "myths" or "misconceptions" to be corrected rather than legitimized. I also describe a pattern of providers portraying negative side effects as normal and, therefore, encouraging patients to "stick with" methods despite dissatisfaction. Finally, I explore how these themes manifest in racialized and classed discourses about patient populations.

3. Methods

Data come from an interview study I conducted with reproductive healthcare providers (N = 24), investigating their attitudes and beliefs around reproductive planning and unintended pregnancy. Interviews were semi-structured, open-ended, and covered topics like contraceptive counseling, abortion, preconception care, pregnancy, and infertility. Here, I focus on data about approaches to contraceptive counseling and provision, including how clinicians described helping patients select a method of birth control, how they addressed dissatisfaction and discontinuation, and what they saw as common challenges in family planning.

I conducted a purposive sample with the goal of reaching providers who served a broad range of patient populations to capture the breadth of clinical experiences. I recruited participants at a national conference and online forum for nurse practitioners as well as through a snowball sampling technique, starting with personal and professional contacts. I conducted all interviews in 2013. About half were conducted in-person and half by telephone. In-person interviews typically took place in the respondent's workplace or a local café. All interviewees gave both oral