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COMMITTEE STATEMENT

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Patient-Centered Contraceptive Counseling

Committee on Health Care for Underserved Women and Committee on Ethics. This Committee Statement was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women, Contraceptive Equity Expert Work Group, and Committee on Ethics in collaboration with Melissa Kottke, MD, MPH, MBA; Lisa Goldthwaite, MD, MPH; Kavita Arora, MD, MBE, MS; and Jennifer Villavicencio, MD, MPP.

Contraception can be a fundamental part of an individual's health and wellness. Therefore, contraceptive counseling is an important interaction between patients and obstetrician–gynecologists and other health care practitioners. Counseling is an opportunity to solicit an individual's values, preferences, and insight into what matters most to them as it relates to contraception. However, contraceptive counseling may be subject to undue influence, such as a counselor's personal biases (implicit or explicit), pressure or coercion from a counselor or partner, or even the ideology of the institution at which someone is seeking contraceptive access. Intentional application of a patient-centered reproductive justice framework and use of a shared decision making model is the recommended approach for providing supportive contraceptive counseling and care to help patients to achieve their reproductive goals.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

Based on the principles outlined in this Committee Statement, the American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

Obstetrician–gynecologists (ob-gyns) should intentionally incorporate the reproductive justice framework into contraceptive counseling by:

- **acknowledging historical and ongoing reproductive mistreatment of people of color and other marginalized individuals whose reproductive desires have been devalued;**
- **recognizing that counselor bias, unconscious or otherwise, can affect care and working to minimize the effect of bias on counseling and care provision; and**
- **prioritizing patients' values, preferences, and lived experiences in the selection or discontinuation of a contraceptive method.**

Ob-gyns should adhere to the recommended ethical approach of shared decision making through patient-centered contraceptive counseling.

BACKGROUND

Contraception allows an individual to prevent pregnancy and control when and if they become pregnant. As such, contraception can offer people support in achieving their reproductive, educational, economic, social, health, and personal goals. Many contraceptive methods also have additional noncontraceptive benefits, including but not limited to menstrual regulation and treatment for certain conditions such as endometriosis, polycystic ovarian syndrome, and heavy menstrual bleeding, among others.

Given that individual goals and needs change over time, it follows that contraceptive use, needs, and priorities will also change across the lifespan. Stopping, starting, and switching contraceptives may occur with changes in desire for pregnancy, relationship status, or health status or in response to contraceptive side effects. Ability to access a contraceptive method, as well as clinical care that may be needed to discontinue a method, can also affect how and when an individual uses contraception. As with many health inequities, Black, Indigenous, and other people of color, people who are uninsured, and people with low incomes disproportionately face barriers to accessing the full spectrum of contraceptive care, from initiation to discontinuation; the effect of these inequities is far-reaching, resulting in adverse health outcomes (1).

Interaction with a clinician is often required to access contraceptive methods. As such, counseling about an individual's values, preferences, and goals is a frequent and important interaction between ob-gyns and patients. Providing patient-centered contraceptive counseling is an opportunity for ob-gyns to help patients obtain contraceptive methods that best suit their values, needs, and priorities. Because various multidisciplinary team members may provide contraceptive counseling, we use the term "counselor" to reflect the person doing contraceptive counseling.

Contraceptive counseling for adolescents requires specific attention to topics beyond the scope of this document. These issues include the adolescent developmental spectrum, barriers to confidentiality and coverage, and potential limits on adolescents' ability to consent to health care services and are addressed elsewhere (1–7).

RECOMMENDATIONS AND CONCLUSIONS

Ob-gyns should intentionally incorporate the reproductive justice framework into contraceptive counseling by:

- **acknowledging historical and ongoing reproductive mistreatment of people of color and other marginalized individuals whose reproductive desires have been devalued;**
- **recognizing that counselor bias, unconscious or explicit, can affect care and working to minimize the effect of bias on counseling and care provision; and**
- **prioritizing patients' values, preferences, and lived experiences in the selection or discontinuation of a contraceptive method.**

Intentional incorporation of a reproductive justice framework is necessary to support noncoercive, patient-centered contraceptive counseling. The reproductive justice framework was created in 1994 by Black women and is grounded in a human rights framework to explain that all people have a fundamental right to bodily autonomy, to have children, to not have children, and to parent the children they have in safe and sustainable communities (8, 9). This framework encourages counselors to explore a person's reproductive goals and contraceptive priorities and preferences while considering the systemic and structural barriers that may impede their ability to do so (8, 9).

One key aspect of understanding how a person may form contraceptive preferences is acknowledging that, throughout U.S. history, contraceptive experimentation without informed consent, government-sponsored forced sterilization, and other reproductive mistreatment have and continue to target people of color, people with low incomes, people who are incarcerated, and people with mental illness (10). Counselor awareness of this egregious history and work to address and mitigate ongoing mistreatment are essential to ensure that each patient's goals and preferences are respected, valued, and prioritized during contraceptive counseling.

In addition to understanding how historical and ongoing mistreatment affect patient preferences, contraceptive counselors should be aware of their own personal biases and the potential effect on counseling and prescribing practices. These unconscious or implicit biases may reflect the counselor's differential value placed on childbearing for people from various backgrounds or views on whether and when an individual should or should not have children, as well as opinions and preferences for long-acting reversible contraceptives or sterilization. Some counselors may prioritize their beliefs about how to best optimize patient health and pregnancy outcomes over their patients' reproductive goals, particularly in cases in which the counselor has concerns about the patient's high risk for adverse pregnancy outcomes. It is important that contraceptive counselors acknowledge that they may have bias, whether unconscious, implicit, or ideologic, and work to minimize the effect it has on patients' ability to receive the care that best matches their expressed values, needs, and desires. Counselor bias should neither interfere with patient interactions nor perpetuate health inequities (11).

Prioritizing patient values, preferences, and lived experiences in the selection or discontinuation of a contraceptive method is an essential aspect of contraceptive counseling; therefore, counselors should explicitly begin with ensuring that the patient is interested in contraceptive counseling at all and, if so, solicit the patient's values and preferences. As part of understanding how lived experiences affect patient decision making, counselors should be aware of and understand how discrimination, stigma, racism, intimate partner control or violence, difficulty accessing health care, and counselor behaviors create additional barriers to successful achievement of reproductive health goals. Some people report clinician resistance or refusal when they request removal of an intrauterine device or implant (12). This may be because the clinician prioritizes the efficacy of the contraceptive, its potential length of use, or the cost of the device over the patient's request for removal. Creating barriers to contraceptive discontinuation is unacceptable, compromises individual autonomy, and results in frustration and decreased satisfaction, harming the patient–practitioner relationship (13–15). Intersecting factors that contribute to patient contraceptive choice, declination, or discontinuation may be unfamiliar to a counselor but should be respected and honored without pressure or bias (16).

Obstetrician–gynecologists should adhere to the recommended ethical approach of shared decision making through patient-centered contraceptive counseling

Various models for contraceptive counseling exist along the spectrum of patient decision-making autonomy (17). A nondirective "informed choice" model favoring complete patient decision-making autonomy lies at one end of the spectrum. In this model, the counselor provides information but does not insert opinions or values into the conversation. The counselor remains objective, nonjudgmental, and avoids influencing the decision-making process. In an example of the "informed choice" model, a counselor lists the same attributes about each contraceptive method (eg, efficacy, mechanism of action, cost, side effects) and encourages the patient to make a decision based on the list of information provided. This approach has the advantage of avoiding undue influence and possible coercion but does not provide an individualized experience. Directive counseling is found on the opposite end of the continuum, where counselors emphasize *their* predetermined priority, which historically has been efficacy (18). Placing contraceptive methods into ranked tiers based on efficacy is an example of directive counseling; the counselor presents the most effective method as what they believe to be the "best" method ("top tier"), which results in an emphasis on long-acting reversible contraceptives (19). Although this model can be an efficient means of transferring important information about method efficacy and failure rates, patients do not always prioritize method efficacy over other factors; thus, this model leaves little room for exploring patients' values and needs (20).

Shared decision making lies between the nondirective and directive counseling models (21, 22). In the shared decision-making model, each party—counselor and patient—is recognized as having valued expertise. The counselor is recognized as the expert in clinical information, and the patient is recognized as the expert in their own experience, values, and preferences. Information can be shared, priorities can be explored, and, ultimately, the patient is the final arbiter of their decision, arriving at a choice that best meets their needs informed by the clinician's expertise. Counselors can initiate this interaction by asking open-ended questions about the patient's priorities and values relative to pregnancy goals and contraceptive attributes (eg, menstrual side effects, efficacy, privacy, ease of use, cost, patient control, hormone content, noncontraceptive benefits, reversibility, invasiveness). Counselors can share details about medical contraindications, risks, and benefits and reflect knowledge back to the patient about desired attributes and how individual contraceptive methods may or may not satisfy those priorities. The patient can then consider and weigh these priorities and method attributes in deciding on a method. This model promotes open dialogue and supports both patient autonomy in decision making and counseling directly tailored to the patient's expressed preferences and values. Shared decision making improves trust, understanding, and satisfaction (17, 23–25).

CONCLUSION

Contraceptive counseling is a common and important patient–clinician interaction. When approached through a framework of reproductive justice, contraceptive counseling helps patients achieve their reproductive goals in a manner consistent with their priorities, values, and lived experiences. Being aware of and minimizing personal biases and using a patient-centered shared decision-making approach to counseling are the recommended ethical standards for contraceptive counseling.

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CONFLICT OF INTEREST

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