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Shared Decision Making in Contraceptive Counseling

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Abstract

Background—Shared decision making (SDM) is a potentially valuable but underexplored approach to contraceptive counseling.

Methods—We determined the correlation between patient report of SDM and of whether their provider had a method preference with measures of satisfaction.

Results—Women reporting SDM were more likely to be satisfied with counseling than those reporting a provider-driven decision, and were more likely to be satisfied with their method than those reporting a patient-driven decision. Patients who felt the provider had a method preference were less likely to be satisfied with their method.

Conclusions—SDM in contraceptive counseling is associated with patient satisfaction.

Keywords

Counseling; shared decision making; patient satisfaction; contraception

1. Introduction

Shared decision making is an increasingly emphasized model of health communication that has been found to be associated with increased patient engagement and improved patient

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outcomes, including enhanced experience of care and, in some studies, improved health status.[1–3] This model is particularly relevant for preference-sensitive decisions, when two or more options are medically appropriate and the best choice for an individual patient depends on his or her own assessment of the relative importance of different characteristics or potential outcomes associated with these options.[4] In shared decision making, the health care provider is responsible for contributing his or her medical knowledge, while the patient provides expertise on his or her own values and preferences.[2] Together, the provider and patient collaborate to achieve the goal of the patient making a decision that is most consistent with their preferences.

The choice of a contraceptive method is a prototypical preference sensitive decision, in which multiple methods are medically appropriate for the majority of women. In addition, women have different assessments of the desirability of outcomes associated with contraceptive use, including menstrual changes and the risk of pregnancy.[5] The role of shared decision making in contraceptive counseling had not been well described. We sought to determine whether patient's experience of shared decision making during contraceptive counseling was associated with their satisfaction with their family planning visit and with their choice of contraceptive method. We also investigated whether a patients' perception of their provider having a preference for a specific method was associated with patient satisfaction.

2. Methods

Briefly, we used data from the Patient-Provider Communication about Contraception study, which has been previously described.[6] In this study, women were recruited at the time of a contraceptive counseling visit from six clinics in the San Francisco Bay Area. Following their visit, they were surveyed about their experience of counseling. Questions included "During this visit, who made the decision about what birth control method you would use?", with response options of the provider, mostly the provider, the provider and me together, mostly me, or me. This variable was collapsed into three categories: provider-driven decision (response options of "the provider" and "mostly the provider"), shared decision ("the provider and me together"), and patient-driven decision ("mostly me" and "me"). In addition, patients were asked "Did your health care provider have a preference for what birth control method you would use?" with response options of yes or no. Outcome variables were satisfaction with the process of decision making ("How satisfied are you with how your health care provider helped you to choose what birth control method you would use?") and satisfaction with their chosen contraceptive method. Responses were measured using a 7-point Likert scale, and for analysis dichotomized as completely or very satisfied vs. less satisfied.

Analysis was conducted using chi-squared tests and multivariate mixed effects logistic regression, with a random effect model used to account for clustering by provider. We adjusted for pre-specified variables measuring patient characteristics considered likely to be associated with the outcome of interest.

3. Results

A total of 345 participants from the practices of 38 providers contributed data for this analysis. Demographics of patients and providers are described in Table 1. The only variable associated with what type of decision making occurred was having seen the provider previously (40% reported patient-driven decisions, 56% shared decision making, and 4% provider-driven decisions, compared to 50%, 41% and 8% for those who had not seen the provider before, p=0.04). In multivariate analysis, those who had seen the provider before were significantly less likely to experience provider-driven decision making than shared decision making (OR 0.28, p=0.049). Younger patient age was associated with being more likely to report that the provider had a preference in bivariate analysis (70% for those 16–20, decreasing to 49% in those greater than 35, p=.02 for overall comparison) with a significant difference between the youngest and the oldest groups in multivariate analysis (aOR 0.31, p=0.043 for patients >35 compared to those 16–20) (data not shown).

Patients who reported having engaged in shared decision making with their provider were more satisfied with the process of decision making than were those who reported either that they made the decision or that the provider made the decision (96% vs. 88% and 63%, both p values <0.05). The significant differences between shared decision making and provider-driven decision making persisted in multivariate analyses (P<.001), with a trend towards greater satisfaction comparing shared decision making to patient-driven decision making (p=0.09). Similarly, satisfaction with the chosen method was significantly higher in bivariate analyses among women who reported experiencing shared decision making than among those who reported making the decision independently (66% vs. 55%, p<0.05), with no significant difference between shared decision making and provider-driven decisions (66% vs. 54%, p=0.24). In multivariable analyses the results were similar (p value 0.03 for greater satisfaction with shared compared to patient-driven decision making and 0.28 for shared compared to provider-driven decision making).

Patients who reported that their provider indicated a preference for which method they would use had no difference in satisfaction with the process of decision making. With respect to satisfaction with the chosen method, fewer women reported satisfaction with the chosen method when the provider had expressed a preference (57% vs. 66%, p=0.03 in multivariable analysis).

4. Discussion

Women who reported experiencing shared decision making during contraceptive counseling were more likely to be satisfied with their family planning experience. These results indicate the value of engaging with patients in a supportive manner when providing contraceptive counseling. This is of particular interest given that the shared decision making approach is distinct from an approach to counseling commonly discussed in the family planning literature and often used in practice, in which providers only give information about contraceptive options and do not assist with decision making.[7,8] While this model of counseling has been motivated by a desire to respect patient autonomy in decisions about reproduction, the finding of increased method satisfaction and a trend toward increased

decision making satisfaction with shared decision making, as compared to purely patient-driven decision making, suggests that engaging more actively in decision making can be perceived positively by patients and can help them to find a method that is a good fit for their preferences. However, the finding of decreased method satisfaction when women reported their provider expressed a preference underscores the importance of providers explicitly focusing their support on the needs and preferences of individual patients, rather than their personal preferences.

Limitations of this analysis include the modest sample size, which may have limited our ability to identify statistically significant differences. Further, our predominantly female population of providers, the fact that the majority of women were seeing their provider for the first time, and the inclusion of only licensed health professionals, with the exclusion of health educators, may limit generalizability. While the reliance on patient report of counseling can be perceived of as a limitation, patient-derived measures of health communication best represent the subjective experience of the interaction.[9]

In summary, given that patient experience is an essential component of health care quality,[10] as well as the fact that the experience of contraceptive counseling is linked to contraceptive outcomes,[6] these findings support the development and implementation of shared decision making interventions for contraceptive counseling.

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Table 1

Description of study sample, n = 345

Demographics	Total
Total (%)	
Mean age, SD	26.8 (6.9)
Age categories, years (%):	
16–19	11.9
20–24	33.6
25–29	26.1
30–34	11.3
35+	17.1
Race/ethnicity (%):	
Black, non-Hispanic	28.4
Hispanic or Latina	25.8
White, non-Hispanic	45.8
Federal poverty level (%):	
<100%	42.6
101–200%	20.3
>200%	37.1
Highest level of education completed (%):	
High school or less	26.4
Some college	38.0
College or higher	35.6
Highest level education completed by parent/guardian (%):	
High school or less	36.9
Some college	25.6
College or higher	37.5
Pregnancy history (%):	
Never pregnant	47.8
At least one pregnancy, no births	19.4
At least one birth	32.8
Visit and provider characteristics	
Contraceptive method selected at visit (%):	
LARC (IUC, Implanon)	24.9
Injectable (DMPA)	9.6
Pill, ring, or patch	55.1
Condom, none	10.4
Type of provider seen at index visit (%):	
APC, Other	59.7
APC, Reproductive specialist	15.9
MD, Ob/Gyn	15.7
MD, Family Medicine	8.7

Demographics	Total
Race/ethnicity of provider seen at index visit (%):	
White, non-Hispanic	70.4
Other	29.6
Sex of provider seen at index visit (%)	
Female	98.0
Male	2.0
Have had a previous visit with provider seen at index visit (%):	
Yes	28.5
No	71.5

APC = Advanced Practice Clinician (i.e., advanced practice nurse, physician's assistant, certified nurse midwife); MD = Medical Doctor

Table 2

Patient satisfaction with visit process, by type of visit decision making and provider preference, n = 345

	Satisfied with Process			
		Bivariate Analysis	Multivariate Analysis*	
	Yes	V value	aOR, 95% CI	P value
Decision making type				
Shared decision making (n=157)	150 (96%)	Ref	Ref	Ref
Patient-driven decision (n=164)	144 (88%)	.01	0.42 (0.15–1.2)	.09
Provider-driven decision (n=24)	15 (63%)	>.001	0.06 (0.01–0.21)	>.001
Did provider have preference?				
Yes (n=220)	198 (90%)	Ref	Ref	Ref
No (n=125)	111 (89%)	.73	1.4 (0.57–3.3)	.48

* In multivariate analysis, variables included were decision-making type, provider preference, age, pregnancy history, income, birth control method choice, race, and whether the patient had seen the provider before, with a random effect for provider.

Table 3

Patient satisfaction with method, by type of visit decision making and provider preference, n = 345

	Satisfied with Method			
		Bivariate Analysis	Multivariate Analysis*	
	Yes	P value	aOR, 95% CI	P value
Decision making type				
Shared decision making (n=157)	150 (96%)	Ref	Ref	Ref
Patient-driven decision (n=164)	144 (88%)	.05	0.52 (0.33–0.94)	.03
Provider-driven decision (n=24)	15 (63%)	.25	0.60 (0.24–1.51)	.28
Did provider have preference?				
Yes (n=220)	198 (90%)	Ref	Ref	Ref
No (n=125)	111 (89%)	.08	0.52 (0.31–0.88)	.01

* In multivariate analysis, variables included were decision-making type, provider preference, age, pregnancy history, income, birth control method choice, race, and whether the patient had seen the provider before, with a random effect for provider.