

Beyond Coercion

Let Us Grapple With Bias



Melissa L. Gilliam, MD, MPH

The past decade has seen significant change in access to contraception, including long-acting reversible contraception (LARC), the intrauterine device (IUD), and subdermal implant. A new hormonal IUD, Liletta, has introduced healthy market competition. Data from large studies in St. Louis and Colorado demonstrate the population-level effect of contraception. There is also guidance for the practicing clinician created by the Centers for Disease Control and Prevention: the “U.S. Medical Eligibility Criteria for Contraceptive Use” describes which men and women can safely use which methods of contraception.¹ The companion document, the “U.S. Selected Practice Recommendations for Contraceptive Use,” provides guidance on the uptake and maintenance of contraception.² Finally, with the contraceptive mandate of the Affordable Care Act, more people should have access to all methods without a co-pay. These and other factors have contributed to the changing contraceptive method mix among women in the United States.

In the current issue of *Obstetrics & Gynecology* (see page 917), authors Kavanaugh, Jerman, and Finer seek to document changes in LARC method use among U.S. women.³ The authors use the National Survey of Family Growth—a large, nationally representative, cross-sectional survey of fertility behaviors, family formation, and health. The authors examine the use of LARC methods among reproductive-aged females aged 15–44 years, comparing the 2008–2010 National Survey of Family Growth cycle with the 2011–2013 cycle. Variables such as parity, insurance type, prior contraception use, and reason for discontinuation are used to characterize the user and consider whether there is disproportionate use among any one group compared with another. They note that earlier increases in LARC use among African Americans have not continued throughout the past decade. In fact, in controlled analysis, African American women now appear to be less likely to use the IUD compared with women of other racial-ethnic groups. The authors suggest that this pattern makes coercion less likely and that underuse might be attributed to medical mistrust or poor access to these methods.

Contraceptive coercion may seem like an old problem, as few of us can claim to practice medicine coercively. Yet all of us have biases. Holding biases is natural. From an early age, to recognize friend from foe and identify potential threats, we learn to recognize patterns. Similarly, being a health care provider depends on recognizing patterns. Demographic, physical, and cultural clues help us make diagnoses, recognize distress, and tailor the treatment plan.

Pattern recognition can also morph into preference. As a society, we privilege specific attributes pertaining to skin color, gender, age, religion, hair color, sexual orientation, and sexual identity. Possessing certain attributes can result in a positive bias or privilege. There is also negative bias that manifests as stereotype, prejudice, and even hatred (for others or even oneself).

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Dr. Gilliam is from the Department of Obstetrics and Gynecology at the University of Chicago, Chicago, Illinois; e-mail: mgilliam@babies.bsd.uchicago.edu.

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Although these biases often go unrecognized, they are perpetuated by people and also by systems, contributing to disparities in access to quality schools, safe neighborhoods, quality food, good transportation, and jobs. Similarly, societal biases affect how we provide medical care and, within that, family planning care.

Studying contraceptive use by user characteristics is invaluable for identifying unusual and unexpected patterns. However, this analysis provides a fairly foggy lens for examining coercion, medical mistrust, and access to health care. Provider behavior, patient agency, and equitable care come into sharper focus using a lens of health care quality. In 2001, the Institute of Medicine published *Crossing the Quality Chasm: A New Health System for the 21st Century*, calling for care that is patient-centered, timely, efficient, and equitable.⁴ Ensuring quality care requires a three-pronged approach: training providers, empowering patients, and creating maximally reliable systems.

These three strategies can help to ensure quality family planning care and health care in general. First, we must train providers to address bias. Addressing bias is deeply personal work. Each of us must examine our values and identify when we are ignorant or intolerant, when we invoke stereotypes or hold prejudices. To counter bias, it helps to be a student of diversity, learning about other people, cultures, and religions through reading, exploration, and asking questions. Addressing our own biases is a dynamic, messy, lifelong process.

The second strategy for ensuring quality is to empower patients. In patient-centered care, the patient's satisfaction and wishes are at the center of medical decision making, and providers must learn the skills and practices to elicit the patient's experience of the illness and treatment. Placing patients at the center of care helps to guard against the potential to prioritize the public health or medical benefits of contraception over the patient's desires. Patient-centered care positions patients as educated partners in their medical decision-making. In the case of family planning care, they would feel empowered to select whatever method they prefer, even if it is less effective.

Yet, humans are fallible. Thus, the third strategy is to address systems of care. Health care systems must be safe and reliable, achieving equitable outcomes for all people regardless of age, race, class, or income. Leading organizations such as the Institute for Healthcare Improvement remind us that practices must be systematically evaluated and redesigned to protect against hazards and ensure consistent quality of care. "Providing Quality Family Planning Care: Recommendations of CDC and the U.S. Office of Population Affairs" offers recommendations for providing high-quality family planning services.⁵ More recently, quality-improvement approaches have been applied to family planning care to include patients alongside the research team in redesigning systems.⁶

The authors conclude that we should perhaps be reassured by no clear trend in increased IUD use among African American women. Yet, a counter suggestion is to insist on not being reassured. Being uncomfortable will compel us to do the hard work of addressing our biases, empowering our patients, and ensuring our systems are high quality and equitable.

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