

Title: “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.

Keywords: United States; birth control; side effects; reproductive healthcare; embodiment; evidence-based medicine

1. Introduction

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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

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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 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

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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

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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.

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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

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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 and written consent to participate and all but one agreed to have their interviews recorded and transcribed.

As Table 1 shows, the majority of respondents were nurse practitioners, but the sample

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also included nurse midwives and doctors. I limited my sample to providers who could prescribe medication, including birth control, and had more than two years of experience working in reproductive healthcare. The respondents worked across a range of settings, including hospitals, private practices, non-profit and federally-funded clinics, university health centers, and workplace wellness centers. Many simultaneously held teaching positions at academic institutions. At the time of interview, 23 respondents were living and working in United States and most came from the Northeast. One was living abroad, but her most recent clinical experience was in the United States. The majority of respondents were white and female, which closely parallels the demographics of nurse practitioners and nurse midwives overall (Sipe et al. 2009). The providers served diverse patient populations and their practices ranged from serving predominantly poor, uninsured clientele to high-income patients with private insurance.

[TABLE 1 HERE]

I transcribed interviews and coded them using QSR NVivo computer software. I used thematic analysis, trying to understand the “underlying ideas, assumptions, and conceptualizations” in the data (Braun and Clarke 2006, 13). Because interviews were broadly focused, I adopted an inductive approach to identifying themes in how interviewees described contraceptive counseling and patient satisfaction. For example, in initial coding, I identified a theme of providers minimizing patient dissatisfaction because of side effects. In iterative coding, I documented how this minimization often arises from distinction between formal and informal knowledge about contraception.

A key strength of in-depth interviews is that they can document provider attitudes and motivations, which are often difficult to discern from patient reports or direct observation of

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clinical interactions. However, the data can only account for provider reports of their own perspectives and practices; they likely do not fully capture clinical practice or patterns of behavior among their patients.

4. Results

4.1 Formal and Informal Knowledge

Providers’ approaches to contraceptive counseling often matched medical literature and public health guidelines. For example, the Centers for Disease Control and Prevention (CDC) provides evidence-based guidelines so that healthcare practitioners can assess the safety of contraceptive methods for individuals with various medical conditions or characteristics (Curtis et al. 2016). The providers I interviewed reported screening patients for such contraindications and restricting certain methods when the risk of potentially life-threatening events — like blood clots, heart attack, and stroke — was elevated. For example, this nurse midwife drew a clear line about instances about when she refuses to prescribe hormonal contraceptives:

If you get somebody with a lot of illnesses -- the other day I had an older woman who smoked, had hypertension, high triglycerides -- there's not a whole lot of options. And I just had to come right out and say, "This is what I would give you for birth control and I won't give you anything else." (*Nurse Midwife 2*)

Providers commonly reported exercising this type of caution and restricting methods, especially those containing estrogen, for patients with a combination of risk factors like older age, smoking, and high blood pressure.

However, providers had a much wider range of responses when discussing those non-life-threatening side effects that are often reported by birth control users. Providers frequently framed side effects — especially those not verified by the medical literature — in terms of patient misconceptions. Many juxtaposed their formal medical knowledge and expertise with “myths”

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that patients derive from informal sources, including television, the Internet, and peers. Some also categorized patients’ past or current embodied experiences of side effects as unreliable. Occasionally, clinicians referred specifically to their reliance on “evidence-based medicine” as a counter to this informal knowledge. On the whole, interviewees believed addressing these myths is essential to their role as clinicians and viewed themselves as trustworthy, educational resources on whom patients can rely to sort through the confusing and contradictory information they encounter about birth control. For instance, this nurse practitioner said:

Myths are a big issue. Everyone thinks they're gonna gain weight using contraception. Everyone. And the reality is, weight gain happens, but it's usually not related to the birth control method. So we have to be mythbusters, that's a lot of what we do. (*Nurse Practitioner 1*)

Another nurse practitioner talked about the importance of educating patients who are upset when a method causes amenorrhea:

There are a lot of women that like to see their period. They wanna see it every month. That’s fine. You know...myths (*Nurse Practitioner 17*)

I argue that this emphasis on using formal medical knowledge to correct myths can create a tension in contraceptive counseling: while it can provide patients with important, factual information (for instance, the reason that some contraceptives cause amenorrhea), it also has the potential to create an adversarial relationship between clinicians and patients. In the process of correcting misconceptions, providers may simultaneously delegitimize those sources of knowledge that patients find most important in decisionmaking (Lowe 2005) or minimize their personal preferences. For instance, in the previous example, the nurse practitioner affirmed that it is “fine” for patients to prefer a monthly bleed, but also asserted that this preference is based on a “myth.”

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That tension also arose for this nurse practitioner when her patients reported weight gain from the pill: “We have patients [who say], ‘I can’t be on the pills, they all make me fat,’ even though evidence-based medicine says it won’t.” (*Nurse Practitioner 12*). In light of institutional medical knowledge, patients’ embodied experiences of weight gain appear unreliable. She continued to explain the difficulty of counseling patients who have reservations about multiple methods of birth control:

NP12: [They say,] “I can’t use the ring, because I’m not putting anything up there. No, I don’t want the shot, because I gain weight. I don’t want the IUD, because it’s unnatural having anything in my uterus.” You know, so for everything you come back at, there’s always something different.

LS: Do you think there’s anything behind that or do you think that they just really don’t like all the different methods?

NP12: I just think that they had misinformation from friends or whatever or that they went on the Internet and they’re reading stuff that isn’t really true.

(Nurse Practitioner 12)

In this provider’s view, patients’ reliance on informal sources of knowledge about contraception (personal experience and information from friends and the Internet) makes contraceptive counseling difficult, especially when patients become resistant to all medicalized forms of birth control. Though this nurse practitioner faulted misinformation, there is slippage here between beliefs that do not align with evidence-based medicine (that the pill will cause weight gain), patient preferences (not wanting to place and remove the ring from one’s vagina every month, finding the IUD unnatural), and beliefs that are *supported* by evidence-based medicine (that the shot can cause weight gain).

Another nurse practitioner was skeptical of the common reasons her patients discontinue birth control:

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NP10: The biggest one probably is irregular bleeding, mood disorder -- presumed mood disorder [...]

LS: Tell me about the presumed mood disorder. Why do you say presumed?

NP10: Well they just assume that their PMS-y type of symptoms are related to this new birth control pill.

(Nurse Practitioner 10)

Implicit here is that patients misattribute mood changes to the pill and that their embodied experiences are not reliable enough to distinguish between pre-existing symptoms and new instances of mood disorder. By contrast, from patients' viewpoints, hormones can have a real and significant effect: some users reported such extensive mood changes from hormonal birth control that they had difficulty managing their interpersonal relationships (Littlejohn 2013). The same nurse practitioner explained her process of managing patient complaints about side effects:

Most of them will come back and just say "I don't like it" and then you have to really get more information from them in terms of what they don't like and when it's occurring, so you can make an education change [...]. *(Nurse Practitioner 10)*

I read her focus on making an “education change” as a signal that she tries to counter patients' informal knowledge and preferences with formal medical knowledge. She said her education focuses particularly on correcting the misconception that “birth control may be a harm to their body.” However, she did not explain whether or how she ameliorates those side effects that patients dislike.

The nurse practitioner quoted below, who works at a university health center, also asserted that her patients misattribute side effects to contraception:

Weight gain really is not a true side effect of birth control [...] Most of the time it's actually, they're at that level where they decrease their activity and they increase their food intake and their beer intake and their weekend partying intake and *that's* what's leading to the “freshman fifteen,” not the birth control that you got started on. *(Nurse Practitioner 13)*

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The same nurse practitioner talked in detail about her own experiences using hormonal birth control and the difficulty of finding a method that did not cause nausea — she switched pill formulations multiple times and “felt like I had morning sickness for the first three months I was on pill packs.” Though she doubted that weight gain is a consequence, she affirmed “[...] there *are* a lot of side effects with birth control, especially if you have a very sensitive stomach, that’s the main thing.” Current epidemiological research cannot confirm that either weight gain or nausea is associated with hormonal birth control (Grimes and Schulz 2011). While this provider applied formal medical knowledge in the case of weight gain, it appears that she thought about the legitimacy of nausea through the lens of her own personal history. She went on to explain that she is particularly sensitive and understanding of patients who also experience nausea with hormonal birth control.

It is important to note that some providers in my sample did attribute side effects not verified by randomized controlled trials, like weight gain and mood swings, to hormonal birth control. For instance, the nurse practitioner quoted below categorized both side effects like weight gain and more serious risks as legitimate reasons to switch methods. She explained the common causes of patients discontinuing a method: “For instance, the birth control pill: headaches, bloating, weight gain, then, more seriously, elevated blood pressure.” (*Nurse Practitioner 18*). She listed these side effects without doubt or objection and addressed patient complaints by prescribing a different formulation of pill or suggesting a new method altogether.

Others prioritized patient preferences, whether they were grounded in formal medical knowledge or not. For example, this nurse practitioner explained her model of contraceptive counseling:

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NP14: I never prescribe where a patient's not comfortable or they're like "oh, geez, I don't know," because I know that's gonna be a failure. So, I'd rather go through what their preferences are and what their life is [...]

LS: And, ultimately after that type of education and counseling, they're usually able to find something that they can [use]?

NP14: Yeah, but I also tell them, “Look, you're not married to anything I give you. If you have side effects, there's somethin' else [...]”

LS: And then, do you get people who come back multiple times to switch?

NP14: Every once in awhile because, I think socially and their friends. Like "Oh, my friend said this pill was better than mine." Or [there's a difference between] what they think they want while they're in the office and then they experience it as not what they really want.

(Nurse Practitioner 14)

Here, patients' initial comfort level, their personal experiences using a method, and their peers' opinions are all legitimate criteria to consider in the selection and continuation of a contraceptive method.

4.2 “Stick With It”

In addition to dismissing patients' concerns and experiences about methods, when providers did acknowledge these issues, they sometimes employed a narrative that patients should tolerate negative side effects. Providers sometimes encouraged patients to “stick with it,” at least temporarily, in exchange for effective pregnancy prevention. One reason for this was providers' belief that most side effects would decrease or disappear within the first few months of use. This nurse practitioner explained that only a minority of her patients who struggle because of side effects have legitimate reasons:

I would say that people who have a lot of trouble finding a birth control method, only 20 percent of them truly have an issue. The other 80 percent, it's either because their friend told them it was bad or they don't give it enough time or they don't really stick with it or they're not taking it right. *(Nurse Practitioner 5)*

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Among those who do not have a true issue are users who do not “give it enough time” or “stick with it.” In this view, users should expect and be willing to endure side effects temporarily. Here, we also see another example of portraying informal knowledge (friends) as illegitimate and unreliable.

Another nurse midwife was more rigid in her expectation that patients continue contraception, particularly the IUD, despite side effects. She reports counseling new users: “I’m not removing this [IUD] for six months. No matter what happens. If it’s there and it’s doing its thing, remember, big picture, you don’t need to be pregnant [...]” (*Nurse Midwife 1*). She went on to explain her strategy of convincing patients to stick with IUDs:

They'll come back for their six week check and they say, "Well, I don't like this. I've been having bleeding every day since you put this in." I say, "Well that's what's to be expected. Remember our previous conversation? Okay? So this is the best choice for you at this time and we need to continue with this." Very often I can get by with that. (*Nurse Midwife 1*)

She minimized continuous bleeding as acceptable, because it is “expected” and because she has already communicated to patients that she will prioritize the IUD’s efficacy in preventing pregnancy “no matter what happens.” The assertion that the IUD is the “best choice for you at this time” foregoes the possibility that the patient may have re-evaluated her decision and priorities after experiencing a month and a half of bleeding. The declaration that “very often I can get by with that” communicates that the provider’s ultimate goal is for patients to continue IUD use (as opposed to, for example, alleviating symptoms or finding a more acceptable method); therefore, by changing a patient’s mind about removal, she has been successful. Because LARCs require a provider for removal, clinicians have the ability to pressure or even coerce patients to “stick with” these methods when they find complaints to be illegitimate.

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Others echoed the sentiment that side effects are to be expected with birth control use, as with this nurse practitioner who affirmed that weight gain is a side effect of Depo-Provera. However, she minimizes the importance of the contraception relative to her patients’ eating habits:

[...] People make choices all the time. You know, if you want to eat this, that's fine, but you're gonna gain weight. If you're on Depo [-Provera], and you're eating like a little friggin' pig, you're gonna gain weight and if you eat healthy food, you hopefully won't gain a whole lot of weight. (*Nurse Practitioner 12*)

Though evidence-based medicine does link Depo-Provera use to weight gain (Bahamondes et al 2001), here responsibility shifts to individual women to engage in healthy diets and mitigate its effects; if they do not, they can be criticized for their lack of self-control.

While addressing her patients’ concerns about hormones, another nurse practitioner portrayed side effects as inherent to *all* contraception:

I have a large population of patients that are like, "Well, I want all-natural." [...] I think that they think that if something is non-hormonal, there will be no side effects. That the only side effects come from hormones. And that's a misconception [...] I was talking to a patient yesterday about birth control and I said, "You know what? There's nothing free in the world. Even your non-hormonal IUD, it's not nothing. There's gonna be side effects to everything. What we're choosing is, what are the side effects that you can deal with best?" (*Nurse Practitioner 7*)

Here, side effects are part of the “price” of pregnancy avoidance. In this way, she encourages her patients to change their thinking from ‘How can I avoid side effects?’ to ‘Which side effects can I accept?’ With this re-framing, the nurse practitioner can correct what she sees as a misconception: that non-hormonal contraception is less physically burdensome than contraception with hormones.

Although the above provider is resigned to the idea that every birth control method will

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have side effects, this nurse practitioner pushed back against the notion that her patients should have to make serious trade-offs when contracepting. She often finds patients cycling through multiple methods without finding one that is acceptable, explaining:

I wish I could make a birth control pill that you didn't have to take quite as often...see, that's the double-edged sword of the birth control pill right now is that it's a lower dose, so they don't have a lot of breast tenderness and they don't have the headaches and they don't have the weight gain. But then the compliancy is more strict, they have to take it every 24 hours [...] I wish they could make a pill that had a little bit better leeway [...] If somebody devised even a *new* method, could keep looking for more and more methods. (*Nurse Practitioner 17*)

This provider acknowledged a number of adverse effects of the pill, including weight gain. Yet, her frustration was not directed towards the women who do not accept the trade-off; instead she directed it towards the insufficiency of the technologies themselves.

4.3 Race and Class in Counseling

In a few instances, providers drew on racialized and classed discourses to describe their patients' resistance to certain contraceptive methods, especially those containing hormones. According to the providers, sometimes these patients expressed concerns specifically about side effects related to hormones and sometimes patients held a general dislike of hormones. In these examples, two broad “types” of patients emerged: patients who rejected these methods because they were uneducated or irresponsible and those who rejected them because they were *too* educated and selective. As I describe below, race and class were integral to building these two patient types.

The first patient type is a woman who rejects contraception because of an ignorance of formal medical knowledge about the safety and mechanics of birth control and/or because she holds an ambivalent attitude about pregnancy prevention. In providers' descriptions, I found

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subtle or explicit references to race and class that mark these patients as minority and/or of low-socioeconomic status. Like nurse practitioner 17 quoted above, a number of providers portrayed their patients’ dislike of menstrual suppression as a preference based on misconceptions. One nurse midwife, who works in a clinic with mostly Latina patients on the United States-Mexico border, echoed this and explained how she counsels her patients about why this side effect should be perceived as harmless:

One of the barriers, one of the problems we have with family planning down here is through cultural superstitions and beliefs [...] like, with [some hormonal methods], sometimes you stop menstruating, and that's a bad thing to some people. [...] That] you're not cleaning yourself [...] and so they've got their aunts and grandmas saying, "Oh that's not good. You have to have a period every month" and I try to explain to them and go through and show them the reason nothing's coming out is because your body's not making anything to come out and explain all that, very simply. (*Nurse Midwife 2*)

The language here, that patients’ beliefs about menstruation are “cultural superstitions” fueled by “aunts and grandmas” that need to be explained away “very simply,” suggests that patients’ beliefs are a matter of ignorance and poor education. The nurse midwife also evoked this dislike of amenorrhea as a racialized problem, identifying the cultural superstitions as specific to the border region where she works.

A number of providers also expressed confusion or exasperation when patients desired to avoid hormones altogether and rely on less effective non-hormonal methods or use no contraception at all. This nurse practitioner described two recent patients who wanted to discontinue hormonal contraception:

Unfortunately, they were both African-American and they wanted to quote unquote give their bodies a break and I said, "Well, if you get pregnant, are you okay with that?" And they go, "Yeah." They are. They may or may not have a successful job. (*Nurse Practitioner 10*)

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Here, pregnancy prevention becomes a primary goal over and above a negative feature of birth control, even when patients are okay with pregnancy. First, this provider expressed disapproval of the patients’ belief that they should not use hormones continuously and that one’s body might need “a break” from medicalized contraception. I read her use of “quote unquote” to indicate that this belief is not supported by her medical knowledge. Second, she expressed disapproval of their openness to pregnancy, particularly because they may not be employed. I interpret the use of “unfortunately” with the mention of the patients’ race as signifying both that the provider found their actions regrettable and that she found it distasteful to stereotype patients based on race, but unfortunately believed it was fitting in this case. Here, stereotypes about race and class manifest in anxieties that run deep in American discourse: that black women’s fertility is uncontrolled, that they are financially irresponsible, and that they cause cycles of poverty by having children while poor (Gordon 2002; Roberts 1997).

Another nurse practitioner talked about serving patients who participate in Job Corps, a federally-funded program for low-income young people to complete high-school education and job training. She reported that some of these patients want to discontinue birth control because of side effects while expressing uncertainty about the prospect of getting pregnant:

So, here they are going back to school, they've gotten into this program [Job Corps] and I'll say, "Where does that leave your career goals if you get pregnant right now? And how badly do you not want to get pregnant? Or how badly *do* you want to get pregnant?" And they'll go, "Well, I don't know. I don't really wanna use this because of that [...]" That's another person, too [...]. They'll make an excuse for every single method. About why they don't want it and why they don't like it...they can't take hormones or they don't wanna take hormones. [...] (*Nurse Practitioner 17*)

Although this nurse practitioner was more open to supporting patients who do want to get pregnant, she still connected this group of low-income patients’ ambivalence about pregnancy

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prevention and concerns about hormones back to their job prospects. Her initial question, “where does that leave your career goals [...]?” indicates that disadvantaged young people who are on path to social mobility should be particularly concerned about pregnancy prevention.

The second patient type emerges as a woman who rejects or fears hormonal contraception, because she is highly educated. In these examples, providers did not make explicit references to race, but I interpret the emphasis on education as a marker of the patients’ perceived high socioeconomic status. The following two providers also talked about the difficulty of counseling patients who want hormone-free birth control:

I mean, I don't know if it's prissy or not prissy [...] I have a patient who doesn't want anything with chemicals in her body. She doesn't want anything unnatural in her body. So that leaves out a lot of contraception. (*Nurse Practitioner 12*)

I have a patient who's very intelligent and who's had an unintended pregnancy before and who I've done a termination on before who calls me panicked periodically, because she only wants to use condoms and the condoms fall or break off and she doesn't wanna take the emergency contraception, because she doesn't like the use of hormones. So you know sometimes there's a little *overly* intelligent unintended pregnancy failures [...] (*Medical Doctor 3*)

Here, providers depicted women’s concerns about hormones as “prissy” or “overly intelligent.” Allusions to the “natural” also evoke well-educated, often white, women who reject mainstream medical advice to maintain their lifestyles (see Bobel 2002). This patient-type, typically portrayed as compliant contraceptive users, becomes problematic when they want to avoid hormones. In the second case, they are especially problematic when their reliance on less effective methods leads them to experience unintended pregnancies and seek abortions.

Another nurse practitioner said her educated patients, in particular, become overly concerned with birth control risks and side effects:

[...] then there comes a certain point when a lot of our patients, especially

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educated patients, become completely paranoid and they get fixated on the package insert [...] then they turn to this sort of crazy ruminator. (*Nurse Practitioner 1*)

As with this the previous two examples, patients’ education becomes problematic when it causes them to fear hormonal contraception. This is also an interesting counter-example to juxtaposition of formal and informal medical knowledge I have described previously. In this instance, the provider worried that patients focus too much on the reference material provided by pharmaceutical companies — arguably a formal source of medical information.

These explicit and implicit references to race and class when discussing resistance to or dissatisfaction with hormonal contraception were relatively infrequent. Nevertheless, they illustrate how broader social discourses may enter into clinical thinking about patients’ relationship to medical technologies like birth control.

5. Discussion

Women using provider-prescribed forms of birth control commonly report dissatisfaction and negative side effects, especially from those methods containing synthetic hormones. (Brunner Huber et al. 2006; Littlejohn 2013; Moreau et al. 2007). At the same time, research drawing from patient surveys and observations of clinical interactions suggests that clinicians often neglect to discuss or discursively downplay the importance of side effects in contraceptive counseling (Dehlendorf et al. 2014; Littlejohn and Kimport 2017; Minnis et al. 2014). Here, I use interviews with reproductive healthcare providers to explore how their attitudes and beliefs may contribute to this minimization patient concerns and dissatisfaction. I find that many clinicians portrayed patients’ dissatisfaction as based in “myths” and “misconceptions” that can be corrected with formal medical knowledge. A number also recounted encouraging patients to

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“stick with” a method despite negative side effects. In a few instances, providers drew on race- and class-based stereotypes when making these claims.

Clinicians’ tendency to portray formal medical knowledge as more authoritative than those informal sources patients often turn to makes sense in light of dominant medical paradigms, especially the contemporary emphasis on evidence-based medicine (Timmermans and Berg 2010). This paradigm can have the effect of disadvantaging those women whose experiences are not legitimated by evidence-based medicine. Historically, women’s embodied experiences have been cast as incredible and unreliable sources of knowledge (Kempner 2014). Despite its marginalization, lay, embodied knowledge has been crucial in challenging existing medical and scientific paradigms (Brown et al. 2004). The recognition and legitimation of women’s embodied experiences, particularly in relation to reproduction, was a central goal of the women’s health movement in the United States and helped, for example, to document the dangers of synthetic diethylstilbestrol (DES) and the first-generation contraceptive pill (Morgen 2002).

The recommendations to “stick with” a method of contraception despite negative side effects illuminate the physical burdens of the unequal, gendered responsibility for reproduction. The burden of fertility management, including pregnancy prevention, falls heavily on women (Daniels 2006; Kimport 2018). The idea, for example, that “there’s nothing free in the world” with birth control squares with the cultural notion that women are responsible for contraception and must make sacrifices in exchange for protection from pregnancy. Women’s discomfort – their bleeding, weight gain, depression – is minimized in relation to a state of non-pregnancy. Yet, there is something “free” for the heterosexual men whose partners bear the physical effects

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of birth control, as they do not have to choose among the side effects they can best cope with.

Though providers did not explicitly talk about weighing side effects against contraceptive efficacy, the themes I describe here form a pattern in the aggregate whereby providers minimize patient concerns and dissatisfaction, particularly concerning those methods ranked most highly in the WHO tiered-effectiveness model of contraceptive counseling (WHO 2007). In effect, if providers downplay patient concerns about highly effective methods, they may silence discussion about less-effective methods that patients may find more acceptable and less physically burdensome. (Downey et al. 2017; Kimport 2018; Lessard et al. 2012) Importantly, research has documented how the most effective methods – LARCs – also have the potential to be coercive, because they require a medical procedure for removal (Higgins 2014; Roberts 1997). In some cases, providers have resisted or even refused to remove devices upon request, effectively restricting a woman’s autonomy to control her own fertility (Stevens 2015; Hoggart et al. 2013). When providers prioritize continuation of a method over patient concerns they may, intentionally or not, continue this broader legacy of medical paternalism and reproductive coercion.

Pregnancy prevention is a formidable goal when it matches the priorities of patients, but previous research shows that a significant number of women describe unexpected pregnancies as positive and wanted (Aiken et al. 2015; Higgins et al. 2012), indicating that healthcare providers should be careful to assess their patients’ goals and values rather than assuming that pregnancy prevention is a priority. Here and elsewhere (Stevens 2015), I have documented instances of providers’ discomfort when their low-SES and minority patients express ambivalence or openness towards pregnancy. In this paper I highlight how the emphasis on pregnancy

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prevention can be classed and racialized, and further exploration of these dynamics should be a concern for future research, given the history of contraception as a tool for population control (Gordon 2002) and contemporary disparities in family planning care (Dehlendorf et al. 2010). Overall, the findings here demonstrate how women’s embodied experiences are often not legitimized in contemporary medicine and this legitimacy may be even further out of reach for marginalized women.

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Table 1: Characteristics of Interviewees

	N (24 total)
<i>Provider Gender</i>	
Female	22
Male	2
<i>Provider Race</i>	
White	19
Black or African-American	2
Asian or Pacific Islander	1
Hispanic	1
Unknown	1
<i>Provider Type</i>	
Certified Nurse Midwife (CNM)	2
Nurse Practitioner (NP,DNP, or PhD in Nursing)	19
Medical Doctor (MD)	3
<i>Type of Insurance(s) Accepted at Most Recent Practice</i>	
Private Insurance Only	7
Private Insurance and Medicaid	8
Private Insurance, Medicaid, and Uninsured	9
<i>Geographic Region</i>	
Northeastern U.S.	18
Midwestern U.S.	1
Southern U.S.	3
Western U.S.	1
Abroad	1