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Provider Characteristics Desired by African American Women in Prenatal Care

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Abstract

Purpose—The purpose of this study was to describe provider characteristics African American pregnant women identified as important when interacting with their prenatal care providers in an outpatient office setting.

Study Design and Method—A descriptive qualitative design was used to explore provider characteristics desired by African American women receiving prenatal care at two inner-city hospital-based obstetric clinics. A total of 22 African American women between the ages of 19 and 28 years participated in the study.

Findings—Four major provider characteristic themes emerged from the data: (a) demonstrating quality patient-provider communication, (b) providing continuity of care, (c) treating the women with respect, and (d) delivering compassionate care.

Discussion and Conclusion—An overarching theme revealed by the data analysis was the desire by African American women in this study to have their prenatal providers *know* and *remember* them. They wanted their providers to understand the context of their lives from their prenatal interactions. Incorporating findings from this study to improve patient-provider interactions during prenatal care could provide an increased understanding of the many complex variables affecting African American women's lives.

Implications for Practice and Research—Prenatal care provides an opportunity for African American women to develop a trusting relationship with a provider. Developing models of prenatal care congruent with the realities of African American women's lives has the potential to improve patient-provider interactions and potentially affect birth outcomes.

Keywords

maternal/child; transcultural health; women's health; focus group analysis; African American

Introduction

Prenatal care plays an important part in ensuring healthy pregnancy outcomes. After the seminal 1985 Institute of Medicine (IOM) report highlighting the relationship between prenatal care utilization and low birth weight (LBW), the leading cause of infant mortality, there has been a nationwide public health effort to increase access and availability of

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prenatal care through expansion of Medicaid for low-income pregnant women and children (Alexander & Kotelchuck, 2001; Lu, Tache, Alexander, Kotelchuck, & Halfon, 2003). As a result, prenatal care utilization has risen steadily for all women (Kogan et al., 1998; Martin, Kochanek, Strobino, Guyer, & MacDorman, 2005). Despite this rise in prenatal care, the rate of infant mortality for African Americans remains twice as high as Whites (Hoyert, Mathews, Menacker, Strobino, & Guyer, 2006). Thus, controversy exists in the effectiveness of prenatal care in reducing infant mortality for African American women (Alexander & Kotelchuck, 2001; Lu et al., 2003) and requires further examination of what actually occurs during prenatal care.

The purpose of this study is to describe the provider characteristics that African American pregnant women desired when interacting with their prenatal care providers. The results provide prenatal care providers with a deeper understanding of African American women's perceptions of the clinical encounter as well as recommendations to deliver culturally congruent care, increase meaningful communication, and improve quality of care.

Review of the Literature

A key to successful health care encounters is the quality of the patient-provider relationship. Positive patient-provider relationships as characterized by effective communication skills, respect, and trust have been associated with higher patient satisfaction (Beach, Hill-Briggs, & Cooper, 2006; Benkert, Peters, Clark, & Keves-Foster, 2006; Korenbrot, Wong, & Stewart, 2005; Saha, Arbelaez, & Cooper, 2003). However, studies show that African American women perceive interpersonal barriers with their prenatal providers (Moore, Ketner, Walsh, & Wagoner, 2004; York et al., 1999) and differences in communication have been evident among African American patients in primary care settings. Providers were more verbally dominant, used less patient-centered communication, and exhibited lower positive affect with African American than with White patients (Cooper-Patrick et al., 1999; Johnson, Roter, Powe, & Cooper, 2004). Providers were also more likely to adopt a "narrowly biomedical" communication style with African Americans and poorer patients (Roter et al., 1997).

Despite the importance of the patient-provider relationship, few studies have examined qualities that African American women desire in a prenatal care provider. Handler, Rosenberg, Raube, and Lyons (2003) found that African American women were more satisfied with prenatal care when providers engaged them by asking and answering questions, explaining procedures, and spending more time with them. Other studies on what women expect from providers have been completed but have not focused on pregnant African American women (Carr-Copeland, Hudson-Scholle, & Binko, 2003; Houle, Harwood, Watkins, & Baum, 2007) or reported the race of the pregnant women (Douglas, Cervin, & Bower, 2007). Given the opportunity that prenatal care presents to intervene with pregnant women, it is important to examine the qualities desired in a prenatal provider in order to improve the patient-provider relationship and overall quality of prenatal care.

Method

A descriptive, qualitative study design was used to explore pregnant African American women's perceptions of the prenatal care encounter and to identify provider characteristics desired by African American women in prenatal care. Focus group interviews were selected as the data collection strategy because of the type and range of data generation being sought. Focus groups allow for rich data collection in part because of the social interaction and synergy of group members (Thomas, MacMillan, McColl, Hale, & Bond, 1995).

Institutional review board approval for the research was obtained from the investigators' institution and the two health systems where the focus groups were conducted.

Procedures

A convenience sample of 22 African American pregnant women between the age of 18 and 35 years, with at least two prenatal care visits, were recruited from two inner-city hospital-based obstetric clinics. Both hospitals serve a large African American population. To assist with recruitment and minimize staff burden, flyers were posted in the waiting rooms of the two clinics in southeastern Michigan with a toll-free number for patients to call if they were interested in participating in the study. Additionally, a research assistant (RA) and clinic staff handed out flyers in the clinics. Women interested in participating were given information about the study from one of the investigators by phone or in person in a private area within the clinic. The place and time for the focus group discussions was provided and women were told they would receive a cash incentive following the interview.

Data Collection

Prior to data collection, informed consent and confidentiality statements were obtained from participants and a demographic questionnaire was completed. Three focus groups were held in a private space near the prenatal clinics. Group size varied with two groups of 5 and one group of 12. The focus group sessions lasted 60 to 90 minutes and were led by the investigators with the assistance of the RA. A semistructured interview guide was used that included questions on perceptions of the prenatal care interaction. Examples of focus group questions and probes from the interview guide include (a) "Tell me about your past experiences with your prenatal care. What did you like about your visit? What did you dislike about your visit? What parts of the visit do you think need to be changed or improved?" (b) "Tell me about your interaction with your health care provider. What did you discuss during your visit? What would you have liked to discuss that wasn't? Tell me how you were treated. Did you feel you were treated with respect? Why or why not? How would you like your provider to treat you? What would you tell other women or close friends about your provider? What kind of 'vibes' do you get from your provider?"

The research team consisted of the three investigators (one Asian American and two Caucasians) and one African American RA. The RA and one investigator took notes and monitored the recording equipment while another investigator asked the interview questions and facilitated the focus group.

Fontana and Frey (2007) describe "empathetic interviewing" as an active technique that promotes a partnership between the researcher and the participant. The researchers developed a rapport of open communication at the onset of the focus groups to provide an atmosphere for the women to feel comfortable to express their experiences and thoughts related to the prenatal care encounter. The methods for developing understanding and empathy, as described by Davis and Dodd (2002) were used to uphold trustworthiness in data collection. This included providing a nonthreatening, confidential environment for all interviews. Participants were assured the sole purpose of the research was to understand and not appropriate blame because of the sensitive nature of the context. This approach centers on acceptance of experiences as presented by the women giving voice to a population often marginalized or silenced by the majority.

Data Analysis

Data analysis was guided by the research question, "What characteristics do African American women desire in their prenatal care provider in an outpatient setting?"

Glaser's constant comparative method of analysis (Glaser, 1978, 1992) was used to identify patterns or themes related to provider characteristics the participants perceived strengthened the patient-provider relationship and improved the quality of the interaction during the prenatal encounter. The research team analyzed the data separately and then together at team meetings until common themes emerged. First, the transcripts were read and reread line-by-line, and open coding was conducted to identify characteristics the African American women desired in their prenatal care providers. Over the three focus groups these codes were compared, then assigned to categories that appeared to cluster together and finally into common themes to explain the data. Data were discussed until agreement was reached and an audit trail was maintained to documented decisions throughout the process. Additionally, an environment of reflexive self-examination of our own biases and assumptions was upheld as a continual effort to ensure trustworthiness.

Findings

A total of 22 African American pregnant women between the ages of 19 and 28 years who had at least two prenatal visits participated in the study. Parity and gestational age varied among the participants with the majority of women (68.4%) in their third trimester with two or three living children. Seven (31.8%) women worked full-time whereas eight women (36.4%) stated they were unemployed. The remainder worked part time or listed their occupation as student. The majority (86.4%) of participants listed Medicaid as their primary insurance coverage.

An overarching theme revealed by the data analysis was the desire by African American women in this study to have their prenatal providers *know* and *remember* them. They wanted their providers to understand the context of their lives from their prenatal interactions. Four themes relating to prenatal provider characteristics facilitated the process of knowing and remembering as described by the women in this study. They included (a) demonstrating quality patient-provider communication, (b) providing continuity of care, (c) treating the women with respect, and (d) delivering compassionate care.

Demonstrating Quality Patient-Provider Communication

Women perceived that quality patient-provider communication included providers listening actively, asking questions, and explaining diagnoses and procedures clearly. Overwhelmingly, women wanted someone who would listen to and acknowledge their concerns. Women perceived competence in their provider when the provider listened to them.

She [the provider] made you feel comfortable ... one by listening ... because she listens, you relax. She's very confident in her skills. It's not her being aggressive. She's willing to listen to what your problem is and then she'll say let me check and then she does. Part of being a good provider is listening to what we're saying.

One woman who previously delivered two preterm infants felt her providers never listened to her.

My two children with my husband have been premature, have been sick. They have had surgeries for this and that. I say [to my provider] I want you to take care of me in this. But you're not listening. But this is the point when the doctors are not listening. The nurses are not listening. You're not hearing what I am saying.

Providers asking psychosocial questions led to increased comfort level, which increased disclosure of personal information. For instance, one woman described how her provider was able to ease her anxieties over her first prenatal care experience.

I was scared. Because I wasn't sure I'd be a good mother. She [provider] asked me personal questions that made me feel comfortable enough to answer them. I opened up to her and it made me feel comfortable being pregnant and helped me to overlook my fears.

I want my [provider] to ask me questions. Because if you're not asking me questions, then I feel like you don't care about what's going on with me.

Women also desired to receive information that was clearly communicated in language they could understand. One woman said, "My [provider], she doesn't use huge medical terminology. Use layman's terms and explain why you are getting a colposcopy while you're pregnant." Another woman who was going through depression stated, "My [provider], she talks to me. She cut the whole [provider] talk. She stopped and talked to me and got to the point so that I felt better."

Providing Continuity of Care

The women in the focus groups also stressed the importance to them of being able to see the same provider at each of their subsequent prenatal visits. Having to repeat their health history and building a relationship with a new provider at each visit was viewed negatively by the participants. One woman described,

I like coming here because I see my same [provider]. Every time (before) I went to prenatal care, it was a different [provider], and I really cannot stand that because you couldn't get personal with them because it was a new face every time you came. And I go to (the other clinic) and they ask the same questions all over again. And you're like; if you guys wouldn't stop switching my [providers], if I wouldn't see a different [provider] every time you would know this.

Women who were able to see the same provider at subsequent visits during the pregnancy were more satisfied with their prenatal care. They expressed being able to establish a trusting relationship with their provider and to accomplish more at each of their visits because they did not have to constantly repeat portions of their history to each new provider.

Treating Women With Respect

Women wanted to be shown respect by their providers. They gave examples of the provider who walks into the room, does not make eye contact and goes directly to the chart. They wanted to be acknowledged and to be heard when they expressed concerns about their health or asked questions. Women often felt their questions went unanswered or were not valued by their providers.

Let's say you're in the room and you're going through depression. The [provider] comes in and you tell her what you're feeling, (she) writes it down, and then she straight up goes for the next situation. She pays no attention to what you're basically saying, and you will leave out of there and you still feel the same.

Delivering Compassionate Care

Delivering compassionate care involved making the women feel "comfortable" and not judged during the prenatal visit. Women stated being more comfortable with their provider facilitated disclosure of sensitive issues. Characteristics of providers that made women feel comfortable included coming into the exam room with a smile, maintaining eye contact and asking a simple question of how are you doing today. One woman described how her provider made her feel "comfortable."

Some [providers] where you just feel an automatic warmth when you start talking. So they come in, "Hi, how are you?" Some break the ice and say a little

joke. It's all about the vibe you get when they come in the room. You get a pleasant type of vibe when you know that they respond and they want to help you and your child.

The women also talked about the need for providers to display a nonjudgmental attitude. Women were sensitive to being judged by the providers and the staff at the clinics.

So you don't know, treat me the same way you would want to be treated if you was sitting on this table ... be honest. Don't come in here mad. Because you do have some [providers] say, "Why are you having another? How many kids is that?"

Discussion

Women in this study overwhelmingly wanted to establish a close relationship with their prenatal care providers. They expressed a desire to have more trusting relationships with providers that fostered an understanding of the complexities of their lives. Women wanted providers to communicate clearly; deliver care compassionately, nonjudgmentally and with respect; and provide continuity of care. Our results are similar to Bennett, Switzer, Aguirre, Evans, and Barg's (2006) findings that effective patient-provider interactions that motivated African American women to use prenatal care were characterized by clarity, continuity of care, trust, and a close patient-physician relationship.

Women in the focus groups described quality patient-provider interactions when providers listened, asked questions, and provided clear explanations. This is consistent with other research studies with African American pregnant women. For African American women, prenatal care characteristics predictive of satisfaction included provider communication, length of time spent with the client (>15 minutes), receiving care at an urban clinic, and having spent shorter time in the waiting room (<30 minutes; Handler et al., 2003). Bennett et al. (2006) found that pregnant African American women viewed their relationship with providers as partners in which a reciprocal exchange of questions and answers flowed "easily, accurately and completely."

Participants in our study expressed prior negative interactions with providers in which they were judged and treated with disrespect. This is consistent with quantitative survey findings that African Americans were four times more likely than Whites to perceive discrimination in medical settings, more likely to mistrust health care systems (LaVeist, Nickerson, & Bowie, 2000) and believed they received lower quality of health care compared with Whites (Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000). Specifically, in a cross-sectional survey of young (aged 18-39 years), healthy African American women, Watson, Scarinci, Klesges, Slawson, and Beech (2002) found African American women were less likely to talk to someone when treated unfairly and perceived more discrimination at every education level than White women.

Other studies have shown the significance of treating patients with respect. For instance, an important priority for primary care among low-income African American women included being treated with concern and respect by providers (Cricco-Lizza, 2006; O'Malley, Forrest, & O'Malley, 2000). Similarly, among a national sample of African Americans, providers treating patients with respect was the greatest predictor to overall satisfaction (Saha et al., 2003).

Providers displaying caring nonverbal and verbal behaviors such as making eye contact, smiling, and asking questions were identified as interpersonal provider qualities the focus group participants desired. This is consistent with other studies showing the positive effects of displaying concerned nonverbal behaviors. When providers made eye contact, leaned

forward, used an expressive tone of voice, smiled, and had an open posture, greater patient satisfaction resulted (Aruguete & Roberts, 2002; Griffith, Wilson, Langer, & Haist, 2003).

Implications for Practice and Research

Prenatal care is often the first encounter as an adult a woman has with the health care system. It provides an opportunity to develop a trusting relationship with a provider, to promote a healthy lifestyle and to integrate positive health behaviors. Prenatal care also serves as a bridge to connect women to other health care services such as social work, nutrition consultations, and the Women, Infants and Children program. During prenatal care, provider behaviors can influence the woman's acceptance of treatment regimens, develop patient trust, and set the stage for future interactions with the health delivery system.

There is increasing evidence that many of the determinants of health disparities are not medical but rather social or contextual in nature. If the health and well-being of the individual and community does not improve with equitable access and utilization we must look for a breakdown in the environment by other contributors to disparities. Developing models of prenatal care congruent with the realities of African American women's lives can contribute to the improvement of patient-provider interactions and potentially affect birth outcomes.

Nurses are well positioned to influence how women experience the prenatal care encounter. Incorporating findings from this study to improve patient-provider interactions during prenatal care could provide an increased understanding of the many complex variables affecting African American women's lives. Improved patient-provider interaction supports pregnancy as a normal, healthy part of a woman's life, focusing on the need for information and education, and dispels the biomedical belief model of pregnancy as an illness. By ignoring the importance of this interaction we reinforce many of the negative attitudes and feelings women may have about prenatal care and contact with the broader health care system.

Results of this study contribute to a limited body of knowledge on provider characteristics that influence African American women's interaction with their health care provider during prenatal care. Findings from this study are consistent with the theme of attentive listening described by others (Bennett et al., 2006; Mann, Abercombie, DeJoseph, Norbeck, & Smith, 1999; Moore et al., 2004). Our work expands these findings with identification of provider characteristics that facilitate interaction during the prenatal encounter.

In the current health care environment of shortened prenatal visits and increased technology, nurses and other health care providers can improve communication with women attending prenatal care by being cognizant of the provider characteristics valued and sought out in prenatal care. Until we address the self-identified needs of African American women of childbearing age, disparities in pregnancy outcome and the effectiveness of prenatal care will remain one of our most elusive public health problems.

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