Published in final edited form as:

Acad Pediatr. 2012 September ; 12(5): 399–404. doi:10.1016/j.acap.2012.06.003.

African American Parents' Trust in their Child's Primary Care Provider

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Abstract

Objectives—Patients' trust in their primary care providers has important implications in terms of health outcomes and, among minority patients, mitigating racial health disparities. This study aims to identify family, provider, and health care setting characteristics that predict African American parents' trust in their child's primary care provider and whether provider partnership building communication style explains this association.

Methods—Data were collected via retrospective telephone interviews completed 2 weeks after a child's health care visit to one of seven pediatric primary care clinics in Washington, DC (3 community health centers, 3 private practices, and 1 hospital-based clinic). 425 self-identified African American parents of children 0–5 years of age participated. Parents completed several standard survey instruments about trust and provider communication style as well as demographic questionnaires about their family and their child's provider.

Results—A step-wise linear regression revealed significant independent effects of having a previous relationship with the provider and seeing a provider in a community health center (CHC) on higher trust. There was also evidence of mediation by provider communication style,

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Funding Disclosure: This study was funded by the National Center for Research Resources grant K12 RR017613 awarded to Dr. Horn. None of the authors have any conflicts of interest to disclose.

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suggesting that parents who take their child to a CHC report greater trust in their child's provider because they have higher perceptions of provider partnership building.

Conclusions—African American parents' trust in their child's provider may be enhanced by continuity of care and greater use of a partnership building communication style by providers.

Keywords

parent-provider communication; trust in provider; African American

Introduction

Despite evidence that parents' trust in their child's provider may enhance child health outcomes,^{1–45} few studies have examined parents' trust,⁶ particularly in minority families. It is important to examine trust among African American parents because this patient population's mistrust of the medical system is generally higher than other racial/ethnic groups,^{6–10} and African American children experience poorer health outcomes (e.g., higher asthma rates) than Whites.^{11–13} This study aims to identify modifiable correlates of African American parents' trust in their child's primary care provider, which may suggest targeted interventions for improving health outcomes and reducing racial health disparities¹⁴ by increasing levels of trust.

While there is some conceptual overlap between patient trust and provider communication,¹⁵ researchers have posited that partnership-building aspects of providers' communication style engender trust,^{16–21} which, although not consistently agreed upon by researchers, can be defined as “the optimistic acceptance of a vulnerable situation in which the trustee believes the trustor will care for the trustee's interests” (p. 295).²² In the current study, we define trust as a parent's belief that the pediatric healthcare provider has their child's best interest in mind. We will specifically examine the association between primary care providers' partnership building communication style and parents' trust because such a participatory communication style has been linked to parent satisfaction with their child's healthcare and likelihood of carrying out prescribed treatment.^{23, 24}

In so doing, we extend our previous research on partnership building, which identified parents' education and provider practicing in a community health clinic (CHC) as having significant independent effects.²⁵ In the current study, we test whether the family and healthcare setting characteristics that predict providers' partnership building – parent education and provider practice setting – in turn predict increased parental trust. We will also explore family, provider, and healthcare setting characteristics that have previously been linked to qualities of patient-provider relationships. Among low-income and/or minority patients, there is evidence of positive associations between patient education,²² income,¹⁷ and child age⁶ with trust in providers. Also, continuity in the patient-provider relationship and visit length have been consistently linked with increased trust.^{2, 9, 18, 19, 26} To summarize, this study examines how family and provider/setting characteristics are associated with African American parents' trust in their child's primary care provider, specifically testing associations of characteristics previously shown to predict provider's partnership building. We hypothesize that partnership building mediates the association between these variables and trust.

Methods

Participants

A telephone survey was conducted with a sample of 425 self-identified African American parents of children 0–5 years of age recruited from seven pediatric primary care sites in

Washington, DC between May 2004 and March 2006. Three recruitment sites were CHCs, three were private practices, and one was a hospital-based primary care clinic.

Survey participation was limited to English speaking parents. To reduce the likelihood of confounding effects, children with parents or grandparents born outside the mainland U.S. (i.e., Puerto Rico, Dominican Republic, Africa) were excluded because interactions in medical settings may differ based on ethnic background and immigration status. In addition, parents of children with special health care needs, previously identified behavior problems, or an illness requiring care by more than one sub-specialist or ever requiring more than one hospitalization were excluded to prevent bias due to greater reliance on the healthcare provider for discussion of medical, behavioral, and psychosocial issues.

Procedure

The Institutional Review Board at Children's National Medical Center approved and monitored this study. Information sheets were given to parents at the seven recruitment sites by a designated staff person or displayed in a prominent location. Parents interested in participating ($n=748$) filled out an information sheet and placed it in a locked box. Research assistants collected information sheets from each site weekly and successfully contacted 606 (81%) parents by phone to screen them for eligibility. Of those screened, 78% ($n=472$) were eligible for the study, and 90% of eligible parents ($n=425$) completed the 20–30 minute structured telephone interview. During the interview, verbal informed consent was obtained, and parents were instructed to respond based on their interaction with the provider (all of whom were pediatricians or pediatric nurse practitioners) at the most recent visit that they attended with their child.

Measures

Trust in provider—Parents' trust in their child's provider was measured using a modified version of the Interpersonal Trust in a Physician scale,²⁷ originally developed to assess patient trust in primary care relationships (including with non-physicians). The scale consists of 10 items (e.g., "You completely trust your doctor's decisions about which medical treatments are best for you.") which were modified by substituting the phrases "my child's doctor" for "my doctor" and "my child" for "me". Parents responded using a 5-point Likert scale (range of total score: 10–50), and the internal consistency in this sample was good (Cronbach's $\alpha = .88$).

Provider partnership building—Parents completed the partnership-building subscale of Street's Provider Communication Style Instrument,²⁴ modified to be appropriate for well child visits. Participants responded to 3 items ('The doctor encouraged me to express my concerns and worries,' 'The doctor asked for my opinion on what to do about my child's health/development,' 'The doctor asked for my thoughts about my child's health/development') using a six-point Likert scale from strongly disagree to strongly agree, thus scores could range from 3–18. The internal reliability in this sample was good (Cronbach's $\alpha = .74$). Partnership building scores in this sample were negatively skewed ($M = 15.04$, $SD = 3.76$), raising concerns with using the continuous scores in our analysis because each one-point increment in scores may not correspond to meaningful differences in parent perceptions of provider partnership building. We identified two easily characterized groups (see Table 1): those who disagreed with at least one of the three items (31.4%) and those who agreed strongly with all three statements (40.2%), leaving an intermediate group that, while not disagreeing with any of the three statements, expressed less than uniformly strong agreement (28.4%). This three-level categorization of partnership building (low, high, and moderate, respectively) is used in subsequent analyses.

Family characteristics—Parents' self-reported highest level of education was categorized as less than a high school diploma, high school degree, at least some college, and post-bachelors degree. Annual household income was reported on a seven-point ordinal scale from < \$10,000 to \$100,000; we used mid-point dollar amounts to represent family annual income.²⁸ The 2006 HHS Poverty Guidelines²⁹ were used to derive the appropriate poverty threshold for each family based on self-report of the number of people in their household. We divided each family's annual income by their respective poverty threshold to calculate percentage of poverty. The 150% of poverty cut-off was used to create poverty status categories because it is a common standard for Medicaid eligibility.³⁰ We also included several family demographic characteristics as covariates: parent's number of biological children, marital status (married/single), parent age in years and child age in months (calculated from parent-reported dates of birth), and parent-reported child gender.

Provider characteristics—Parents' indicated whether the provider's race was White/Caucasian (51.7%), Black/African American (33.0%), Asian/Pacific Islander (8.5%), American Indian/Alaskan (.2%), Latino/Hispanic (.2%), or unknown (6.4%). These were combined into three categories: White/Caucasian, Black/African American, and Other. Parents also indicated whether the provider was male or female. Finally, parents were asked whether or not their child had seen this provider before (i.e., had a previous relationship).

Healthcare setting characteristics—Based on recruitment site, participants' visits to their child's primary care provider were categorized as having occurred in a private practice, hospital, or CHC. Parents indicated whether the visit was a regular (well) check up or a sick visit. Also, parents reported how long in minutes the doctor spent with their child at the last visit.

Analysis Plan

First, using Stata statistical software,³¹ we generated descriptive statistics for family and provider/setting characteristics as well as for partnership building and trust in provider. Next, we computed Pearson correlation coefficients and conducted one-way ANOVAs to examine the bivariate associations of trust with each of the independent variables. Then, we tested the unique effects of each independent variable on parents' trust in provider by conducting step-wise linear regressions, with family characteristics entered in the first step, provider/setting characteristics entered next, and partnership building added in the final step. Family and provider/setting characteristics were retained in the multivariate models if they were significantly associated with trust at the bivariate level or if they were previously reported predictors of partnership building. The first two models estimate the unique effects of family, provider and healthcare setting characteristics on parents' trust in their child's provider, and the final model reveals whether providers' partnership building accounts for any additional variance.

We follow Baron and Kenny's criteria to test for mediation.³² Based on previous findings from this study,²⁵ there are significant associations between two independent variables (parent education and practice site) and the mediating variable, partnership building. Models 1 and 2 of the current analyses establish any significant associations between these independent variables and the outcome variable, parent trust in child's provider. The final criterion for mediation is met if the proportion of variance in trust accounted for by the independent variables is reduced in the final model when partnership building is included.

Results

Characteristics of the family, provider and healthcare setting are summarized in Table 1. The vast majority of parents participating in the study were biological mothers. Parent average age was 29.7 years ($SD=7.8$, range 0–63). Less than a third were married, and the mean number of biological children per parent was 2.3 ($SD=1.4$, range 1–9). The mean age of focal children was 24 months ($SD=22.5$, range 0–167), and half were female. Almost half of participating families had incomes below 150% of the federal poverty threshold, and just over half of parents had more than a high school level of education. Approximately half reported their child's provider's race as White/Caucasian, 33% Black/African American, and 15% other (8.5% Asian/Pacific Islander, .2% American Indian/Alaskan, .2% Latino/Hispanic, 6.4% unknown). The vast majority of children were seen by a female provider. Over two-thirds of children had been seen for a well-child visit, 41% in private practices, 36% in a hospital-based clinic, and 23% in CHCs. The mean visit length, as reported by the parent, was 26 minutes.

The sample's average rating of trust in child's provider was moderately high given the possible range of scores ($M=36.5$, $SD=3.4$, scale range 10–50). Table 2 shows how trust was associated with each of the family, provider, and healthcare setting characteristics as well as parent-reported partnership building by providers. Higher trust was correlated with having more biological children. While the F statistic was significant for differences in trust by parent education, Bonferroni's multiple comparison test revealed no significant pair-wise differences between education groups. Parents who reported a previous relationship with the provider had significantly more trust than those who did not have a previous relationship. According to Bonferroni's multiple comparison test, parents whose child was seen by a provider in a CHC reported significantly more trust than those seen in a private practice ($p=.008$). Finally, there were significant differences in trust across levels of partnership building such that parents who perceived the highest levels of partnership building also reported more trust in providers than those who rated their providers as moderate or low, and those who perceived moderate partnership building reported more trust than those who rated their provider as low on partnership building.

The first two models in Table 3 reveal significant independent effects of having a previous relationship with the provider and seeing a provider in a CHC (reference category for practice type) on higher trust. In model 3, the beta [absolute] values of these two variables are reduced when partnership building is included; the association of previous relationship is reduced from $\beta=.12$ to $\beta=.11$, and the associations for private practice and hospital-based are reduced from $\beta=-.13$ to $\beta=-.03$ and $\beta=-.05$ to $\beta=.01$, respectively.

In model 2, there is also a trend-level effect of CHC attendance on higher trust in comparison to seeing a provider in private practice. This beta value is also reduced in model 3 with the inclusion of partnership building, meeting the third criteria for mediation. In conjunction with our previously reported finding of a significant association between attendance at a CHC and higher partnership building, the current set of findings suggests that the significant association between CHC attendance and higher trust in child's provider is mediated by perceptions of greater partnership building by the provider.

Discussion

The current study found that African American parents, on average, report moderately high levels of trust in their child's healthcare provider. This study examined within-race differences in levels of trust and found that greater trust was associated with parents' previous relationship with the provider, the type of practice where their child received care,

and parents' perception of the providers' communication style. Moreover, there was evidence suggesting that parents are more trusting of providers practicing in CHCs (vs. hospital-based or private practice settings) because these providers have a more partnership building communication style.

This study's findings are in line with research in adult populations that also linked continuity of physician relationship and provider communication style with greater patient trust.^{9, 17–20, 33} Using data from a nationally representative sample of adults who had seen their physician in the past year, Doescher and colleagues found that lacking physician continuity for repeat visits was associated with lower trust, explaining more of the variance in trust than patient race/ethnicity.⁹ Moreover, the association between physician continuity and trust was stronger among African American patients than Whites. The current study provides additional evidence indicating that for African American patients, whether adults or parents of children receiving care, trust in their healthcare providers is particularly dependent on continuity of care.

While few studies have explicitly focused on the association between provider communication style and trust, those that have tested it report that patients are more trusting of providers who are more patient-centered.^{17–19, 33} In a predominantly minority sample (47% African American) of adult patients from an inner-city medical clinic, Aragon and colleagues found that physician patient-centeredness accounted for 82% of the variance in patient trust.¹⁷ Using observational measures of physician's communication style, Fiscella and colleagues found that physicians who explored standardized patients' experience of a disease were given higher trust ratings by their patients.¹⁸ The current study builds on this line of research by providing evidence that parents' trust in their child's provider is also greater when providers use a more patient-centered or partnership building communication style.

This study also found that there are differences in parents' perceptions of trust by practice setting. While there were significant demographic differences between settings (e.g., parents attending private practice had higher education and income; results not shown), there remained a unique effect of practice type on trust when covariates were controlled in the multivariate models. In contrast to the current study's results, adult research typically finds lower trust among African American patients seen in CHCs compared to those seen in private practices.²¹ Other researchers have suggested that the healthcare setting characteristics of CHCs hinder the establishment of effective patient-provider relationships.²¹ However, the inconsistency between research findings in adult and pediatric populations suggests that CHC-based pediatric providers are able to develop positive relationships with parents, which this study finds is through partnership building. African American parents in the current sample reported greater partnership building among CHC providers, which in part explained their greater levels of trust in CHC providers.

Limitations

The findings of this study are limited due to the cross-sectional nature of data collection, unknown identity of providers, potential for conceptual overlap among measures, and the racial homogeneity of the sample. Although the test of mediation suggests that the partnership building communication style of CHC providers engenders greater trust, we cannot determine the causal direction of this association because all measures were assessed at the same time. Also, the finding regarding differences by practice setting have limited generalizability because patients were recruited from a small number of clinics. Because providers were not consented as study subjects, we could not identify which provider the participants described. Thus, we were unable to account for any shared variance attributable to certain providers having seen multiple participants. As noted in the introduction, there is

conceptual overlap between provider partnership-building and patient trust, which should be examined in methodological studies of relevant measures. However, the proportion of variance explained in trust by partnership building does not imply a disconcerting level of collinearity between the measures used in this study. Finally, while this study makes important contributions by examining within-group variation, future research is needed to examine the associations between family, provider, and healthcare setting characteristics and parents' trust in their child's provider among other populations. Additional research is also needed to examine the effects of provider communication style and parent trust on treatment adherence and child health outcomes.

Conclusions

The results of this study suggest several avenues for enhancing parents' trust in their child's provider and thereby encouraging treatment adherence and better health outcomes among African American children. In line with the medical home model,⁵ continuity of care by the same provider may provide the foundation on which parents and providers build trust. It is also important for pediatric providers to use a partnership building communication style, which parents perceived as higher among providers practicing in CHCs. Further research, including qualitative studies, is necessary to understand how this setting facilitates providers' participatory communication style with the aim of translating to those practices into other healthcare settings.

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What's New

These findings suggest that African American parents' trust in their child's provider, which influences provider recommendation adherence and child health outcomes, may be improved by continuity of care and greater use of a partnership building communication style by providers.

Table 1

Descriptive Statistics for Parent-reported Trust and Family and Provider/Setting Characteristics (N=425)

	<i>Mean (SD)</i>	<i>N (%)</i>
<i>Family Characteristics</i>		
Parent relationship to child		
Biological mother		397(93)
Biological father		18(4)
Other biological caregiver		6(1)
Non-biological caregiver		4(1)
Parent age	29.7(7.8)	
Marital status (married)		128(30.1)
Number of children in family	2.3(1.4)	
Child age in months	24.0(22.5)	
Child female		211(50.5)
Family poverty status (< 150% FPL)		186(48.7)
Parent education		
< HS graduate		41(9.7)
HS graduate		163(38.4)
At least some college		184(43.4)
Post-bachelors		36(8.5)
<i>Provider Characteristics</i>		
Provider race		
African American		140(33.0)
White		219(51.7)
Other		65(15.3)
Provider female		356(84.2)
Previous relationship with patient		289(68.5)
<i>Healthcare Setting Characteristics</i>		
Practice type		
Private practice		176(41.4)
Hospital-based		152(35.8)
Community health center		97(22.8)
Visit type (sick child)		134(31.5)
Visit length (in minutes)	25.5(18.7)	
<i>Partnership Building</i>		
Low		128(31.4)
Moderate		116(28.4)
High		164(40.2)
<i>Trust in Provider</i>	36.5(3.4)	

Table 2

Bivariate Associations of Trust with Family, Provider, and Healthcare Setting Characteristics

	Trust in Provider			
	r^2	Mean	F²	p
<i>Family Characteristics</i>				
Parent age	-.02			.73
Marital status			1.59	.21
Single		36.59		
Married		36.12		
Number of children in family	.16			.001
Child age in months	.01			.89
Child gender			.17	.68
Female		36.54		
Male		36.40		
Family poverty status			1.80	.18
< 150% FPL		36.76		
> 150% FPL		36.29		
Parent education			2.78	.04
< HS graduate		37.13		
HS graduate		36.89		
At least some college		36.06		
Post-bachelors		35.64		
<i>Provider Characteristics</i>				
Provider race			.13	.88
African American		36.56		
White		36.41		
Other		36.32		
Provider gender			2.03	.15
Female		36.56		
Male		35.91		
Previous relationship with patient			4.59	.03
Yes		36.71		
No		35.94		
<i>Healthcare Setting Characteristics</i>				
Practice type			5.07	.007
Private practice		35.86		
Hospital-based		36.66		
Community health center		37.18		
Visit type			.00	.97
Well child		36.45		

	Trust in Provider			
	r¹	Mean	F²	p
Sick child		36.44		
Visit length (in minutes)	.08			.09
<i>Partnership Building (M)</i>			25.6	<.001
Low		34.94		
Moderate		36.41		
High		37.68		

¹ Pearson correlation of independent variable with trust score

² Oneway ANOVA testing difference in trust score across levels of the independent variable

Table 3

Linear regression predicting trust from family, provider, and healthcare setting characteristics

	Trust in provider					
	Model 1		Model 2		Model 3	
	β	p	β	p	β	p
<i>Family Characteristics</i>						
Number of children in family	.09	.09	.06	.24	.09	.09
Parent education (<HS)	$R^2=.01$	.20				
HS graduate	-.005	.96	.008	.93	-.01	.87
At least some college	-.11	.25	-.07	.34	-.07	.44
Post-bachelors	-.08	.24	-.05	.51	-.02	.76
<i>Provider/Setting Characteristics</i>						
Previous relationship with patient			.12	.03	.11	.04
Practice type (CHC)			$\Delta R^2=.021$	.05		
Private practice			-.13	.08	-.03	.67
Hospital-based			-.05	.49	.01	.87
Visit length			.06	.28	.02	.71
<i>Partnership Building</i>					$\Delta R^2=.10$	<.001
Moderate					.21	<.001
High					.39	<.001
R^2	.02		.05		.15	
F	2.38	.05	2.41	.02	6.48	<.001