Patients' Assessments of Family Planning Health Care in the United States: What Are Key Factors That Facilitate or Hinder Equitable Care?

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Background:

Previous research has documented the potential and pitfalls of providing equitable family planning care in the United States, especially as they relate to health care systems and providers (Dehlendorf et al. 2010; Frost, Gold, and Bucek 2012; Stevens 2015). Studies have traditionally relied on large-scale surveys; more recently, innovative research combining patient surveys with audio-recordings of contraceptive counseling visits have provided a window into provider-patient interactions in family planning (Dehlendorf et al. 2014; Littlejohn and Kimport 2017; Minnis et al. 2014). However, few studies have collected in-depth, qualitative data exploring how women think about the provision of care in relation to their contraceptive use and reproductive health.

Family planning programs provide crucial services, including contraception, abortion, STI testing and treatment, and preconception care. Yet, the exam room of a family planning clinic or gynecologists' office is a place of discomfort and anxiety for many patients. Patients disclose the number of sexual partners they've had, the kinds of sex they engage in, and their history of abortions and miscarriages. These anxieties can be compounded by existing inequalities and biases in reproductive health care. This paper investigates how patients assess their interactions with family planning health care institutions and providers. I pay special attention to what factors feel supportive in this otherwise stressful environment and how provider interactions impact the quality of their reproductive health care.

Methods:

I conducted in-depth interviews with a theoretically driven, non-random sample of 48 reproductive-age women (18-44) in the northeastern United States. 42% of participants identified as white and 58% identified as minority. I aimed to capture socioeconomic diversity in my sample, with a focus on higher socioeconomic status (SES) women and use respondents' educational attainment and their parents' educational attainment as a proxy for SES. Using this metric, 40% of participants are low or mid-SES and 60% are high-SES.

The Rutgers University Institutional Review Board approved this study and all participants gave verbal consent before beginning the interview. I recruited participants through a combination of craigslist advertisements, publicly posted flyers, and referrals through personal contacts. Each participant received a $15 gift card. I recruited from the general population, rather than family planning clinics, in order to capture both individuals who do and do not receive reproductive health care on a regular basis. All participants had received some form of reproductive health care in the past, but many sought care inconsistently.

I used a grounded theory process (Charmaz 2006) of collecting and coding data. I conducted open and then focused coding in early interviews in order to identify themes that arose from the data and hone the interview guide and further explore emerging topics in later interviews.

Interviews focused on women's attitudes and experiences with birth control, pregnancy, and (not) having a family as well as their interactions with and evaluations of health care providers.

Results:

The following dominant themes arose when women talked about what they valued most in reproductive health care experiences: they wanted to see a clinician who was thorough, acknowledged their concerns, and with whom they could establish a personal connection. Interestingly, most of these concerns revolve around interpersonal interactions rather than medical skills. Patients do want competent health care providers - about a fifth said they wanted their clinician to be knowledgeable and many concerns about thoroughness were related to accurately diagnosing symptoms or describing treatment options. However, overwhelmingly, my interviewees wanted to have a trusting relationship where they experienced concern, could share some of the most intimate parts of their lives without judgment, and feel heard and respected.

Many identified specific experiences when this lack of rapport negatively affected their family planning care. Importantly, a quarter of my sample alluded to times when they could not be open and honest with their health care providers: they had either lied, withheld information, or refrained from asking questions they would have liked answered. In nearly all of these situations, patients perceived a lack of trust or empathy and many anticipated (or had already experienced) judgment. Nearly all of those who had been dishonest with their providers made comparisons of situations where they did feel comfortable sharing sensitive information and situations where did not. These examples demonstrate that it is possible to develop a line of open communication with patients about even the most sensitive issues (for example: weight and reproductive health, anal sex, STDs, sexual pleasure, and use of less effective methods of contraception, like withdrawal), but this level of communication can require a trusting, nonjudgmental provider-patient relationship.

This research has important implications for the provision of complete and equitable family planning care. In the full analysis, I will examine how race, class, and other markers of status interact with patients' experiences of reproductive health care.

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