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RESEARCH

Expectations of Pregnant Women of Mexican Origin Regarding Their Health Care Providers

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ABSTRACT

Objective: To explore the expectations of pregnant women of Mexican origin regarding trust and communication with their health care providers.

Design: Qualitative, descriptive inquiry.

Setting: A large metropolitan area community clinic in Texas that provided services to predominately Hispanic women.

Participants: The sample consisted of 13 women between ages 19 and 36 (mean = 29) who received prenatal health care at a community clinic that offers care to Hispanic women.

Methods: Semistructured interviews were conducted with open-ended starter questions and follow-up questions based on the participant responses. Based on the women's language preference nine interviews were conducted in Spanish and four in English.

Results: Themes emerged from the beginning interviews, and after five interviews, saturation was reached. Data were arranged by the emerged themes of the model of trust and communication (Figure 1). The themes reflected the perception of trust, communication, patient centeredness, and satisfaction with health care providers.

Conclusion: These women wanted their providers to provide them with "everything," to be direct, to speak their language, and to present information as friends. Health care providers need to be able to provide communication not only in the participant's preferred language, but also in a way that is culturally sensitive.

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Hispanics represent the largest and fastest growing minority in the United States, so it is important to understand how they view the health care system and their providers. A subset of the Hispanic population, which encompasses many North, Central, and South American cultures, is women of Mexican origin. We focused on this specific subset group. The term *Hispanic* is a government-designated ethnicity, encompassing Cuban, Mexican, Puerto Rican, South or Central American (except Brazilian), and those having a Spanish culture. *Latino/a* on the other hand is a term that individuals use to self-identify their ethnicities. Hispanics/Latinos are not a heterogeneous group.

Research focused on disparities of care has mostly been conducted on the technical aspects of care, but little is known about the perception of women of Mexican origin regarding their experiences. Two key factors, communication and trust, are important components of prenatal care (duPré, 2010; Raine, Cartwright, Richens, Mahamed, & Smith, 2010) and influence how women perceive they are treated. Communication between the patient and health care provider is a current pressing issue for the U.S. health care system to reduce racial, ethnic, and language disparities (The Joint Commission, 2010). Trust is an important component, and it is expected that an effective health care provider shows that the patient's interests are a priority (Jones, 2014). Further, Madriz (2000) suggested that the "voices of women of color" have not been heard in research, and the interviews facilitate women of color "writing culture together" (pp. 835–836). The purpose of this study was to explore the expectations of pregnant women of Mexican origin regarding trust and communication with health care providers.

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Background and Significance

Many Hispanic women do not consider their care to be patient centered (Tandon, Parillo, & Keefer, 2005) and focused on the patient and her individual health needs (Reynolds, 2009). Hispanic women want their prenatal care providers to be responsive to their culture and language. The Institute of Medicine (2001) described patient-centered care (PCC) as care that honors the individual patient and respects his or her choices, culture, ethnicity, social context, values, and information needs. Hispanic women seeking prenatal care may experience barriers to seeking and receiving PCC because of language, cultural incompatibility with their providers, and concern for their immigrant status (Bergman & Connaughton, 2013). Health care outcomes are affected by women's understanding and asking appropriate questions during prenatal visits. Because patients and providers come with their own unique beliefs and expectations, understanding these differences may improve PCC and health care outcomes, because prenatal care is often a point of entry for health care in the United States (Bergman & Connaughton, 2013). Hispanic women are less likely to consider their care as patient centered when their care is rushed and impersonal (Tandon et al., 2005).

According to the 2010 U.S. Census, "50.5 million Hispanics comprise 16% of the U.S. population" (Ennis & Albert, 2011, p. 1), an increase of 56% from year 2000 to 2010 (Passel, Cohn, & Lopez, 2011). More than one fourth of Hispanic adults do not have permanent health care providers, nor have they obtained health care information from medical personnel in the past year (Livingston, Minushkin, & Cohn, 2008). When indigenous people immigrate to the United States, they bring health beliefs and then assimilate those beliefs to a new health system (Geist-Martin & Bell, 2009). Those who do not have permanent health providers say they are seldom sick (41%) or they prefer to treat themselves (13%; Livingston et al., 2008).

According to the Institute of Medicine (2002), racial and ethnic disparities in health care are not entirely explained by access to health care, clinical appropriateness, or patient preferences. To understand these disparities in economic terms, LaVeist, Gaskin, and Richard (2011) estimated the direct health care expenditures to be $230 billion and the indirect expenditures from death and illness to be $1 trillion. Hispanics are generally pleased with the health care they receive, but one in four who received health care in the past 5 years reported having received poor quality medical treatment. They attribute this poor quality care to their financial limitations, their race and ethnicity, or the way they speak English and their accent (Livingston et al., 2008).

This study is based on the framework (Figure 1) that the perceptions of women of Mexican origin regarding trust and communication are important for quality of and satisfaction with care. The model of trust and communication (Figure 1) was developed from the literature (Bender, Harbour, Thorp, & Morris, 2001; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; DeVoe, Wallace, & Fryer, 2009; Geist-Martin & Bell, 2009; Livingston et al., 2008; Tandon et al., 2005; Zander, 2007) and the authors experiences in working with Hispanic women. Communication and trust are the building blocks of patient-centered care and influence

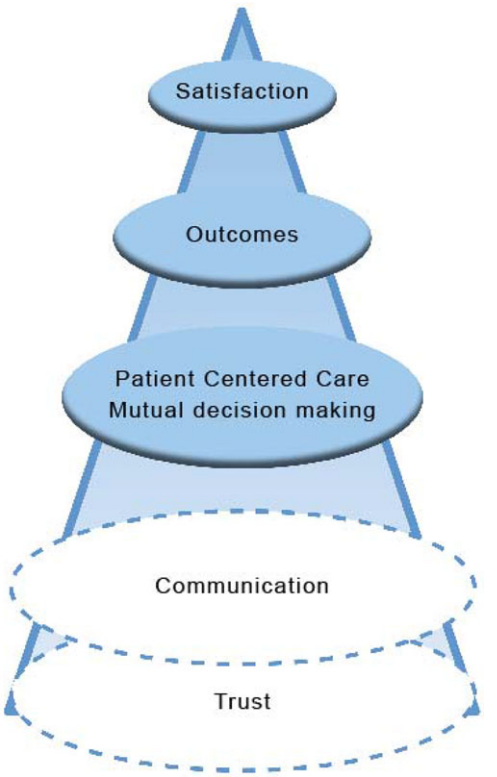

Figure 1. Model of trust and communication.