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Trust and Distrust Among Appalachian Women Regarding Cervical Cancer Screening: A Qualitative Study

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Confirmation Statement

I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

No conflict of interest exists with this manuscript.

Abstract

Objective—To explore Appalachian women's perceptions of trust and distrust of healthcare providers and the medical care system as they relate to views about cervical cancer and screening.

Methods—Thirty-six Ohio Appalachia female residents participated in community focus groups conducted by trained facilitators. Discussion topics included factors related to cervical cancer, and the issues of trust and distrust in medical care. The tape-recorded focus groups were transcribed and analyzed to identify salient themes.

Results—Five themes emerged related to trust in healthcare. Patient-centered communication and encouragement from a healthcare provider led women to trust their physicians and the medical care system. In contrast, lack of patient-centered communication by providers and perceptions of poor quality of care led to distrust. Physician gender concordance also contributed to trust as women reported trust of female physicians and distrust of male physicians; trust in male physicians was reported to be increased by presence of a female nurse.

Conclusions—Important factors associated with trust and distrust of providers and the medical care system may impact health-seeking behaviors among underserved women.

Practice Implications—Opportunities to improve patient-centered communication around the issues of prevention and cervical cancer screening (such as providing patient-focused information about access to appropriate screening tests) could be used to improve patient care and build patients' trust.

Keywords

cervical cancer; health services accessibility; vulnerable populations; patient-centered communication; cancer screening; trust; distrust; physician gender concordance; Appalachian populations

1. Introduction

While the introduction and adoption of Papanicolaou (Pap) smear screening programs have helped reduce both incidence and mortality rates from invasive cervical cancer among U.S. women over the past several decades, women continue to die from this disease. The American Cancer Society estimated that in 2010, 12,200 cases of invasive cervical cancer would be diagnosed and 4,210 women would die from the disease [1]. Notably, factors such as poverty, low levels of education, rural location, and problems with access to medical care are associated with higher cervical cancer incidence and mortality rates. Appalachia Ohio, in particular, has higher incidences of cervical cancer and related mortality compared to both the rest of non-Appalachia Ohio and the U.S. [2]. A joint report by the American Cancer Society's Ohio Division and the Ohio Department of Health prepared in 2003 revealed that Appalachian women had a 48.8% higher incidence of cervical cancer and a 42.9% higher mortality rate compared to non-Appalachian women [3].

The Centers for Disease Control (CDC) recommends cervical cancer screening at least once every three years. Furthermore, Healthy People 2010 targets a 97% national goal for Pap test utilization by women age 25 years and older [4]. Yet cervical cancer screening rates among women of Appalachia Ohio are well below recommended frequencies. According to Ohio data, only 78.5% of women in Appalachia Ohio received a Pap test within the last three years compared to 86.4% of women in non-Appalachia Ohio [3]. Pap screening rates in Appalachia Ohio also trail national figures, which are 84.5% and 81.3%, respectively, for metropolitan and rural women.

Many factors affect women's compliance with recommended screening practices, with recent research emphasizing the importance of patient-centered factors such as communication and trust [5–17]. Studies have shown that trust is very important in medicine [12–43], and in the delivery of healthcare services to vulnerable populations, trust may be critical. Trust facilitates care-seeking among patients and promotes open dialogue and adherence to physician recommendations [23–25; 29–33].

Yet while trust has been explored in a variety of settings and with various populations [34–39], little is known about how an underserved, low-income population, such as women in Appalachian Ohio, trust or distrust healthcare organizations and healthcare providers. Because distrust has been found to inhibit care-seeking behaviors [36–37; 40–41], women's distrust of physicians, healthcare institutions, or both, may be an important mediating factor associated with both the low rates of cervical cancer screening and high rates of cervical cancer within this population.

We conducted exploratory focus groups with women in Appalachia Ohio in order to learn more about the factors that may contribute to both lower screening rates and higher mortality rates for cervical cancer. In this paper we specifically examine the factors of trust and distrust of providers and healthcare institutions as they relate to cervical cancer screening practices.

2. Methods

2.1. Data Source

The data for this study are from five focus groups conducted in Spring 2005 as part of the Community Awareness, Resources and Education (CARE) Project of the Ohio State University (OSU) Center for Population Health and Health Disparities. The overall research project, Reducing Cervical Cancer in Appalachia, was focused on understanding why high rates of cervical cancer incidence and mortality are observed in Appalachia Ohio. Participants were all residents of counties in Appalachia Ohio, and included both White and African-American women. All women provided written informed consent, and the study was approved by the Institutional Review Board at The Ohio State University (OSU).

2.2. Participant Recruitment

We sought to recruit female participants from across the 29-county Ohio Appalachia region in order to ensure broad representation from this group of underserved women. For this recruitment effort, community partners from OSU's extension offices throughout Ohio Appalachia posted fliers to advertise the focus groups in various public locations, and informational messages were also sent via email to local list-serves and electronic bulletin boards. Fliers invited women ages 18 and older to participate in a one-hour focus group discussion about "women's views on cancer and healthcare," and stated that each participant would receive $20 in appreciation for her time, in addition to refreshments and free babysitting. Women were instructed to call a toll-free number so that study personnel could ask them a few eligibility questions. Women were considered eligible to participate if they resided in the counties of Ohio Appalachia, were not pregnant, were over age 18, and had no prior history of cervical cancer.

Seventy-five women from 11 different Ohio counties called and requested more information. Study personnel successfully contacted all but three of the women for eligibility screening. Three women were deemed ineligible for the study. Of the 69 eligible potential participants, 36 participated, for a participation rate of 52%.

2.3. Focus Group Process

We held focus groups in five different locations of Appalachia Ohio to ensure broad geographic representation among the women targeted by our recruitment. Focus groups ranged in size from 4 to 11 participants.

A focus group guide was used to ensure consistency across groups [42]. The focus group guide included a series of open-ended questions with supplemental probing questions organized into the following five question domains: 1) Introduction/Background; 2) Smoking; 3) Screening (Cervical Cancer); 4) Trust/Distrust of Doctors; and 5) Conclusion. In this paper we focus on women's responses to questions in the Screening and Trust/Distrust domains. Questions in the Screening domain asked women about their perspectives and experiences with cervical cancer screening and detection. The two general questions in the Trust/Distrust domain asked women about what makes them trust their doctors (and probed about the specific factors of age, gender, ethnicity, race, education, practice location), and what makes them distrust their doctors (and probed about the factors of focus on payment, competence, communication skills, and perception of discrimination).

Focus groups were supervised by a single project investigator and conducted by different trained moderators. All moderators were white women. Focus group discussions lasted from 90–180 minutes, ending only after all women had finished answering all questions posed, and the discussions had come to a natural conclusion. While we held five focus groups to ensure representation across our target population of women, we found saturation emerging around the topics of trust and distrust after we had completed three focus groups [42, 44]

Focus groups were audio recorded and transcribed verbatim. Transcripts were reviewed for accuracy in transcription.

2.4. Coding and Analysis of Focus Groups

The focus group data analysis process enabled us to use both inductive and deductive methods of qualitative analysis [43–44]. Led by a senior researcher (JMO), a team of four investigators was involved in the coding process, and used the NVivo software program to support their analyses. First, a preliminary codebook was developed based on the focus group discussion guide, and used to facilitate the coding process. Next, each investigator used the preliminary codebook to code the same randomly selected focus group transcript independently, and then the coders met to review their codes and reach consensus when there were discrepancies. The preliminary codebook was subsequently revised based on this initial coding.

Throughout the coding process, the coding team met regularly, and coders were able to suggest the addition of new codes and their definitions. These periodic team meetings thus enabled the coding team to reach consensus about coding decisions and emergent findings, consistent with the standards of rigorous qualitative research [e.g., 45–46]. In addition, when new codes were added, previous transcripts were reviewed by the senior researcher to permit proper re-coding when necessary.

After all focus groups were coded, the senior researcher ran reports on all nodes in NVivo, corresponding to patterns within the data, and reviewed the findings. Final themes were identified based on the number of focus groups in which each node was mentioned. Using a group-to-group validation approach, we classified a node as a theme if it was reported in at least three of the five focus groups [42].

Further analyses of the data by theme involving additional review and discussions among investigators enabled us to identify emergent sub-themes within the major themes we found.

The results we report in this paper are related to the themes and sub-themes around screening and trust/distrust.

3. Results

3.1. Characteristics of the Study Population

Participants included 36 women from Appalachia Ohio. The mean age of the 35 participants who reported age was 43.5 years, with an age range of 21–84 years. Of the 34 women who reported race, 27 reported White, 6 reported African American and 1 reported other. Of all women who answered the question about if they had ever had an abnormal Pap test (N=34), 17 participants (50%) reported "*yes*."

3.2. Themes

We found themes around the issues of both trust and distrust in all of the focus group discussions. Specifically, two major themes emerged that were associated with trust in medical care: 1) patient-centered communication; and 2) healthcare provider encouragement to have a routine Pap test. Additionally, two major themes emerged around the issue of distrust: 1) lack of communication by providers; and 2) perceptions about poor quality of care. Related to this second theme around quality of care were three sub-themes related to perceptions of: a) low-quality care; b) poorly qualified physicians; and c) inappropriate or missed diagnoses. The fifth emergent theme of physician gender concordance was related to both trust and distrust of healthcare providers. Below we describe each of these themes and sub-themes further.

3.2.1. Trust Themes—When asked specifically about trust of their healthcare providers and the medical care system, women's comments revealed two primary themes—patient-centered communication and healthcare provider encouragement. Examples of comments supporting these themes are presented in Table 1, and below we describe each of these themes in greater detail.

Patient-Centered Communication: Across participants, women reported that one of the most important factors in establishing trust either with a provider or in the medical care system was their perception of the healthcare provider's patient-centered approach to care. Representative comments included descriptions of women's experiences with providers who were relationship-oriented and focused on them as people rather than diseases. As one woman explained about her physician,

> "he comes in and talks to me first, and then I get ready for the exam, and then he comes back in with his nurse. And I've just establish(ed) a comfortable relationship with him."

Other comments were similarly related to this relationship-building effort, with frequent mentions about the importance of a physician asking about the well-being of one's family, being attentive, taking time with the patient, and focusing on the patient.

Comments about trust related to patient-centeredness also suggested that participants had a positive perception of care that was linked to trust built from their provider's communication behavior. One respondent noted this about her physician:

> "She focuses completely on you…takes her time, and listens to you…. She's up-to-date on things."

This apparent spillover benefit of a provider's communication style to encompass medical competency was noticeably linked to women's perceptions of trust of both their providers and the medical care system.

Healthcare Provider Encouragement: The second emergent theme around women's perceptions of trust was healthcare provider encouragement. In discussions about how other people influence a woman's decision to obtain a Pap test, encouragement from a healthcare provider was mentioned in four of the five focus groups. Encouragement appeared to take different forms, ranging from providing explicit directions and encouragement to get routinely screened, to more of an educational approach that helped women understand the need for cervical cancer screening. At this first end of the spectrum, one representative comment was that the doctor,

> "makes me do it every year."

Common consensus among those who had a healthcare provider who encouraged Pap tests was that timely reminders in the form of a letter or postcard in the mail were useful and served to encourage women to get screened. As one woman described,

> "I get notified by my doctor once a year, you know, right before it s time to have one."

The more intensive educational encouragement approach also appeared associated with women's perceptions of trust. One woman described how her doctor had encouraged her through education:

> "And I've had a hysterectomy as well, but my doctor told me that I still needed to have the Pap smears done…simply because that you can still get cancer, even though you don't have your cervix, you could still get cancer at the top of your vagina just the same as you could if you still had your cervix. So I still go."

Another woman explained about how, at her doctor's office,

> "They were really on me because of so much cancer in my family, and they make sure."

Both types of provider encouragement appeared to build women's trust in their healthcare providers, and, as a result, appeared to make them more apt to comply with providers' recommendations for cervical cancer screening.

3.2.2. Distrust Themes—Women's comments about what makes them distrust their healthcare providers or the medical care system were also categorized into two different themes—lack of patient-centered communication and poor quality of care. Representative comments associated with these themes are shown in Table 2. While this first distrust theme, lack of patient-centered communication, is characterized as the opposite of the trust theme of patient-centered communication, the poor quality of care theme is distinctly different from the trust themes. It also appears that there is a more complicated relationship between distrust and poor quality of care. Specifically this is revealed in women's perceptions of distrust related to: a) low-quality care; b) poorly-qualified physicians; and c) inappropriate or missed diagnoses. A more detailed discussion of each of these distrust themes and the associated data patterns is included below.

Lack of Patient-Centered Communications: When asked what made women distrust their providers or the medical care system, a lack of patient-centered communication was commonly mentioned. This lack of patient-centeredness was described in several ways, including women commenting that their providers were poor listeners or that providers did

not take necessary time to perform examinations, explain diagnoses, or answer questions. As one woman explained,

> "…but he has so many patients, now he does not take time. If I say something, he wants you to come in, and when you finish talking and he done wrote four prescriptions, he hasn't done anything…. And I don't keep the appointments now because I told my husband, Why should I go out there and sit and small talk with him, and he does nothing but write prescriptions. "

Women were also able to describe the contrast between patient-centered communication and the lack of patient-centered communication in relation to trust. One woman described this contrast explicitly:

> "The fact that he seems interested as me as a patient and he takes time. I've been to physicians before where I felt like they just weren't quite…their mind was somewhere else, and they just wanted to get me in and out. The doctor I see right now I don't feel that way with. I feel like when he comes in that room, he's not thinking about anything else, and I am sure he is, but he doesn't let ME know he is thinking about anything else but me at the time."

Another woman similarly explained this contrast when she told of her mother's experiences with different types of doctors:

> "She has never been, and she's 76, and she has never been for a Pap smear. But she would let her medical doctor that sees her for her heart and blood pressure, she'll let him do a Pap smear on her. But she won't go to an OB and have one done."

Similar to the trust theme around patient-centered communication, there were spillover effects of the lack of patient-centered communication that women associated with providers' lack of competence. As one woman explained,

> "…they got so many offices and too many patients, and they are not that good."

Similarly, another woman stated how,

> "They're not good, and they are uncaring."

This association highlights the importance of building trust through patient-centered communication and positive relationship behavior rather than increase the risk that women distrust their providers when they link a lack of patient-centeredness to care that is "*not good*."

Poor Quality of Care: The second distinct distrust theme emerged around women's comments that they believed that doctors in their community did not provide high-quality care. This theme included three patterns, or sub-themes, in the data, with the first emphasizing the reported link between distrust and perceptions of low-quality care.

Across focus groups, women's comments described how perceptions of low-quality care led them to distrust their providers and the medical care system. Several participants noted that they did not think doctors in rural areas could effectively provide medical care for their families, and many women told stories of driving a few hours to the closest cities in order to obtain medical care that they trusted to be good. As one woman noted,

> "It doesn't matter if you have…coverage or not. Doctors and stuff around here stink. It is just the truth. They stink. You have to go all the way to Pittsburgh or someplace to get good medical coverage."

Another explained how she would seek care locally,

> "..(for)…your routine everyday things, even emergency type things, but if it was like my child and it was something a little more serious or…if I had cancer or something, I probably would not go here."

Yet another concurred:

> "If I have to have a procedure done and I could live until I had it to Columbus, that is where I would have it done."

A second key pattern that emerged in one of the focus groups was around the issue of participants' distrust in physicians' medical qualifications. Participants questioned if local doctors were truly physicians, and were even skeptical of the degrees and certificates posted in offices. One woman noted,

> "…all these things on the wall. Look at the dates. There's no way he could've gotten all these things. There's no way, and when you see all a whole lot of…they don't have a license to practice. I'm serious. I don't trust them."

Another woman related how,

> "…I went to a meeting and this [doctor] came in, and he said, 'There's 75 doctors in [our town] who don't have a license to practice medicine, and practice medicine every day. "

Similarly, some women noted distrust of the regional hospitals and clinics. One participant discussed news she heard about a regional hospital and Pap smears:

> "I heard today that there's a question at [title] hospital about Pap smears on the news before I came that they weren't doing something right…"

These associations between beliefs about poor quality of care and distrust in both providers and institutions were common across all five focus groups.

The third pattern around the relationship between distrust and poor quality of care emerged around comments and stories about distrust associated with inappropriate or missed medical diagnoses. One woman explained how a missed diagnosis led to her distrust her physician:

> "I just had back surgery two and a half weeks ago. I had part of the bone taken off my spine and two ruptured disks removed, and I suffered in pain for quite awhile because I was misdiagnosed…I did not trust my doctor after that, and he let me go on in pain. And I had to get another doctor, and it took awhile, so I went around in some pretty bad pain for awhile."

Similar stories were told about how missed or inappropriate diagnoses led to distrust of the healthcare institution. As one participant explained,

> "I had an aneurysm, and I went out there four times, and they told me I was overreacting to a sinus headache. And I went to see a neurologist in a neighboring county, and he told me I had an aneurysm. He took me…to (another hospital). When we got there it had started leaking. I read medical books before going and asked questions like, 'Could I be having a stroke?' and they said, 'No, you are just overreacting to a sinus headache.' That's what they did. They gave me care for a sinus headache."

Even fear of missed diagnoses seemed to build distrust as one participant described what made her distrust her providers and the medical care system:

> "maybe they would read the test wrong and miss something."

Similarly, another woman shared how,

> "If you look on TV, this is happening everywhere. You know, like, I felt sorry for myself. And I read where they cut off a woman's wrong breast off in another state. It happens everywhere."

3.2.3. Physician Gender Concordance—A fifth emergent theme related specifically to women's trust and distrust of providers involved physician gender, and was discussed by women in all five focus groups. The majority of comments about physician gender indicated a preference for female physicians, although a handful of participants described the positive professional relationships they had experienced with male physicians. The general sense was that female physicians could be better trusted to perform Pap smears, and many participants expressed discomfort with male physicians—discomfort that often contributed to distrust of these male doctors. Representative comments associated with this theme and the sub-themes associated with physician gender and trust are shown in Table 3.

Related to this theme, women in four of the five focus groups raised issues about their desire for a nurse to accompany a male physician during patient examinations. While one participant noted that,

> "My doctor always has a nurse in the room,"

another complained that in her clinic,

> "They have NEVER had a nurse in the room. The nurse comes first, and she takes all…she never comes back… They should have nurses in the room to examine you…."

When the practice of having a nurse accompany a male physician did occur, it appears to have contributed to patients' trust of the male physicians, but when it was not practiced, it apparently contributed to patients' distrust.

4. Discussion and Conclusion

4.1. Discussion

We designed this study to learn more about how trust and distrust of providers and healthcare institutions might contribute to the lower cervical cancer screening and higher cervical cancer mortality rates found among women residing in Appalachia Ohio compared to women from other parts of Ohio and the US. Across our focus groups we found that trust was established when providers used a patient-centered approach to care and when patients received encouragement from their providers to receive recommended screening tests and medical care. In contrast, patients felt distrust when they noted a lack of patient-centered communication with their physicians, or when patients perceived that the care they were receiving was of poor quality. Our results are consistent with findings from previous studies that have indicated that a positive association exists between patient-centered communication and trust [12; 47–49].

Interestingly, we also found that there was a link between patient-centered communication, women's perceptions of provider competence, and trust. Women who reported patient-centered communication as having engendered their trust were also likely to describe physicians as "*good*" in the same comments. The reverse was also true; physicians who were not patient-centered were viewed as not trustworthy and "*bad*" healthcare providers. While prior research has indicated that physician use of patient-centered communication is related to positive patient outcomes [4–6; 50–57], we believe ours is the first study to link patient-centeredness, patients' perceptions of the healthcare provider, and trust.

Further, perceptions of poor quality of care was a distinct determinant of distrust among our participants, apart from a lack of patient-centered communication. Women described beliefs about their local doctors that seemed ingrained in their Appalachian culture--that physicians who practiced in their communities provided low-quality care and possessed poor qualifications to practice medicine. These beliefs appeared to have been reinforced through the processes of sharing their experiences with others, and through exposure to the media. Ultimately, these beliefs then contributed to their perceptions of distrust, and, as they reported, led them to seek care outside their own communities. This finding highlights the importance of continuing to focus on the issues of quality improvement and reducing medical errors in the Appalachia Ohio region, as well as throughout the US, and suggests that both providers and institutions may need to seek opportunities to promote the locally available healthcare services as care that is patient-centered, safe, appropriate, and accessible to residents of these communities.

Finally, the issue of physician gender also appeared to affect women's trust of their providers. Consistent with prior studies that have noted an association between gender concordance and patient trust in physicians [58–60], our study participants were reportedly more likely to trust female than male physicians, especially in the context of needing Pap test procedures. However, our findings also suggest that the influence of gender on women's trust of physicians may be mitigated by the fact that a female health care professional should be in the room when a male physician is performing a pap smear, highlighting the opportunity to reduce women's distrust of physicians to the extent that this distrust is due solely to physician gender.

4.1.1. Limitations—Our study was limited by both its setting and its selected methodology. We elected to use qualitative methods in order to obtain a rich understanding of the issues of trust and distrust among women of Appalachia Ohio, yet we recognize that these results have limited direct generalizability. While other studies have considered the issues of trust and distrust among different racial/ethnic populations [34–39; 61–66], our research was designed to explore this issue from the perspective of an underserved group of women about which we knew relatively little. However, it is possible that our "opt in" focus group participant recruitment process may have biased our sample to women who were more active and engaged in their communities. Finally, our study was limited because of its relatively small sample size. Future studies would benefit from larger sample sizes and expanded study aims which permit direct comparison across a broader population of underserved women.

4.2. Conclusion

Understanding the nature of trust and distrust among women in Appalachia Ohio around the issue of cervical cancer screening will help providers and policymakers in attempts to increase cervical cancer screening rates among these and other underserved women. Our findings contribute to the growing body of evidence about the importance of patient-centered communication in cancer screening as we have highlighted how patient-centeredness can help build trust and reduce distrust in healthcare.

4.3. Practice Implications

Our findings highlight important factors associated with trust and distrust of both providers and the medical care system in Appalachia Ohio. These factors are likely also present among other populations of underserved women. In particular, these findings suggest important opportunities to improve patient-centered communication around the issues of prevention and cervical cancer screening to both improve patient care and build patients' trust. By utilizing patient-centered communication around cancer screening and specifically

encouraging women to receive guideline-appropriate screenings, providers can engender women's trust and facilitate care-seeking behavior. For instance, by exhibiting relationship-building behavior and providing women with details about where and how frequently to get screened, and offering women information about topics such as insurance coverage, transportation, and what to expect during a screening test, doctors can build women's trust. These actions can demonstrate that their interest in helping patients seek screening in the future is both genuine and appropriate. In addition, by focusing on delivering patient-centered care, doctors may be able to improve women's perceptions of their competence, and help address an important apparent barrier to cervical cancer screening. Emphasizing patient-centered care and effective patient-centered communications can thus help physicians and healthcare institutions reduce distrust and, potentially, misunderstanding that may contribute to unnecessarily high cervical cancer incidence and mortality rates among underserved populations such as these women of Appalachia Ohio.

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Table 1

Trust Themes among Appalachian Women

Patient-Centered Communications

" I have established a pretty good relationship with my gynecologist. I just think he, he's easy going. He has a good bedside manner, and I think that's important."

"…a doctor I have in Pittsburgh....he was so just genuinely nice. He was concerned not just (about) my health, but me, myself....he asked questions about everyone in my family, how I was doing, how I was getting along.....there was a point in time when I couldn't pay my bill....and I just told him, "Well, I can't pay today." "It's no problem…I will miss this one payment." He was just nice. He was genuinely nice. That's what I liked about him…"

"She is. She cares. She really cares about you. She's old, but she finds out the root, you're sick, she is going to find what the matter with you."

Health Care Provider Encouragement

"Well, I go every year. My doctor makes me…"

"And usually it's, I think women that have children, you get into that routine, you get a gynecologist or OB or whatever, and so you establish a relationship with a physician, and so then they send you reminders in the mail… Because I don't know how conscious I would have been about, if I hadn't had, you know, my children and been exposed to that to begin with."

"Well, my doctors, before I came here, they were always saying, 'Well, ok, go get your Pap smear, go get your Pap smear.' … they start telling me that because so many people in my family had some cancer, you can't take yours once a year. You must take one every six months, so I started taking it every six months. Before, I took it once a year."

"I go every year, too."

"Well, I heard that you need a Pap smear at least once year. Women, I get a Pap smear once year."

"Cause we're told we have to."

Table 2

Distrust Themes among Appalachian Women

Lack of Patient-Centered Communications

"They don't take the time, they don't take the effort."

"It like, she's right, you know some of them, they really don't care, and it is really hard to tell which ones do care and which ones don't until you are dead smack in the middle of… your problem."

"…usually I can judge people pretty good, and if I see one that just looks at your chart, and he doesn't say much, you know, well, you do not want him"

Poor Quality of Care

Perceptions of low-quality care

"…I know when I get sick, my kids like, they are going to kill me up there. I got a better chance trying to doctoring myself at home, then I get to the point I gotta go there, and I am scared they are going to kill me. (laughter) I hope I don't get sick when I am here. I am hoping I am some place close to Pittsburgh if I ever get sick again…"

"This hospital is really scary."

Perceptions of poorly qualified physicians

"I will call him now and say, "I have strep throat, and I need you to call me in an antibiotic to the pharmacy." And he will call it in because he does not have time to se me, and he just goes on my word. The last time, he gave me an antibiotic with 5 refills and said only take them when you need them. Who ever heard of a doctor giving refills of antibiotics? You just don't do that, you should be seen again."

"…I will not go back because he will not let you know in a reasonable amount of time if there is a problem."

Perceptions of inappropriate or missed diagnoses

"When I was five, my mother took me into the pediatrics I don't know how many times, and they kept telling her there wasn't nothing wrong with me. It was just stuff I was doing to get attention….(S)he changed doctors, and he suggested a CAT scan, and that's how they found out I had brain cancer when I was five years old."

"…I am allergic to bug bites, so, of course, when I get bit, I get little bumps on my skin. While I was living near, when I first went to this particular doctor, he said that they were bug bites, and he gave me something to counteract the itch. So I took it, and, yeah, it helped the itching for a little while. Then a week later, yeah, there they were again. I went back to him again. I went back to him like three times, and he insisted that's what it was. So I moved back to Ohio, and I had a real bad cough. I went to the hospital here, and they told me I had Hodgkins."

Table 3

Physician Gender Sub-Themes Among Appalachian Women

Preference for Female Physicians
"My OB/GYN is a woman…my personal opinion she's probably the best doctor at Hospital X."
"We should get a woman gynecologist. There's woman gynecologists, too, you know?"
"I think a woman [physician] would have been more gentle."
"…her big thing was that she wanted it to be a female doctor, so I made sure she had a female doctor."
Discomfort with Male Physicians
"…they [female patients] don't want the man [physician] to be looking at them."
"They're [female patients] are afraid, and they don't like to undress in front of a man doctor."
"Laying down in front of a man.… I hate that. It's uncomfortable…Yeah, I need a woman gynecologist."