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A Qualitative Analysis of Women's Satisfaction with Primary Care from a Panel of Focus Groups in the National Centers of Excellence in Women's Health

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ABSTRACT

Health issues unique to women and differences in healthcare experiences have recently gained attention as health plans and systems seek to extend and improve health promotion and disease prevention in the population. Successful efforts focused on enhancing quality of care will require information from the patient's perspective on how to improve such services to best support women's attempts to lead healthy and productive lives. The National Centers of Excellence in Women's Health program (CoE), sponsored by the Office on Women's Health within the Department of Health and Human Services, is based on an integrated model uniting research, training, healthcare, and community education and outreach. To examine women's concept and definitions of healthcare quality, 18 focus groups comprising 137 women were conducted nationwide on experiences and attributes of healthcare that women value in primary care. Following the focus groups, a woman-focused healthcare satisfaction instrument was developed for the purpose of assessing and improving healthcare delivery. We describe the qualitative results of the focus group study.

INTRODUCTION

RECENT STUDIES OF WOMEN'S HEALTHCARE utilization and quality of care have documented the unique and complex healthcare needs women face. Such issues as the complexities of preventive care, compartmentalization of healthcare by specialty and service level,[1,2] reliance on multiple providers,[2,3] family issues and caregiving, and timing of preventive care and counseling (e.g.,

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routine gynecological examinations, prenatal care) have been addressed. Women's expectations of care may also be shaped by their unique roles in healthcare seeking. For example, appraisals of healthcare might include not just women's own experiences with healthcare but also their experiences obtaining care for others, including children, spouses, or parents. Women's frequent encounters with healthcare may raise (or lower) their expectations for some aspects of care, such as the timeliness of appointments, the clarity or quality of communication with providers,[4] and the availability of timely follow-up care. It is unclear how these experiences of access barriers, fragmentation, and complex healthcare needs can be best represented in such outcomes as satisfaction and quality of care ratings.

Large descriptive studies, such as The Commonwealth Fund Survey of Women's Health,[5] have assessed the performance of healthcare systems in meeting recognized healthcare objectives for women and have identified gaps in care and services. However, there is little information on women's views of their experiences with healthcare and the qualities they desire or seek to support their health. Studies examining patient priorities for care have varied considerably in the aspects of care that were addressed. Typical domains included in satisfaction instruments are humaneness (warmth, respect, interpersonal skill, willingness to listen), informativeness (explanations of procedures), overall quality (including time with providers), competence (technical performance), availability/accessibility (convenience, hours, waiting time), and facilities (aesthetics, parking, adequacy of equipment).[6] These domains also rank high among topics that patients nominate as their highest priorities for care.[7] However, topics assessed less frequently in satisfaction surveys or in studies about patient priorities and expectations for care also appear to be of high importance to patients. For example, the review by Wensing et al.[7] found that relatively few studies of patient priorities for care asked about such topics as exploring patient needs, patient privacy, self-help needs, burden, and aspects of relationship and support from health professionals (beyond warmth and respect items included in humaneness).

This gap in knowledge is important to address if we are to incorporate women's perspectives in quality measures[8–10] and to recognize women's own expectations for healthcare, their common experiences with the healthcare process and system, and their health needs in the design of patient satisfaction instruments.[11]

This paper presents results from a focus group study. Subjects are 137 women recruited in a series of 18 focus groups from six National Centers of Excellence in Women's Health (CoEs), each in a different region of the United States. The focus groups were designed to elicit women's views on primary healthcare needs, preferences for care, and definitions of quality. The CoE program is based on a model of integrated women's health uniting research, medical training, clinical care, public education, community outreach, and the career advancement of women in the health sciences. The goal of the program is to establish standards of excellence for a comprehensive, multidisciplinary, and culturally competent approach to women's healthcare. The CoEs are developed as model centers that strive to provide woman-focused care, with emphasis on comprehensive services, care coordination, easy access, and patient and family education.[12] This coordinated effort provided the means to initiate the development of a measurement tool for evaluating this new program and, in a larger context, a new evaluation tool for women's healthcare research.

MATERIALS AND METHODS

This study relied on focus group methods to generate in-depth qualitative data on patient satisfaction and preferences for healthcare. Relative to more familiar quantitative analytical methods, the advantage of focus groups stems is ability to identify a range of perspectives held and clarification and qualification of those views through group dynamics.[13] Following general procedures for focus group research,[14] this step involved semistructured small group discussions to obtain data about feelings and opinions about a topic, where the groups could be purposively constituted to represent a range of views that might exist in a community (e.g., age, ethnicity, health status, wealth or economic position, sexual orientation). A moderator's guide with initial topic areas and prompts for clarification and elucidation was developed centrally by the study group. At each site, moderators were trained to conduct the groups, and each site provided audiotapes for the sessions for central transcription and analysis.

Focus groups were conducted in 1998 at 6 of the 18 CoEs: The University of Michigan, Wake Forest University, Magee-Women's Hospital, University of California at San Francisco, University of Pennsylvania, and Boston University. Each center conducted up to three focus groups of women recruited from the community, for a total of 137 women participants. In order to include diversity in healthcare experiences and access, the focus groups were composed of both CoE and non-CoE patients. The groups were stratified by age (ages 18–34, 35–54, and ≥55) and race/ethnicity (Latina, African American, Asian, Caucasian). Each group included between 5 and 9 women (Table 1).

About 25% of the participants were publicly insured or uninsured. Among the insured, a variety of healthcare sources was represented, including managed care plans, community-based health centers, private providers, and alternative providers.

Women facilitators conducted the groups using a standard protocol. The protocol was designed to elicit women's expectations and preferences for their healthcare, as well as their met and unmet needs. Women were asked to discuss the meaning of "women's health" and what they value in their healthcare. Dimensions of quality of care included accessing healthcare, checking in for an appointment, provider-patient interactions during the visit, other sources of healthcare used, and interacting with office staff and follow-up care.

Data analysis

Thematic coding procedures were used to analyze the data qualitatively. The focus group transcripts were first closely examined for significant remarks that identified distinct dimensions of healthcare processes, content, and interactions experienced by women in the groups. An initial set of content categories on woman-specific and generic aspects of healthcare was identified, not limited by the original categories introduced by the focus group facilitator. Each participating CoE site reviewed the content for additions based on their own transcripts. Once the content classification was complete, the categories were clustered, analogous to specific items grouped within a scale, as distinct themes. Operational definitions were formulated for each theme and assigned specific codes by content clusters (Tables 2 and 3). The codes were entered into the NUD*IST (nonnumerical, unstructured, data-indexing, searching, theorizing; Centtric Marketing System, Markham Ontario, Canada) qualitative software program. The codes were then used to retrieve and organize the text units as they related to each category. A paragraph of text defines a "text unit," the smallest piece of text to be referenced by NUD*IST.

TABLE 1. NUMBER OF PARTICIPANTS IN FOCUS GROUPS BASED ON AGE AND RACE/ETHNICITY

	Age (years)			
Race/ethnicity	*18–34*	*35–54*	*>55*	*Total*
African American	(2) 14[a]	(2) 18	(2) 15	(6) 47
Caucasian	(2) 18	(2) 17	(2) 17	(6) 52
Asian	(1) 6	(1) 7	(1) 7	(3) 20
Latina		(2) 10	(1) 8	(3) 18
Total				(18) 137

[a](No. of groups) No. interviewed.

RESULTS

A total of 31 categories was identified, from a total of 13,655 text units coded, and comprised approximately 5% of the text. The uncoded content either was not related to a healthcare issue, did not contain a meaningful unit of information, or related to a healthcare experience but did not appear frequently enough to form a category. The concrete themes and the content that emerged as distinct clusters are shown in Tables 2, 3, and 4. These were then aggregated into dimensions of general and specific appraisals of care to include general views on women's healthcare and health needs; processes of care, such as access, empathy, care coordination and comprehensiveness, privacy, empowerment, and environment; and disease-targeted issues. Representative quotations (edited for brevity and clarity) for each theme were selected to depict more fully the relevant issues and experiences.

General views on women's healthcare and health needs

The concept of women's health was viewed as being holistic, involving physical and mental and emotional health, and counseling (this integration is representative of the CoE model concept). Women valued medical approaches treating

TABLE 2. INITIAL CONTENT CLUSTERS: GENERAL VIEWS ON WOMEN'S HEALTHCARE

General	General views or comments on women's health
Psychological health	Treatment for (i.e., therapy, medication) or coping with (i.e., stress management) psychological or mental health problems (i.e., depression, stress, panic attacks, loneliness) and preventive strategies for psychological health and well-being
Social support	Social groups, including family and friends, who provide patient support
Roles	How healthcare issues relate to women's various roles as spouses, workers, mothers, and so on.
Reproductive health	Reproductive health concerns (i.e., menstruation and endometriosis)
Childbirth	Concerns surrounding the childbearing process, including contraception (i.e., birth control and family planning), prepartum care, pregnancy, birthing process (midwifery), and postpartum care
Alternative medicine	Nontraditional medical practices (i.e., alternative or holistic medicine and adjunct therapies), including use of such methods and attitudes toward them
Prevention	Preventive strategies for nonspecific disease (i.e., wellness), including self-care (i.e., exercise)

health issues that included both traditional and alternative (or complementary) medicine, such as herbal medicine, massage therapy, acupuncture, and chiropractic.

> Women's health should be holistic, devoted to mind, body, spirit. [We shouldn't] automatically think of Ob-Gyn, women's problems, breast cancer, ovaries.

> When you reach menopause, to have programs that tell you more about it, the changes you are going to face.

> Sometimes we need someone to talk us thorough the adjustments of widowhood, the empty nest, and leaving the workforce. I don't mean someone who wants to give you pills and shots. You need someone to listen.

In terms of healthcare delivery, a common viewpoint was that the multiple components of women's healthcare were commonly segmented among different providers, resulting in a lack of coordination of care. Thus, the attributes of continuity and personalization in healthcare across providers, employers and health plans, and life stages was a common theme mentioned by all age and ethnic groups.

> Wouldn't it be great if you didn't have to see five different people and have them all ask you the same series of five questions, and that you didn't have to run the gauntlet of this room, that room: "Go here, I'm gonna weigh you, I'm gonna measure you, I'm gonna do this." I think when it's always somebody different, and "I'm going to send this person in now," you never really get anything across.

TABLE 3. INITIAL CONTENT CLUSTERS: DIMENSIONS OF PRIMARY HEALTHCARE

Access	Barriers and supports to using the healthcare system, including understanding how it functions, health insurance, accessing appointments, and checking in
Office staff	Issues with staff members (other than physicians or healthcare providers), including receptionist service and courtesy of desk clerks
Privacy	Showing respect for person by securing information and records, being shielded from others when disclosing sensitive information, not feeling diminished during check-in or examination
Empathy and empowerment	People skills of the healthcare provider or physician, including patient awareness and acknowledgment, sensitivity, caring, attitude, courtesy, communicative abilities, and character, and patient perspective on patient-physician interactions, including comfort level and patient trust
Provider skills	Technical skills of the healthcare provider or physician, including knowledge or expertise, training, and experience
Care coordination	Mention of the follow-up process, including test results and referrals
Environment	Mention of the environment of the clinic, waiting room or examination room, including privacy, room temperature, seating, decor, music, and gowns provided

TABLE 4. INITIAL CONTENT CLUSTERS: DISEASE PREVENTION AND TREATMENT

Diabetes	Concerns and preventive strategies for diabetes, treatment for or coping with diabetes
Cardiovascular heart disease prevention/management	Preventive strategies for cardiovascular heart disease (CVD) and concern with risk factors (i.e., cholesterol, obesity), treatment for or coping with CVD
Breast cancer	Mention of breast cancer that is not specific to prevention or management
Joint/arthritis	Preventive strategies for chronic conditions affecting limbs or joints or both (i.e., osteoporosis, arthritis, rheumatological disease), treatment for or coping with chronic conditions affecting limbs, joints, or both

Another ideal was to bring a focus on family into healthcare services.

> I have a daughter, and we have a very strong bond together. It would be nice if there was a place that both my daughter and I could go and get healthcare as women. Share with her a health provider.

Women viewed the concept "women's health" as also focused on issues important to women, such as nutrition and fitness, complementary medicine, sexuality, domestic violence, and prevention of chronic illnesses, such as heart disease, osteoporosis, diabetes, and cancer. A central viewpoint was to empower women through education, in the form of seminars, self-help classes, and counseling. For example, care relating to childbirth was viewed as being more than medical care focused on the body but including counseling and classes focused on practical experiences that women might face in the future.

> I feel that a health center should help women out if they have psychological difficulties, such as postpartum depression, family problems, difficulty balancing work and caring for the family.

> Not only offer treatment for acute conditions but offer preventive measures for psychological or emotional problems.

Dimensions of care

Several common dimensions of healthcare were investigated to reveal relevant content and their importance in appraising satisfaction with care. In each focus group, moderators elicited discussion about providers' knowledge and attitudes toward women's health, access to healthcare, communication, coordination of care, comfort during the examination, privacy and respect, getting test results, and follow-up care. We sought information on the specific experiences and emphases women value in determining the quality of their care and the extent that the care was woman focused.

Access issues

Women's views on convenience of access to care were focused on such concerns as convenience of time of day the office was open, how well access allowed them to fulfill competing demands, and having adequate and continuous health insurance coverage to maintain access. The participants in our groups had multiple roles, involving work, family, and community. This created a positive value on accessing efficient care, such as healthcare providers who could see them promptly when they needed care and did not keep them waiting:

> I work, I go to school. Time is my most valuable commodity.

> My biggest problem is trying to find child care while I run over to my appointment.

> One thing that I really like about my physician is that he's cognizant that I have children at home and that I always have to hire a sitter to get here.

Another dimension of access to care, overlapping with continuity of care, had to do with the patients' financial means. Some women in the focus groups reported barriers to both continuity of care and access to preferred care (practices or providers) based on insufficient insurance or changes in insurance carrier or policy, such as changes in employers or employment coverage. Many were faced with paying the costs themselves to ensure access to the best care.

> To get the doctor that I feel comfortable with, or remotely trust, I have to pay out of pocket.

> It is too expensive to be put on my husband's coverage. I [would] have to pay two-thirds what

his premium would be even though his company pays 50% [of his benefit].

They [women] choose between heart medicine and caring, or giving money to a child on a medication. Women will sacrifice and not take care of themselves.

There is someone in my family [70 years old] who doesn't get a mammogram as often as she should because she's afraid it's going to cost too much.

Some women were concerned that reimbursement was an important factor in access to referrals (e.g., for testing) in managed care systems or situations where out-of-pocket expenses might not cover the costs for procedures. Thus, a value was placed on trusting that the healthcare provider was an advocate for the patient.

As each year goes by, I feel less and less that physicians are going to suggest, "You need this test," because somebody's got to pay for it.

I had a bone density test done over my doctor's protests. She said, "It's an expensive test, and there isn't anything you can do anyway." Well, I have a bone density problem, and so I went on estrogen at that point.

Empathy, listening, and respect

Such qualities as being nonjudgmental, trusting, and a good listener were central themes for women participants. Women offered views of these qualities that related distinctly to women's roles in society and unique health needs. Participants expressed a positive evaluation of providers who respected the woman's own view of her health, who showed knowledge of women's health issues pertinent to her age or life stage, and who could have empathy, encouraging the patient to discuss complex and personal issues bothering her.

I want whomever I see to trust me, that I know my body. When I say, "This is how it feels," that I know what I'm talking about and not that I'm crazy.

To be aware, depending on your age, what things might be going on in your life as a woman.

I would like to say to the doctor, "I get very upset before my period," and the doctor to understand that and [then] to try to see what we can do.

More than just listening to the patient, desired qualities of openness and trust meant being willing to probe sensitive problems that women may face and to be willing to spend time counseling and advising on personal matters.

If I'm dropping clues about things, I would want them to take the step forward, to address the complicated [issues]. [citing an example] Battering is a really big issue that I think a lot of providers tend to skip because it's not on the checklist.

What I'm looking for is somebody who will have time for me and will sit and listen and talk.

When I was 18, I lost my mother. The doctor took over an hour with me, just to talk to me, to make me feel better. I was so sad, with the responsibility of all my sisters and brothers. I'm over 50, [but] I remember vividly how that particular doctor helped me in my personal life.

Women in the focus groups perceived that the provider's views of their healthcare needs were sometimes inappropriately connected to the patient's age, for example, healthcare relating to age, sexuality, or for the prevention and detection of disease. This perceived bias leads to a mismatch between concerns or needs that a woman patient might have with the services available to her.

It [healthcare] has to be completely nonjudgmental in terms of sexuality and not presume that because you're well over 70, you have no sexual life and no sexual desire.

When it comes to women, you have to be a specific age to get this type of care or that type of test. . . . That's the hardest problem I have is that sometimes age plays a factor in the doctor's decision.

A friend of mine just saw her doctor [about a bladder infection] . . . and the doctor said to her, "Well, I guess we don't have to worry about AIDS because you're no longer sexually active." Well, he deserves to be pounded on the head.

I've been battling with breast cysts. You know in your mind so many women have suffered from

> cancer, and it took 2 years before they said "OK, we will do a mammogram." I think you have to be a certain age before you get a mammogram.

Seeking greater empathy in women's health concerns, some women selected female doctors for their care, even though they felt they had received high quality care from a male healthcare provider.

> [I have] confidence because my male doctor was my doctor for many years. But at the same time I need a woman to talk to.
> I feel more comfortable with a woman doctor. I feel that she's feeling what I'm feeling.

> It's not the same when you want to say, "I want you to tell me [why], when I have sex, it's always hurting me." I don't feel like talking to a man like that.

> I just changed from a male to a female doctor because I'm now at an age that I need one-to-one talking.

Some women reported feeling that their health concerns and experiences (e.g., symptoms) were not being taken seriously or were attributed to psychosomatic processes or stress. The perceived consequence of this circumstance was a lack of effective care for their complaint or concern.

> I've had doctors that have really brushed me off. "Oh well, you're just hyper, just an excitable type." I'm not a stressed or uptight person, so don't brush it off and say that's why.

> They don't say to men, "It's all in your head, you're not feeling that pain, nothing is wrong with you." But to women, they say that all the time.

> You know, they always call everything a "panic attack."

> Everything is: "Oh, you'll be fine, dear." That kind of attitude is very condescending.

Privacy

Privacy is a core dimension of patient satisfaction with healthcare. It emerged in many aspects and processes of care and occurred along with the theme of respect. A respect for privacy communicates a fundamental respect for the patient. Privacy and respect were expressed both in terms of the nature or style of interactions with the patient and in term of environmental features.

An important expression of respect and feeling valued as a person was to have the courtesy of being fully clothed when talking to the provider until the physical examination has begun.

> The first time you see the doctor, I'd like to have my clothes on.

> [I would prefer that] they don't ask me to put a smock on unless I really have to.

Fragmentation of women's healthcare services during an encounter, through testing, examinations, and medical attention, also produced privacy concerns.

> You have different people helping out, and sometimes they will ask really personal stuff. I don't want to tell [this] stuff when I don't know where they fit in the chain, if I'm ever going to see them again, and how accurately it will be conveyed to the person [patient's physician].

Assuring privacy was also a concern in the waiting area and check-in station, where a patient may reveal sensitive information to those not involved in their medical care or be overheard by other patients.

> I get so irritated, standing there in front of God and everybody, being expected to tell the nurse or receptionist what it is that I want to see the doctor about.

> If you think you have a bladder infection, you have to reveal it to the receptionist.

Care coordination and comprehensiveness

Complexity of care processes for women's health was associated with the experience of needing multiple laboratory tests and referrals and the potentially serious health implications of some test results. Women in the focus groups expressed the concern that fragmented healthcare may lead to a breakdown in communication among providers and between provider and patient. A way of evaluating the integration of care was by assessing whether tests results, both positive and negative, were delivered in a way that was timely, preserved privacy, and provided the patient with education and an opportunity for consultation.

> It's nice to know that things are positive, or well and good, as well as when things are not so good.

> I'd rather have a phone call than mail. Look how long the mail takes. If you're afraid about something, a Pap smear, you really don't want to wait.

> What if your results get lost in the mail or delivered to the wrong place? What if they forget to mail it?

> I have lumpy breasts, and when I get terrified, I don't want to wait. In order for me to get my results right away, I had to pay extra.

> If you don't get a response after 3 weeks, then you should call them yourself.

As many women experienced being routinely referred to other providers for aspects of their care and testing, open communication channels between patient and specialist and between specialist and primary care physician received special emphasis.

> I don't have a problem with my own doctor giving me my results. It's when you're referred to someone else that you don't get the results, and she [the referring doctor] doesn't get the results.

Women in the group also perceived a need for more diverse forms of care, such as education and counseling. This included both more comprehensive health topics, such as parenting, sexual functioning, abuse, reproductive health, and menopause, and more routine or general considerations, such as taking medications, diet and nutrition, disease prevention, and treatment options.

> It's amazing how sometimes your doctor doesn't know anything about nutrition.

> When a doctor prescribes any kind of medication, he should also explain the side effects.

> They offered [me] Premarin [conjugated estrogens, Wyeth-Ayerst, Philadelphia, PA], and what information I got, I got on my own. He gave me a little pamphlet off the rack, "Here you go—Menopause."

Empowerment

Being included in treatment choices was another important facet of partnership that cuts across themes of empathy, access, and general views on women's health. Some women felt as if they had, in the past, little say over what medicine they were prescribed or whether other options were available, such as for menopause. Key experiences women reported involved being included in medication decisions and considering alternative or complementary medicines.

> She [nurse] said, "This is the medication he's going to put you on." I said, "I don't want that. [If] it's going to make me not be so alert. I have small children."

> I wanted to know all about the side effects. She pulled out this long thing [package insert] out of the bottle, with all this fine print. I looked at all the side effects, and said, "Oh my God, I'm not taking this."

Participants also wanted to know detailed results of their examination or laboratory test and often want more information than is typically provided.

> Don't tell me what you just think I need to know. I want to know what the test was for. I want to know what you were looking for, what were the results. What does that mean?

> On one of my mammograms, they explained everything: what they did, including my own body; it was not just all technical. I'm involved, it's me, and I'm caring about myself to keep healthy.

> I would prefer that my doctor would send me a list. I would want to monitor my lipid profile and compare this year's profile to last year's. This way, you better understand your health status.

Environment

Another aspect of patient satisfaction had to do with the environment of the clinic and healthcare center. This included views on the clinic waiting room or examination room and such qualities as the amount of privacy offered from the office layout, curtains, provision of gowns, warmth, general comfort, such as temperature and furniture, and apparent cleanliness of bathrooms and apparatus. A patient related a positive experience during a mammography visit:

> They had shelves with all kinds of information, and everything was ready when I got there. They

> knew I was coming. I was taken on time. They had lovely rooms that you could change in. They had lockers—you could lock your stuff up, and coffee and tea while you were waiting.

The necessity of examination gowns, or being partially clothed, gave added importance to the temperature of the examination room, the length of the wait, and privacy from others.

> My office stirrups have booties, so they're not cold.

> I was sitting there like a fool, waiting and waiting. Meanwhile, the air conditioning froze me half to death because I was hardly wearing anything!

> It's best not to have men in close proximity to the area where you are going to be examined.

Office decor that suggested warmth and provided physical and psychological comfort was also highly desired.

> The gynecologist I go to has quilts on the wall that had been made by staff and patients. Now that's my idea of a welcoming decor.

> I think the most important are the seats. You must be comfortable when you're sitting down.

> I would rather have quiet, and maybe the sound of water—rather than someone's taste in music.

These attributes of the environment, whether design, layout, ambience, or amenities, could function to communicate to the patient that the healthcare system both understands and values how women experience their healthcare.

Disease-targeted issues

Many of the older adults in the groups either had a diagnosis of a chronic disease, such as diabetes or arthritis, or had a family history of disease, such as cancer or heart disease. These women reported needing frequent tests and patient education on self-monitoring and wellness. There was a positive value among the group for structured patient education sessions, such as classes and demonstrations of how to do self-examinations. Also important was that the healthcare provider initiate discussion of disease prevention and help the patient track and monitor an often complex schedule of events. Although most women in the group recognized personal responsibility for day-to-day disease prevention and maintenance, they valued assistance with their testing schedule, follow-up visits, and navigation through the healthcare system to obtain good medical care.

> I am willing to take the burden, to educate myself, but I can't be the expert. I have to have the confidence that when I go in, they are prepared.

> My doctor is very educated, that's why I keep him. Whatever he feels I need, he knows where to send me to get it. He is up on everything, and what he doesn't know, he'll find out. He's just really good.

DISCUSSION

The primary goal of this study was to identify clear and distinct qualities of the healthcare experiences women value and how women want to experience their healthcare. Viewpoints on women's health and quality of care were common across our demographically diverse focus groups conducted in different geographic regions of the United States.

Overall, the women studied tended to discuss what they valued in their healthcare from the perspective of their experiences in the healthcare system rather than in terms of an idealized healthcare delivery system. Thus, their expectations were based on reality rather than idealized preferences. When asked about their preferences for a women's health center, most responded positively with the view that such a center could provide many of the services and healthcare experiences they desired, such as easy access and comprehensive and coordinated care.

A high value was placed on finding excellent medical care, generally defined as healthcare that is in tune to women's bodies and lives and holistic in scope. Consistent with the CoE model and philosophy,[12] the concept of woman-focused care was depicted as more than reproductive health, incorporating psychological health, social functioning, sexual health, family, and relationships. Modes for treatment included traditional reliance on medication and surgery, as well as lifestyle, alternative medicines, and counseling and education.

Although some women had kept the same doctor or health provider for several years, others had shifted among health plans and providers. These changes were the result of changes in insurance status (e.g., through employment), health plan, or turnover of health providers or from voluntarily seeking a different provider for better care. The result was that many women had personally experienced distinct contrasts in satisfaction with care, thus offering a practical means for comparing aspects of healthcare across providers and health plans. The results of the focus groups revealed that although specialization of healthcare offers perceived diagnostic advancements, it has become cumbersome for those who now receive their care from different providers in different settings. This tradeoff is expressed in patients' subjective experience of their healthcare as a detached relationship with the healthcare process and decreased awareness of how information flows across providers or departments. Women's perception of a lack of coordination of their healthcare among the various components or services was described as disjointed information flow among stakeholders or characterized as slow feedback to the primary care provider and, sometimes, the omission of a discussion with the patient.

Another concept was a sense of partnership with healthcare providers. Most women felt responsible for their own health, but owing to the complexity of care, they wanted their healthcare provider to advocate and use proper tests at the proper time and provide access to a full range of services. Perhaps a fundamental experience was for the patient to feel that she had been taken seriously and respected, not just listened to. Although many women had a healthcare provider who conveyed this, many had past experiences where this was not the case. Listening was only a segue for a more complex set of interactions, including taking enough time with the patient, asking questions, and counseling or giving advice on health issues. Connected to the concept of partnership was that the healthcare provider think in terms of the patient's life circumstances, not just her medical condition, in health promotion. For example, test results not communicated promptly or those difficult to understand are prominent among experiences that heighten fear and uncertainty of whether a major health event is looming or what future steps are needed to reduce risk.

Other experiences in healthcare settings that were perceived as key issues for women accessing healthcare involved privacy and comfort. Some women felt a loss of privacy in public areas (e.g., near the admission desk) and in the examination rooms by having to reveal personal information to those other than their healthcare provider, or where there was a possibility of being overheard by others. Temperature of the examination room and comfort were important, especially when wearing an examination gown.

Finally, women in the focus groups frequently discussed healthcare expectations not just in terms of their own experiences but also based on their experiences obtaining care for others, including children, spouses, or parents. Office hours that allow flexibility and integration of family care at one site were valued as reducing the barriers some women felt in accessing care. These arrangements when experienced were interpreted as recognition of women's issues and contexts.

The focus group content in this study revealed aspects of care and emphases in satisfaction with care not found in common or generic satisfaction instruments. Scholle et al.[11] discuss the prototype woman-focused patient satisfaction tool that was informed by these results. This instrument is being tested and refined at present. There is other evidence to suggest that satisfaction measurement can be advanced to be sensitive to women's health issues. In a review of satisfaction studies, Hall and Dornan[6] showed interesting differences in the ranking of satisfaction domains. Across studies, patients were most highly satisfied with aspects of care, such as humaneness, technical quality, and overall quality, and these topics were included in nearly all satisfaction studies. In contrast, patients were least satisfied with aspects of primary care, such as attention to psychosocial problems and aspects involving the patient's relationship to the healthcare system, not the provider (e.g., access, cost, and waiting times). The nature of this pattern is unknown, but the authors suggest that one interpretation is that the healthcare system is more effective in addressing patients' biomedical needs (providing high technical quality and good humaneness) than other patient needs related to emotional and cognitive concerns and to their other daily responsibilities. Of course, an alternative view is that patients may be reluctant to judge factors related to their healthcare provider as poor but feel free to judge other factors more critically. These findings sug-

gest that including a broad range of topics in satisfaction surveys that go beyond strict medical needs is likely to yield better distributions of ratings and may be particularly important for women.

In considering the results of this study, it should be noted that focus groups are intended to draw out a range of beliefs and attitudes that are important to consider for a topic or construct. Thus, our results are not indicative of the prevalence of dissatisfaction with women's healthcare in the community but demonstrate key areas of concern and areas of strength that women perceive and value about their healthcare. The wide variation in experiences in healthcare reported by the participants, both concurrently and retrospectively, does suggest that woman-focused healthcare may be uneven or haphazard at best and, in fact, sometimes difficult to get. A woman's health center should be designed for women, based on their expectations, in a format that is clinically effective and valued by patients. Finally, the components of clinical care that women describe in this study are consistent with the objectives regarding delivery of primary care.

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