Cultural Health Capital and the Contraceptive Medical Encounter

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Abstract

Contraceptive medical encounters among low-income women present an ideal context for examining the influence of Cultural Health Capital (CHC; Shim, 2010) in medical interactions as part of the perpetuation of health disparities in the United States. Low-income women face significant problems in obtaining contraceptive care because they have less CHC and are therefore less likely to express their lifestyle constraints to their doctors. I present data from interviews with 40 low-income women in Colorado to demonstrate a cycle of stereotyping and assumptions by medical professionals and paternalistic decision-making and impaired trust relationships between doctor and low-income female patients. These issues are both exacerbated by low-income women's lack of CHC and indicative of the importance of CHC in medical encounters. More attention must be paid to lack of CHC in contraceptive medical encounters to effectively reduce unplanned pregnancy in the United States.

Cultural Health Capital (CHC; Shim, 2010) is the idea that people differentially learn sets of behaviors and ideas from their social world which can help them navigate their health and the health care system. Lack of CHC has been found to contribute to health disparities (Dubbin, Chang, and Shim, 2013; Shim, 2010). Shim's (2010) work simultaneously extends and challenges fundamental cause theory, which suggests that health disparities are the result of underlying social conditions such as socioeconomic status (Link and Phelan, 1995). It does so by suggesting that socioeconomic status can be enacted without purposeful intent to do so (Shim, 2010). The CHC framework, therefore, looks at how disparities in health are created and perpetuated as the result of "often unintentional and unplanned enactment of health-related practices" (Shim, 2010, pp. 5).

The poor have been shown to have less CHC in terms of being able to adapt their interaction styles to the doctors, their level of medical knowledge, being able to take an instrumental attitude toward their bodies, their orientation and concern about the future, and their belief in the value of self-discipline, among others (Shim, 2010). In conjunction with this, doctors serving this population often face structural barriers in the context of clinics serving low-income populations and the "15-minute" appointment (Fiscella and Epstein, 2008; Lutfey and Freese, 2005). In these situations, doctors may rely on heuristics and stereotypes to a greater extent when it comes to making judgments about their patients, and importantly, their likely compliance with treatment (van Ryn and Burke, 2000). It is therefore reasonable to think that stereotype activation may be particularly strong in these circumstances and that low-income women lack the CHC to counter these stereotypes.

Stereotypes of low income women particularly, are strongly connected to unrestrained childbearing and poor use of contraceptive methods (Downing, LaVeist, and Bullock, 2007).

Given the context of this stereotype, while doctors may feel that some sort of contraceptive is necessary to prevent childbearing, it may not be at the top of their list (Brown, Burdette, and Rodriguez, 2008). This in turn is likely to lead doctors to engage in paternalistic decision-making when the issue of contraceptive method choice is addressed in the interest of providing some form of contraceptive to their patient (Henderson et al., 2011). It is unlikely in this scenario that time is available or will be spent on the lifestyle fit of the methods prescribed, which has been shown to be critical for adherence to medical routines (Fiscella and Epstein, 2008 Langston et al., 2010; Pinter, 2002). This sets up a frame in which physicians at the same time encourage women to limit childbearing by using contraceptives, while devoting little to no time to helping them do so. Given the highly personal nature of successful contraceptive use, these circumstances make CHC, especially the ability to interact successfully with their doctors, a necessary component of receiving contraceptive care that will result in women receiving a method that will allow them to engage in successful long term pregnancy prevention.

This paper argues that contraceptive services present a unique and ideal circumstance for examining the role of CHC in the medical encounter as it contributes to the relationship between poverty and health disparities. Because successful contraceptive services are largely based on the input of the women receiving services, and the degree to which doctors are able to take into account their patients life circumstances, women lacking CHC are more likely than others to experience problems with their encounter with the doctor and other medical staff, and to end up with a contraceptive method that is not effective for them. Specifically, low-income women who are hampered by lack of CHC are less likely to openly communicate with their doctors, less likely to successfully convey the constraints of their lifestyles in regards to various contraceptive methods, and less likely to be given power within the interaction to openly negotiate a contraceptive method that they will be able to use successfully over the long-term.

Importantly, I suggest that poor women in these situations engage in a cycle enacted with their doctors. Women come in for medical care and want contraceptives. However, they feel stereotyped by office staff, as well as medical personnel such as doctors and nurses as poor (i.e. having too many children, unrestrained sexuality, promiscuity, etc.). They lack the CHC to counteract the applied stereotypes and successfully engage with medical staff which impedes the development of a trust relationship with their doctor before their appointment even begins. Women then enter their appointment with their doctor feeling that they have been stereotyped in negative ways, leading to reduced communication with their doctor, making them unlikely to bring up and discuss lifestyle issues which may impact their successful use of contraceptives, and discouraging them from using the CHC they do have. This in turn leads to paternalistic decision making on the part of the doctors, who may feel they need to provide the woman with *something* to prevent pregnancy. Finally, there is reduced compliance on the part of the women in terms of successful use of the method prescribed. Unfortunately, this perpetuates and strengthens the doctor’s initial stereotypes of poor women and reproduction and starts the cycle all over again. This cycle demonstrates the consequences of lack of CHC for poor women, and explicates the way in which lack of CHC combined with strong stereotypes of low-income women’s reproductive health perpetuates health disparities.

Specifically, women in these situations lack the CHC to interact with the doctor in ways which will result in the doctor giving them credit for knowledge of their body and lifestyle in terms of pregnancy prevention. Thus CHC or lack thereof, becomes a critical part of both the perpetuation of the stereotype of poor women and reproductive health, and the contraceptive medical encounter. I argue that contraceptive encounters demonstrate the influences of CHC to a greater extent than do other medical encounters and further and is therefore a particularly relevant lens for examining how CHC is played out between physicians and the poor women they treat.

Background

The Influence of Culture on Health and "Cultural Health Capital"

The initial outline of cultural health capital (CHC) focuses on how this capital plays out in medical interactions, particularly the treatment of disease (Shim, 2010). Specifically, it was defined by Shim (2010) as "the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more optimal health care relationships" (pp.1). Although the specific term "cultural health capital" was more recently introduced (Shim, 2010), the idea that culture and learned culturally appropriate behavior influences inequality and health inequality specifically is not new. The concept of cultural health capital is based on Bourdieu's notion of cultural capital in which he argues that cultural capital consists of learned ways of eating, dressing, and speaking, combined with levels of education, and other credentials, that function as forms of capital (Bourdieu, 1977, 1980, 1986). Further, Bourdieu suggests that "systemic inequalities exist in both the ability to accrue capital and to convert it into advantage" (Shim, 2010, pp. 4). Bourdieu introduced the idea of cultural capital in the 1970s, describing it as the representation and promulgation of classes based on knowledge of the social world (Bourdieu, 1985). This "symbolic capital" (pp. 731) is then used to reproduce existing power structures within a society or culture (Bourdieu, 1985).

The idea of CHC is also based on Link and Phelan’s (1995) theory of socioeconomic status as a fundamental cause of health disparities. This theory suggests that in order for health disparities to be reduced, the social conditions which lead to specific health risks must be addressed, and further, that socio-economic status is critical in determining what health information and resources individuals have access to and thus the degree to which they are able to determine their own health. This theory also suggests that people knowingly and agentically have access to resources and take advantage of these resources (Link and Phelan, 1995; Shim, 2010).

The concept of CHC extends fundamental cause theory by suggesting that individuals can acquire and enact CHC unknowingly through repeated interactions with medical providers and their own attitudes toward general consumption of health related information. Importantly, “holders of CHC are not individual free agents who can simply acquire and deploy resources at will” (Shim, 2010, pp. 4), but rather experience CHC through interactions with medical providers. Further, use of CHC is largely determined by ones social position, and what is valued in medical encounters is largely shaped by those from higher socioeconomic status categories. In addition, in recent years medical training and expectations have shifted toward putting more responsibility on the patient to be an informed consumer of medical services, which makes those who have more CHC better able to present themselves in medical encounters in ways which will encourage the doctor to enter into a more equal patient-provider relationship (Dubbin, Chang, and Shim, 2013).

Stereotyping in Medical Interactions

Stereotypes of gender and poverty have been shown to influence the provision of health care (Smedley et al., 2003; Travis, Howerton, and Szymanski, 2012). Doctors often rely, even if unknowingly, on stereotypes and the accompanying attributions of specific characteristics to those social categories, even when they believe themselves to be making judgments based purely on biology and medical knowledge (Balsa and McGuire, 2002). Typically, stereotypes of poor women include characteristics such as lazy, dishonest, criminal, immoral, and sexually promiscuous (Breheny and Stephens, 2009; Downing, LaVeist, and Bullock, 2006). Studies have shown that the poor are more likely to be ill and less likely to obtain medical care for those illnesses (Monnickendam et al., 2007, Berkman et al., 2011). Furthermore, the poor are more likely to feel powerless in interactions with medical staff and institutions, are more likely to experience paternalistic consultations, have trust issues with their medical providers, and to be seen by providers as making substantial compromises on their health (Monnickendam et al., 2007). These concepts are explicitly included in the concept of cultural health capital and are linked within that framework to successful patient-doctor encounters, with those from lower SES groups less likely to have CHC and therefore less likely to be able to successfully navigate today’s medical encounter (Shim, 2010; Dubbin, Chang, and Shim, 2013).

Importantly, women in poverty frequently have life circumstances that are more complex and less regulated than the lives of women in better socioeconomic circumstances and as such, health decisions – such as choosing an appropriate method of contraception – are impacted both by poverty and by their inconsistent lifestyles (Benson, 2000; Monnickendam et al. 2007). With these ideas in mind, doctors may make assumptions about the needs and abilities of their low-income female patients. It is important to note that low-income women face a special burden because they are often stereotyped based on gender **and** socioeconomic status and that lack of CHC complicates their medical encounters in relationship to their membership in both of these disadvantaged groups.

Compounding this is the fact that low-income women frequently use public clinics for medical care, and these clinics are often overburdened with doctors having limited time to care for each patient they see (Smedley, Stith, and Nelson, 2003). Patients in these clinics are more likely to be young, minority, or disadvantaged when compared to patient's utilizing privately funded health services, and this can lead doctors to more readily apply the stereotypes associated with these groups (Landry, Wei, and Frost, 2008).

Finally, stereotypes relating to low income women also sometimes conflict with general cultural values labeling motherhood as positive and as the ultimate means for demonstrating one's femininity and gender role (Thompson, 2002). They can also conflict with sub-culture values in the low-income community in which motherhood is a means to status and self-esteem – and sometimes the only means to achieve those ends (Edin and Kefalas, 2007; Bianchi-Demicheli et al., 2006; Benson, 2000).

Paternalistic Medical Decision Making and Lifestyle Considerations

Research on medical decision making has shown that doctors are more likely engage in paternalistic instead of shared decision-making, when dealing with low-income, low-status populations (Monnickendam et al., 2007), and this is particularly true for poor women as a particularly marginalized group (Breheny and Stephens, 2009). Confusing this issue, is the fact that many doctors use stereotypes to limit contraceptive method choice and information due to their personal association of specific methods with specific stereotypes and their feeling that their knowledge and moral position are superior to that of the patient (Akers et al., 2010; Goodyear-Smith and Buetow, 2001; Parker, 1997).

Unfortunately, some doctors treating low-income patients adopt a paternalistic attitude and feel that low-income patients are poor health decision-makers in general and therefore should not be trusted with their own health decisions (Schuler et al., 1985; Monnickendam et al., 2007). Lack of CHC compounds this problem and so poor women are less likely to have the skills and knowledge necessary to interact with their doctor in such a way that they will be taken seriously (Shim, 2010). All of these factors can lead to bad contraceptive decision-making on the part of physicians and thus the women they treat. In addition, this paternalistic style of doctor-patient communication tends to emphasize the management of the patient's behavior which in turn inhibits patient question asking and their participation in decisions (Aruguete and Roberts, 2000; de Haes, 2006), and this is complicated by the lack of CHC available to most poor women (Shim, 2010).

All of these circumstances can lead medical providers to spend less (or no) time examining social and life circumstances, when in fact, what is necessary for successful medical decision-making in most cases, is a combination of biology as well as lifestyle factors of the individual patient (Bird and Reiker, 1999; Gray et al., 2006). Martinez et al. (2010) stated that "research has increasingly found that biomedicine is part of the cultural system within which it is embedded (pp. 339)." This alludes to the concept of CHC, in that it discusses how important the cultural influence can be on how medicine is practiced (Martinez et al., 2010). Limited time and thus limited opportunity for gathering sufficient knowledge about the specific life circumstances of patients in public clinics can lead to a higher degree of clinical uncertainty in the recommendation of treatment options (Fiscella and Epstein, 2008). This, in turn, can lead to a heavy reliance on assumptions based on doctors' social categorization of the patient and their knowledge of what they consider to be similar patients whom they have treated in the past (Smedley, Stith, and Nelson, 2003; Bianchi-Demicheli et al., 2006; van Ryn and Burke, 2000).

A trust relationship and shared decision-making within the doctor-patient relationship is an excellent predictor of adherence to prescribed treatment (Gray et al., 2006; Ommen et al., 2008; Lipkin, 1996), and a lack of trust can make a patient feel dissatisfied with her treatment and create a lack of faith in her doctor (Johansson et al., 1996). The inherent power imbalance in the doctor patient relationship puts the burden on the more powerful party – the doctor – to establish a pattern of shared decision making which gives the patient credit for being the expert on their own body (de Haes, 2006; Goodyear-Smith and Buetow, 2001; Malterud, 1992; Gwyn and Elwyn, 1999). This is particularly true for low-income women whose socioeconomic status puts them at a greater power disadvantage than a high income patient would be (Freund and McGuire, 1995; Shim, 2010) and is also particularly relevant when it comes to contraceptive decision making, in which finding the appropriate method is largely dependent on women's physical reactions to the chosen method as well as how the method fits into her lifestyle (Brown, Ottney, and Nguyen, 2011). The effect of CHC for low income women is clearly demonstrated in that an inability to communicate lifestyle preferences and engage in discussion with their doctor increases the chances of a mismatch between the woman and the contraceptive method she ends up with.

Women in this study indicated that they felt stereotyped by doctors, that doctors frequently did not present them with available options in regards to contraceptives, and that any trouble with methods provided led them to feel that contraceptives did not work for them, often resulting in discontinuation of use. Women expressed concern that doctors had not provided them with all available methods to choose from, indicated that this was a violation of the trust relationship with their doctors. They further expressed regret that they had not been offered the opportunity to find a contraceptive method that worked for them which they attributed to limitations imposed by their doctors. In some cases, these circumstances resulted in the birth of additional children, which were not planned, and often not wanted. In addition, throughout all interviews women expressed difficulty with finding a doctor with whom they feel comfortable, with being able to get to know a doctor and see them repeatedly over time, and also in communicating successfully with the doctors they do see. The research presented here argues that the contraceptive medical encounters of low income women provide a special and unique framework for examining how culture, and CHC, influence medical decisions and perpetuate health disparities due to the critical importance of the effective communication of personal choice and lifestyle in successful choice and adherence.

METHODS

This paper includes data from semi-structured interviews conducted in September and October 2008 in the Rocky Mountain region of the United States. The interviews focused on contraceptive use and unintended pregnancy in low-income women. Interviews were conducted using a quota sampling procedure. The goal of the original research was to broadly investigate reasons for contraceptive non-use among low income women who stated that they did not want to get pregnant. The themes and narratives discussed in this paper arose inductively from women's discussions of their contraceptive use.

All participants were between the ages of 18 and 44, female, heterosexually active within the past year, not medically or biologically sterile, and on Medicaid at the time of the interview or within the previous year. Only Black and White women were recruited for the study because other research conducted by the author suggested that contraceptive barriers in the local Latina population were unique, while other racial and ethnic groups were not prevalent in the region.

Women were recruited for study participation through flyers posted at public transportation stops serving low income neighborhoods and in addition, the text of the recruitment flyer was posted on Craigslist (www.craigslist.com). Seven women responded to the Craigslist posting and 33 were recruited via flyers. Quota sampling was based on age (18-29 and 30-44) and race (Black and White). Women were offered $50 to participate in the interviews, which typically lasted 30-60 minutes. Interviews took place in participants' homes or in a local public library and were conducted by the author, a White woman in her late 30s. Participants filled out a short questionnaire prior to the interview in which they were asked to estimate their income; indicate the number of household members supported by that income; confirm their Medicaid status, marital status, and whether they were pregnant; and to indicate how important it was to them to avoid pregnancy. In total 40 women were interviewed, 20 women aged 18-29, and 20 women aged 30-44.

Interviews were recorded and written informed consent was obtained from each participant. Interviews were transcribed and then coded using *NVivo* 10 qualitative software. The data were first coded based on interview questions. Following this, the author read the entire set of transcripts. During this process, themes surrounding medical interactions and stereotyping, and paternalistic decision-making arose. The author and an assistant coded the transcripts from the interviews independently and then discussed discrepancies until resolution was reached. Institutional Review Board approval for this project was obtained from a local university.

Results

Women describe multiple instances of a negative cycle of stereotyping, paternalistic decision-making, and trust violation in regards to contraceptive use, and largely attribute it to lack of power and negotiation during medical encounters – part of the concept of CHC. Specifically, many women report feeling that stereotypes are applied to them unjustly by medical personnel, and that medical personnel did not always engage in a back and forth conversation with them, an example of the negative impact of lack of CHC. Some differences were evident by race in how stereotypes were applied. In relation to this, women describe instances of circumscription of contraceptive choice. Women portray these experiences as leading to both trust issues in the doctor-patient relationship and method dissatisfaction. In many instances, women describe encounters during which they felt unheard by their physician or where they were unable to effectively communicate their wishes to their doctor.

Women's Experiences with Stereotyping in Medical Interactions

Women expressed both frustrations with perceived general stereotyping by doctors as well as the restrictions they felt it imposed on their medical care. Many women discussed experiences with "substandard" treatment by medical personal which they attributed to their status as a Medicaid patient. One White woman, 23 years old, said "I think … being on Medicaid you're treated as a substandard person or patient," while another White woman, 33years old says, "I know that I get treated like garbage," referring to her medical interactions while on Medicaid. This woman also discussed an experience she had with medical front office staff in which she was told that because of the lower rates of payment by Medicaid for services, the doctor was "doing you a favor" in seeing the woman at all. These types of interactions create the feeling of being stereotyped before women even see the doctor.

Other women reported feeling "not cared about" and that staff in doctor's offices are "not very helpful." On top of this, women talked about being treated rudely by staff and doctors. One White woman, 34 years old, summed it up nicely, saying: "A lot of places, they're rude. They're rude because they look at you like a second class citizen because you don't have your own insurance." These women felt discriminated against and also felt that medical staff have the attitude that "the state's paying for it, so we don't have to be nice to you." The women described above, all White, experienced stereotyping based primarily on their insurance status, rather than their childbearing history or future plans.

Black women, however, reported experiencing stereotyping more directly related to childbearing and contraceptive use. One 25 year old Black woman referred to experiences she had while pregnant on Medicaid, demonstrating the general application of stereotypes of Black women in the provision of reproductive related medical care.

> "[The doctor] assumed that I had been on Medicaid the entire time [of her pregnancy] and that kind of pissed me off… It made me feel like she kind of stereotyped me. That I was a single African American woman who was pregnant and didn't have a father in the baby's life or anything like that, so I just really felt like I was profiled and stereotyped. If she did stereotype me, she had it all wrong."

Because of her insurance status as a Medicaid recipient and her race this woman felt that her doctor applied inaccurate stereotypes to her and then used these stereotypes to make important medical decisions, rather than basing her assessment on the woman's needs as an individual patient. Another Black woman, 26 years old, also discussed feeling stereotyped with regard to childbearing: "My doctor… she's like 'you don't want to get pregnant…you don't want to get pregnant; we've got to get you on something.' I think maybe she didn't want me pregnant."

One Black woman, 40 years old, with thirteen children, reports feeling that doctors are more likely to bring up contraceptive use, even in situations where they are not visiting the doctor for themselves, but rather are bringing a child in for a visit. She puts it this way: "When they find out how many kids I got, they just all come at me…like they're all putting pressure on me [to use contraceptives]…I don't like that." This woman feels that doctors make the judgment that she has too many children and should not have more, regardless of her own wishes in terms of contraceptive use or childbearing. Another Black woman, 32 years old, reports a similar experience though she has only three children: "I took my son to the [clinic] and that's one of the questions they ask you. 'What form of birth control…?'… I was kinda like, 'why you asking me that?' I was…don't want to say offended, but I was like 'are you trying to say I got too many kids or something?'" This woman was upset that medical staff there to see her son felt it was appropriate to discuss her contraceptive and childbearing choices, and reacted defensively impacting any trust relationship she may have with the medical provider and reducing communication and trust – both important components of CHC.

Paternalistic Decision-Making and Violations of Trust

Women reported desiring encouragement from their doctors regarding contraceptive use. However, they were also clear that they want doctors to be careful in how they provide that encouragement. Specifically women express the desire to make their own choices and not have the doctors' choices and values imposed on them. One Black woman, 32 years old, expressed excitement about her doctor's encouragement and support for an IUD placement.

> Next week, I'm pretty sure [my doctor's] gonna put [an IUD] in...my doctor told me 'you better not come back here pregnant, you understand me?' 'Yes.' 'You're gonna get a pregnancy test before I put it in.' I'm making sure. I told someone if I go in there pregnant, I'm gonna kill him."

However, later in the interview this same woman expressed concern about the level of the doctor's encouragement regarding contraceptive use, especially after pregnancy: "When you go to the doctor after your pregnancy and toward the end they talk to you about it, about what you planned to do. But I don't…think they need to be like 'Lookie here, what you need to do [is]…'" While she clearly liked encouragement from her doctor on one level, at the same time she was leery of her doctor choosing a method without her participation.

Many women also express frustration with the lack of options and discussion regarding choice of contraceptive. One Black woman, 35 years old, discussed restrictions of contraceptive options and her feeling that she was being experimented on.

> I don't appreciate not being given that information [about contraceptive options] before and even after…my little one was born, the doctor never talked about the different options, she never went over, she never even brought that [the IUD] up to me… Maybe if the doctor had talked to me about a couple more different options and explained the situation a little more. It was probably a new product coming out… you [don't] wanna be the first one. They were just pretty much experimenting, to me, with everybody.

A White woman, 23 years old, talked about being upset that even after an unplanned pregnancy, she was not offered a choice from the full range of contraceptive options. "I don't appreciate not being given that information…after…my little one was born. The doctor never talked to me about different options…she never even brought that up to me." This woman went on to say that she feels that had she been presented with a wider array of contraceptive options, she may have been able to avoid an unplanned pregnancy. A 35 year old Black woman also indicated that a wider variety of options would have changed her choice of method: "If I had had more options, I probably would have did something different," she said, expressing her dissatisfaction with the method chosen by her doctor. A 24 year old White woman, also discussed the limitations put on her by her doctor in terms of method choice saying: "If they had made the Depo shot more available, or told me [about] other things besides the pill." She goes on to say she may have made a different contraceptive choice if she had been presented with more options. Other women also reported being offered the birth control pill as their only contraceptive option: “If you need…to see the doctor, and they know that you’re not on birth control, they give you a little package [of birth control pills] before you leave out of there.” This woman describes being given birth control pills without any discussion or consultation with her as the patient. Importantly, none of these women indicated feeling comfortable or able to express their concerns or frustrations to their doctors – in other words, they lacked CHC which resulted in them leaving the medical encounter with whatever method was offered by their doctor.

Other women complain that information is just not provided to them about contraceptives. One 23 year old White woman said: “The doctor never talked about different options,” while another White woman, 21 years old said: “They really didn’t give me much information.” None of these women indicate feeling comfortable asking their doctor for more information. She went on to complain about lack of information being given specifically about side effects saying: “They didn’t even tell me what side effects [to expect] or anything like that.” Another woman, (White, 29 years old), was more explicit about this:

> They didn’t give me enough information as far as side effects, what I should [come] in for, if…I had missed a pill, what should I do…how I should go about preventing pregnancy. And with the Depo, if I missed a shot or if I was a week or two weeks late…they didn’t explain very much to me.

This woman experienced a dearth of information regarding contraceptives that she had been given on more than on occasion, and by more than one doctor which presented a significant barrier for her to successful contraceptive use, but was unclear why they doctor did not give her additional information and did not feel she had enough information to question the doctors' about their choices.

Women indicated that these experiences make them uncomfortable and violate their trust relationship with their doctor. When asked about approaching her doctor for information on contraceptives, one 40 year old Black woman said: "I tried to go to my doctor but he told me wrong." In this case, the woman's doctor had told her that she could drop in for a Depo shot, when in fact, she was required to make an appointment and it took much more planning and forethought than the doctor communicated was necessary. This made the woman feel that the doctor had both not considered her life in the contraceptive recommendation, and that he had not given her the information she needed to make the prescribed method work for her.

Not all women were distressed by the doctor's selection of a method for them, but this appeared to be largely dependent on a solid trust relationship being present between the woman and her doctor when the method was decided on. One white woman, 24 years old, describes her experience with her long time physician: "We talked about a couple of different [contraceptive methods]…but she just said this one will be the best for you and I'm like 'ok.'" This woman felt that because her doctor knew her, she was in a position to recommend an appropriate contraceptive method to her, and was willing to go along with her doctor's suggestion. Another White woman, 32 years old, reported a similar experience with her doctor: "[The doctor] said, 'Well I know the type of person you are because you've been a patient of mine for all this time so I think this would be best.'" This woman was willing to trust that her long time doctor did know what method would fit best into her life. Unfortunately, in most cases women reported seeing different doctors over time and even attending different clinics where there is no history or trust relationship present to facilitate their enactment of CHC with the doctor they see.

Women who are satisfied with their current physicians talked doctors they saw in the past and the lack of a trust relationship in those encounters. Women talked about this in a way that suggests that until their current patient-doctor relationship, they had not been aware of the difference the relationships could make. One White woman, 40 years old, said: “The doctor that I had at the time after I had my last child, if they knew about [the IUD] I don’t know why they didn’t say ‘well let’s try this.’ It’s too bad that I didn’t have a doctor that was like the doctor I have now.” This woman was happy with her current physician and lamented the fact that it had taken a long time to find a doctor that she could form a good relationship with. Specifically, she felt that events in her reproductive history might have been different had she had her current doctor earlier in her reproductive life course.

Being comfortable with their doctor and feeling that they could communicate easily with him or her is important to many women. When they discuss situations in which they were satisfied with their care they mention a high level of comfort. One 32 year old White woman said: “I was very comfortable. He let me know. He told me a few different [contraceptive] options and discussed them with me.” Also emphasizing the importance of comfort, 29 year old White woman talked about how she felt when she **didn’t** know the doctor: “I was dealing with somebody I didn’t know. And it was more uncomfortable.” This woman placed a great deal of value on being comfortable with her doctor and having a trust relationship, and was not happy when that was not present in her medical encounter. Her comment also implied that she didn’t feel as if she could communicate successfully with her doctor without that comfort level demonstrating how lack of CHC impacted her medical encounter. Another sentiment some women expressed is that it is “important that [the doctor] makes me feel like he’s concerned,” also indicating the importance of having a trust relationship with their doctor and the idea that the onus is on the doctor for creating that atmosphere – at least among this population of women. These women said that feeling comfortable with their provider facilitated open discussion and contributed to a higher level of knowledge of the woman's life circumstances on the part of the provider. When the provider instigated it, they were able to enact the CHC they had, even if it was limited.

Overall, women expressed frustration that they were often not allowed to participate in contraceptive decision-making and they indicated that the restriction of information alone was damaging to the trust relationships they desire to have with their physicians. This frustration is directed toward doctors both for not allowing the women to participate in their own contraceptive decision-making process and for not trusting the information they were given by the woman about their own experiences, lifestyles, and bodies. One White woman, 38 years old, described what could have been better about her contraceptive consultation: "They could have listened to me when I told them before, because I knew what I needed. I'd been on birth control for about 20 years at that point so I knew what I was doing…" She felt that her efforts to communicate her own situation, experiences and needs to her doctor were not taken seriously – she was not allowed to have a voice with her provider. She represented to her provider that she was an expert on her own body and knew what methods of contraceptives were going to work for her. However her doctor dismissed her knowledge of her own body and circumstances and ignored of her request for a specific method of birth control, something that would likely not have occurred with a higher income woman who both possessed more CHC and was better able to enact it within the medical encounter. A Black woman, aged 22, reported a similar experience in which she attempted to give her provider information which the provider refused to trust:

> I was [4 days] late, this time [for a Depo shot], and they we're all flipping out like, 'I can't give you the shot until we run the pregnancy test…' 'What pregnancy test, I ain't even had no sex. Just hold your horses.' They're still like 'oh, we just have to check anyway'… they really just were freaking out… and I had to tell them, 'look, I haven't had any sex, I just really need my shot and I need to go.'"

This example shows that a lack of trust can often present a barrier to contraceptive use for women – particularly low-income women who may have more limited time and resources. Presumably the woman in this example knew if she had or had not engaged in sexual relations with a man during the period of her Depo-provera shot and therefore if pregnancy was a possibility. While medical providers do have medical standards they have to adhere to, outright dismissal of a woman's self-report of the possibility of pregnancy in a case where the woman was denying even having had sex may cause the woman in question to feel that she is not trusted by the medical personnel.

Importantly, women felt that regardless of the context of their relationship with their doctors' the final decision on the right contraceptive for them should be theirs. A 40 year old White woman described it this way: "I would put [the doctor's opinion] into consideration but I would still make the final [decision]…what I thought was best for that moment in time for me." Overall, this is the sentiment of the majority of women interviewed. While they want their doctor's input, they also consider themselves to be experts on their own bodies and lives, and want to have the ability to make the final decision on what contraceptive is right for them. Their problem lies in a lack of CHC which inhibits their forming a trust relationship with their doctors and impedes their goal of finding a personally effective contraceptive method.

Implications and Conclusions

As discussed above the contraceptive medical encounter clearly demonstrates the way in which lack of CHC contributes to the perpetuation of health disparities. In fact, contraceptive medical encounters are the ideal context in which to examine how lack of CHC can lead to stereotyping, difficulty in communication and lack of trust between physician and patient. Specific to the situation of low-income women, lack control over reproduction and childbearing is integral to both stereotypes applied to them and to the resulting difficulties they experience in communicating their desires and wishes about childbearing to their medical providers.

Overall, the women interviewed felt that doctors and other medical staff frequently applied stereotypes about reproduction and childbearing to them as low-income women using Medicaid. Further, they felt that assumptions were made about their childbearing choices based on this categorization. Their arguable lack of CHC puts them at a distinct disadvantage in contradicting or counteracting such categorizations. Women discussed a reduction in trust with their doctor because of these assumptions and felt that they did not have the ability or resources (or CHC) to participate in their contraceptive medical encounter unless the doctor allowed or encourages them to do so. Although they did not know the term, women expressed lack of CHC as contributing to them ending up with a contraceptive method that was not a good fit for them, thus putting them at risk for unintended pregnancy. Women specifically felt at a disadvantage in medical encounters because of the lack of open communication with their providers, and did not indicate that they knew how to establish open relationships with doctors who did not offer that type of relationship. This lack of CHC – or the ability to shape the medical encounter to suit their needs and the needs of their physician – made it much less likely for them to obtain an appropriate method of contraceptive and much more likely that they would experience unintended or unwanted pregnancy, which is one of the life circumstances that contribute to women remaining in poverty, and to the associated health disparities.

Several limitations to this data should be noted. First, because the interviewer was a middle income White woman there may have been less disclosure regarding frustrations with the system than there would have been had the interviewer also been perceived as low-income or if there had been race concurrence in all cases. The women may also have responded in accordance with the assumed middle class values of the interviewer. These interviews were with a convenience sample of women from one metropolitan area and issues described here may not be applicable to other low-income women in the same area or in other areas. Finally, this research examines a particular group - low income women - in order to demonstrate how CHC and health disparities are both represented and perpetuated in the context of a contraceptive encounter. Because no middle or high income women were interviewed it is impossible to say if their experiences are similar or different from the ones described here. However, literature looking at SES in general shows that higher income patients are more likely to receive both more information and more explanation from their doctors – two things directly related to building a trust relationship (Roter and Hall, 2006), and also critical to the enactment of CHC.

Despite these limitations, taken together the stories of the women presented here show a real need for doctors who provide contraceptive and other reproductive health services to low-income women to change the approach they take to both counseling and medical decision-making and to explicitly take the concept of CHC into account. Perhaps most importantly, doctors need to spend time with women in determining their values and wishes and how any one particular contraceptive method may or may not meet their needs (Malterud, 1992; Malterud, 1994; Brown et al., 2002). In addition, women face barriers to contraceptive use in the conflicting cultural messages they receive, including the cultural messages that contribute to their lack of CHC and their difficulty in employing the capital they do possess. These values say both that pregnancies should be planned, limited, and controlled (Greil, 2002), *and* that childbirth is a miracle and childrearing a selfless task to undertake – one in which everything can and should be sacrificed for the good of the child (Blum, 2007). Higher levels of CHC are necessary in contraceptive encounters in order for women to navigate these norms, and low-income women are at a particular disadvantage in this regard. In addition, pregnancy and child rearing are frequently a source of status for low-income women and sometimes the only way for them to move into an adult status since options for education and fulltime employment, other common markers of adulthood, are extremely limited (Edin & Kefalas, 2007; Benson, 2000).

Finally, physicians who offer contraceptives should have knowledge of and should offer the full range of contraceptive options (Landry, Wei, and Frost, 2008) to all women they consult with and should encourage women – and low-income women in particular, to actively participate in discussion of contraceptive methods, as well as choice of a specific method. This is especially important for low-income women given the higher likelihood of their experiencing other health problems such as diabetes or heart disease (Pampel, Krueger, and Denney, 2010; Monnickendam et al., 2007) and the high risk of complications a pregnancy would lend to the treatment of these conditions. Physicians should also be more aware of the limitations that poor women face in terms of their lack of CHC and make an effort to provide a comfortable environment in which low-income women feel that they can express both their life circumstances and their contraceptives wishes to their providers.

This cycle of assumptions, paternalistic decision-making, and lack of trust between doctors and patients presents an ideal medical encounter with which to examine the effects of

CHC on medical interactions. Low-income women are both less likely to have CHC, and less likely to feel that they can use what CHC they do have unless a doctor invites them to do so. Medical care, and in particular reproductive health care, is critical for women in poverty, and unless changes are made within the wider health care system poverty will remain a serious barrier to contraceptive practice and reproductive health care in the United States (Gray et al., 2006). Under these circumstances, low-income women will continue to have difficulty with issues related to CHC such as stereotyping and paternalistic decision-making, making it very difficult for them to manage their reproductive health, their lives, and ultimately perpetuating broader health disparities.

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