The Lived Experiences of African American Women Receiving Care from Nurse Practitioners in an Urban Nurse-Managed Clinic


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**ABSTRACT**

The purpose of this qualitative phenomenological study was to discover African American women’s lived experiences of receiving primary health care from nurse practitioners. Leininger’s culture care theory was used as the organizing framework for this study. Eleven African American women who were receiving care in a nurse managed urban care center were recruited as participants for this study. An adaptation of Leininger’s open-ended inquiry guide and the Sunrise Enabler were used along with Colaizzi’s phenomenological method to assist with the data collection and analysis. Audio-taped interviews and the researchers’ observations were analyzed in search of significant statements and formulations of meanings and themes. The findings from this study are useful in understanding African American women’s lived experiences when receiving care from nurse practitioners and assisting nurse practitioners in providing culturally congruent care that is satisfying and beneficial to African American women.

**Key Words:** African American women, Leininger’s culture care theory, nurse practitioner care, phenomenology

**BACKGROUND**

Since the first nurse practitioners were educated at the University of Colorado in 1965, the American Academy of nurse practitioners (AANP) has grown to over 140,000 members. A nurse practitioner may provide primary care in urban, rural, and suburban settings and often as one of a few or only providers in a rural community (Barr, Johnston, & McConnell, 2000). As the role and number of nurse practitioners continue to grow in the primary care setting, many African American women may receive and actively seek health-care from nurse practitioners. This creates a need to prepare and educate nurse practitioners to deliver culturally congruent care which is predicted to lead to improvements in this group’s health and lifeways. Nurse practitioners as primary care providers must have the knowledge to provide care to African American women while being sensitive to their cultural care beliefs, expressions, and practices.

A literature review revealed a gap in the available research regarding African American women and their insiders’ (emic) care views and experiences with health and healthy lifeways. Previous research done with this group has been primarily conducted using...
quantitative research methods. Moreover, it has been focused mainly on health care from the provider’s (etic) point of view rather than the African American woman’s emic experiences with the professional/etic healthcare system.

This study used Leininger’s culture care theory as an organizing framework and Colaizzi’s phenomenological method of analysis to discover the lived experiences of African American women receiving care from nurse practitioners in an urban nurse-managed clinic.

Research Purpose and Goal

The purpose of this study was to discover the lived experiences of African American women receiving primary care from nurse practitioners in a nurse-managed clinic in an urban context. The goal of this research was to use findings to guide nursing actions and decisions in providing culturally congruent care that leads to health, well-being, and beneficial lifeways for African American women.

Research Questions

Broad research questions guided this study and research participants were encouraged to share their personal stories as well as life experiences related to care and health. The research questions were:

1. What are the lived experiences related to care and health of African American women receiving primary care from nurse practitioners in a nurse-managed clinic?
2. In what ways do worldview and Leininger’s culture and social structure dimensions influence the healthcare beliefs, practices, and expressions of African American women?
3. In which ways can Leininger’s nursing action and decision modes be used by nurse practitioners to provide African American women with culturally congruent care?

THEORETICAL FRAMEWORK

Dr. Madeleine Leininger’s culture care theory was used as an organizing framework for this study. The goal of the theory is to provide culturally congruent and competent nursing care that results in health and well-being for people (Leininger, 2006b; McFarland 2006). Leininger holds that there are three modalities of care designed to provide culturally congruent care leading to health and well-being or to face death or disability (Leininger, 2006a & 1991). These three modalities are cultural care preservation and/or maintenance, cultural care accommodation and/or negotiation, and cultural care repatterning and/or restructuring. These nursing actions and decisions are predicted to assist people of different cultures retain, adapt to, and/or modify their lifeways to achieve beneficial health outcomes (Leininger, 2006a & 1991).

The use of Leininger’s Sunrise Enabler (Figure A) guided researchers in their discovery of African American women’s worldview, ethnohistory, religious (or spiritual) orientation, kinship, folk and professional care practices, as well as political, economic, legal, educational, and technological factors affecting the health care received by this cultural group. There are 13 assumptive premises developed by Leininger which support the tenets of the culture care theory. The assumptive premises underlying this research were as follows:

1. Nurse practitioner care is essential for human growth, well-being, health, survival, and to face death as well as disabilities for African American women (derived from Leininger, 2006a & 1991).
2. Leininger’s three theoretical modes of care offer new, creative, and different therapeutic ways to help African American women to promote health
and wellness (derived from Leininger, 2006a & 1991).
3. Qualitative research such as phenomenological methods offer important means to discover largely embedded, covert, epistemic, and ontological cul-
care knowledge as well as practices of African American women (derived from Leininger, 2006a & 1991).

Literature Review

African American women and their healthcare views, beliefs, and practices are the primary focus of this review of literature. There is a dearth of research on African Americans' insider or emic views regarding their healthcare and their satisfaction with the care that is provided to them. Exploring how African American women perceive their healthcare and the care that is provided by nurse practitioners in nurse-managed centers would address the identified gap in the literature and would assist nurse practitioners and other healthcare providers in the delivery of culturally competent care to this cultural group.

African Americans have reported racism and prejudice within the healthcare system. Published research has demonstrated that some African American women viewed the healthcare they received as substandard and often inadequate. These perceptions may be due in part to inadequate access to healthcare when compared to their white counterparts (Kennedy, Mathis & Woods, 2007). African Americans have identified a positive correlation between racism and engaging in risky lifestyle and maladaptive coping behaviors (Shariff-Marco, Klassen, & Bowie, 2010). Nicolaidis, Timmons, Thomas, Waters, Wahab, Mejia, and Mitchell (2010) discovered that African American women experience mistrust of the health care system which is viewed as a “White” system and report negative experiences with healthcare attributed to racism.

A study by Benkert and Peters (2005) addressed African American women’s perceptions of prejudice in healthcare and looked at strategies to cope with those experiences. The study explored perceptions that African Americans received differential care and experienced racial discrimination that could negatively affect healthcare outcomes.

A study by Johnson (2001) used a qualitative method to investigate the healthcare needs as well as perceived barriers to obtaining health care for children, urban and rural women in areas served by nurse practitioner (NP) and certified nurse midwife (CNM) clinics. The researcher determined that it was important that the patients feel welcomed and valued when presenting at a healthcare facility. He concluded that low-income minority women were more likely to experience discrimination at healthcare visits. Reasons cited for this were that: 1) Healthcare providers were unresponsive to their needs, 2) Patients received substandard care, 3) Practitioners lacked cultural sensitivity, and 4) The women were treated with disrespect. All of these reasons contributed to African American women’s negative attitude towards healthcare professionals.

Transcultural Studies Using the Culture Care Theory

Leininger’s theory of culture care diversity and universality purports that people of different cultures are capable of informing and guiding professionals to receive the kind of care they desire or need. Leininger described the meaning of culture as the patterned and valued lifeways of people that influence their decisions and actions (Leininger, 2006a). Several studies using the theory and ethnonursing research method have been conducted with African Americans. McFarland (1997) studied culture care with Anglo and African American elders in a long-term setting. There were four major themes summarized from this study: 1) Residents expressed and lived generic care to maintain their preadmission lifeways; 2) Nursing staff provided care to support satisfying lifeways; 3) Institutional care patterns were viewed as a continuing life experience; and 4) Culture of retire-
The Lived Experiences

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ment home reflected unique lifeways.

Plowden and Young (2003) used ethnographic methods to conduct in-depth individual interviews with urban African American men. They used the Stranger to Trusted Friend enabler from the ethnonursing method to develop trust with African Americans in order to gain access into their community and discover caring processes as it related to their culture. Ehrmin (2005) conducted an ethnonursing research study to discover meanings and expressions of care for substance-dependent African American women in an inner-city transitional home.

During a thorough review of published literature, several common themes related to African American women and their overall care views, beliefs, and practices emerged. The literature review revealed that trust in the healthcare provider and a compassionate approach was important in African American women’s care (Benkert & Peters, 2005). African American women described their limited access to healthcare compared to their Caucasian counterparts and viewed treatment rendered by healthcare providers as substandard (Kennedy, et al, 2007). There was limited qualitative data regarding African Americans’ views of healthcare in the United States and few studies of transcultural care as it pertains to African Americans. Specifically, no research addressed how African American women view healthcare provided by nurse practitioners.

RESEARCH METHODOLOGY

This study was conceptualized within Leininger’s theory of culture care diversity and universality and used Colaizzi’s phenomenological approach (1978) to allow the researchers to gain insight into the lived experiences of African American women receiving primary care from nurse practitioners. As a philosophy and a research method, phe-

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Birth Place</th>
<th>Lives With</th>
<th>Religious Affiliation</th>
<th>Education</th>
<th>Occupation</th>
<th>Marital Status</th>
<th># of Children</th>
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<tr>
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<td>Christian</td>
<td>1 yr College</td>
<td>Employed</td>
<td>Married</td>
<td>2</td>
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<tr>
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<td>Catholic</td>
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<td>2 yrs College</td>
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<tr>
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<td>Christian</td>
<td>2 yrs College</td>
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<td>Married</td>
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<tr>
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<td>Alone</td>
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<tr>
<td>PD</td>
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<td>2 Grown Children</td>
<td>Seventh Day Adventist</td>
<td>3.5 years of College</td>
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<td>RJ</td>
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<td>Baptist</td>
<td>10th Grade</td>
<td>Unemployed</td>
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</tbody>
</table>

Table 1: Participants
nomenology enhances the discovery of the lived experiences of a phenomenon of interest and allows its essences to emerge. The researchers chose the phenomenological method because it was the best fit for this study including the domain of inquiry. Phenomenological studies include data from prolonged conversations between researchers and study participants. Researchers strive to discover the lived experiences of the participants without leading the interviews. The researchers were careful not to let preconceived beliefs or views influence the research process. To support this end, bracketing, intuiting, and journaling, were used while collecting, reviewing and analyzing the data (Colaizzi, 1978).

Open-ended interview questions were designed to stimulate discussion and solicit the participants’ stories during the interview process. All interviews were held with a nurse researcher and the participant in a private and relaxed atmosphere in a setting familiar to the participants. Colaizzi’s method of analysis is unique in that it requires researchers to return to participants to confirm findings as the study evolves (1978). Researchers made follow-up phone calls to confirm findings with participants. Approval for this study was obtained from the Institutional Review Board of the university with which the researchers are affiliated and all participants provided informed consent.

Setting
The selected setting was a nurse-managed healthcare center within an urban context. The nurse practitioners provide primary health care to university students and community adults from 18 to 64 years of age, who qualify for a county-sponsored health plan. These adults must have a limited income and no other health insurance coverage. All participants were receiving their primary care at the nurse managed-clinic during the time the study was conducted. Participants had experienced previous contacts with the nurse managed clinic staff, were comfortable with the site, and eager to recall and discuss their health care experiences.

Sample
A convenience sample of eleven African American women (table 1) was obtained from patients at the nurse managed urban clinic. Potential participants were approached by researchers in the waiting area of the clinic and given a flyer outlining the study. If interested in study participation, arrangements for an interview were made either during that visit or at another mutually agreed upon time. Eligibility criteria for the study were: identified themselves as an African American woman, 18-64 years of age, a patient at the nurse-managed clinic, and willing to participate in the study. To maintain confidentiality, the researchers assigned pseudo initials for each participant as a code name.

Data Analysis
Colaizzi’s data analysis approach demands that the researcher abandons any desire to control the phenomenon in order to focus on the phenomenon itself. Colaizzi’s seven steps of analysis were used to guide the analysis of the data collected during this study. These steps included: 1) Reading all the interviews that were transcribed, 2) extraction of significant statements, 3) formulation of meaning, repeating above steps and organizing clusters of themes, 5) developing exhaustive descriptions of the phenomena under study, 6) extracting statements of identification of the fundamental structure of the investigated phenomena, and 7) validation of findings (1978). A qualitative software package, NVivo, was used for data management and qualitative research experts assisted with the data analysis.

After several readings of each transcribed interview recurring care patterns and themes were discovered and coded using the
data coding system from the Leininger, Templin, and Thompson Field Research Ethnoscript. A sample of this ethnoscript is included in table 2. The use of this ethnoscript was extremely helpful to researchers throughout the coding process, allowing for the processing and categorizing of large amounts of data. The analyzed narrative data was focused on participants’ cultural values, beliefs, social structure, professional healthcare systems, environmental context, and worldview.

Research Findings
The beliefs, practices, and expressions of care of participants in relation to primary care received from nurse practitioners in nurse-managed clinic were compiled into three categories: 1) Professional Nurse Practi-

CATEGORIES AND DOMAINS OF INFORMATION
(includes observations, interviews, interpretive material, and non-material data)

CATEGORY I: GENERAL CULTURAL DOMAINS OF INQUIRY
DESCRIPTION
CODE
1. Worldview
2. Cultural-social lifeways and activities (typical day/night)
3. Ethnohistorical (includes chrono-data, acculturation, cultural contracts, etc.)
4. Environmental contexts (i.e., physical, ecological, cultural, social)
5. Linguistic terms and meanings
6. Cultural foods related to care, health, illness and environment
7. Material and non-material culture (includes symbols and meanings)
8. Ethnodemographics (numerical facts, dates, population size & other numerical data)
9. Racism, prejudice, race*

CATEGORY II: DOMAIN OF CULTURAL AND SOCIAL STRUCTURAL DATA
(Includes normative values, patterns, function and conflict)
10. Cultural values, beliefs, norms
11. Economic factors
12. Educational factors
13. Kinship (family ties, social network, social relationships, etc.)
14. Political and legal factors
15. Religious, philosophical, and ethical values and beliefs
16. Technological factors
17. Interpersonal relationships (individual groups or institutions)
18. Recreation*

CATEGORY VIII: CULTURE CARE MODES
78. Preservation and/or maintenance*
79. Accommodation and/or negotiation*
80. Re-patterning and/or restructuring*
*italics indicate codes created specifically for this study

Table 2: Sample for the Coding Data System for the Leininger, Templin, and Thompson Field Research Ethnoscript Used in this Study
tioner Care, 2) Domains of Culture and Social Structural Dimensions, and 3) Culture Care Modes for Health and Well-being. Each of these categories is presented below with its supporting themes (numbered), corresponding exhaustive descriptions (in bold) and significant statements (participants’ quotations).

**Category 1: Professional Nurse Practitioner Care**

Supporting Themes, exhaustive descriptions and significant statements:

Nurse practitioners show more care than physicians

Nurse practitioners spend more time with patients and take more time to explain things better than physicians.

“When she explains stuff to me she is really down to earth. She doesn’t talk over my head, you know. She even draws me pictures and stuff so I get it.” RJ

“I just feel it was more personalized and not so rushed and harried and not so mechanical. I feel like a person instead of a number.” LK

Nurse Practitioners develop strong relationships with patients to promote their health and well-being

Nurse practitioners develop strong and trusting relationships with their patients and provide non-judgmental care to promote health and well-being.

“The nurse practitioner here, I say my doc cuz she is like a doc but better, she feels like a friend. I feel good around her, not worried what she thinks. She is so nice, she doesn’t act like she is better or high up like my other doctors but she is smart. She knows how to help me.” PD

“The doctor I went to before, he was not open to me. But here she [nurse practitioner] did not pass no judgment on me and she did not close her mind. That is what I respected the most. She still explored everything and didn’t just blame my drugs. Sometimes my other doctor would make me feel so ashamed about my drug use that I just wouldn’t go back when I needed to because it was a terrible experience for me mentally.” LK

It was evident that participants felt that the nurse practitioners showed respect, care and concern while providing culturally congruent care for African American women. Participants felt that the nurse practitioners gave holistic care and cared about them as a whole person and not just their one specific health problem. Many participants stated that the nurse practitioners cared for their problems outside of their chief health concerns and gave suggestions to enrich and improve their overall quality of life. Trust was a repeated pattern within the data that was expressed by several of the participants. They felt that the nurse practitioners cared about them as a person and therefore they felt safe and trusted the nurse practitioner’s input to guide their healthcare decisions.

**Category 2: Domain of Cultural and Social Structural Dimensions: Religion, Family and Economics**

Supporting Themes, exhaustive descriptions and significant statements:

Religious care promoted health and well-being

Religion enhances spiritual health and well-being

“It [religion] gives me some sense of inspiration...it kind of lifts me.” HS

“I believe in God strongly and have a special relationship with Him. I think your life can go much better if you can just talk to Him. I believe He heals from all levels and helps me through the crisis in my life.” MX

Kinship and Social Factors influenced care and health

Generic care from family and friends
leads to health and well-being.
“Right now, with everything that I’m going through, not being very stable with my living situation and so forth, my family has been there for me. My kids and I are still real tight and we look after each other.” JA
“My friends are busy but they show up and pay visits when they can. My best friend just moved to Ohio but she sends me cards and calls when she can.” HS

Local Economic Factors Influenced Care and Health

Patients are grateful for affordable care provided at this clinic because of their past experience of being uninsured, which led to poor, fragmented care.
“I was with a certain doctor you know, he talked down to me and I said, “Don’t do that just because you are a doctor and I’m poor... They don’t treat me like that here. I come here and they take good care of me and treat me with respect.” LT
“It’s nice coming here because they don’t give me the run around ... Here I can get everything at once and it is such a relief for me when I don’t have to fuss with begging someone or paying people to get to around.” NV

It was discovered during this research that many of the African American women rely on religion and family to help guide their lifeways. Religion was a common theme noted throughout the interview process. The majority of the participants practiced spiritual care; this included attending church services, praying or having a belief in God. Many believed that these religious beliefs and practices influenced their health in a positive way.
The support of family and friends had a notable influence on the participants’ healthcare decisions. Many participants revealed that the support of family and friends was invaluable during times of illness or stress. Family and friends also influenced self-care strategies that participants felt were essential for their health and well-being.

Category 3 Culture Care Modes for Health and Well-being; Health Preservation/Maintenance, Accommodation/Negotiation, Restructuring/Repatterning

Supporting Themes, exhaustive descriptions and significant statements:
Nurse practitioner care helps to assist to preserve the state of health and well-being.

Nurse practitioners maintain holistic and culturally congruent care which helps to preserve the African American women’s state of health and well-being.
“I was stressed and my blood pressure was elevated. She [nurse practitioner] took a holistic approach to find me the best treatment. Like she asked what was going on with me, my diet and stuff. She took time to figure out what was causing me stress. It was a temporary stress I was dealing with that was causing me the blood pressure problems and she helped me to alleviate that.” ML
“My nurse practitioner would say, just come on in when you’re here for physical therapy to get a blood pressure check. It seems she was more concerned for my total health.” LT

Nurse practitioners accommodate and negotiate with participants to develop care strategies.

Culture care accommodation and negotiation with participants for culturally congruent professional nurse practitioner care.
“She tells me that instead of going to the hospital when I’m not feeling well to just call her and let her know. She can help me or something so she is trying to keep me out of the hospital as much as possible.” MX
Participant had numerous concerns. The nurse practitioner was observed negotiating with participants to identify and prioritize their three most urgent concerns. A plan was agreed upon to address remaining concerns at next visit. (Researcher Observation)

Nurse practitioners and participants have expressed the need for restructuring the financial support of the clinic to continue providing culturally congruent care.

**Nurse practitioners and participants are concerned about restructuring of community finances which may impact the future viability of this clinic.**

“If this clinic closes I don’t know what I’ll do. The insurance here isn’t the best but if I didn’t have this I’d have nothing.” NV

Funding is from grants and millages. With the high rate of unemployment in [this community], property tax values have decreased so less money comes to the clinic. There is now a disproportionate number of devalued housing. This clinic helps to combat the health disparities seen in this county. (Researcher conversations with nurse practitioner)

The community where this study took place has experienced severe economic losses in tandem with the decline in automobile industry since the 1970s. Today unemployment is among the highest in the nation. This nurse managed clinic was developed to provide healthcare coverage for low income, uninsured adults. Many participants would have little to no access to care and would turn to emergency departments or would overwhelm the county’s single free medical clinic. The clinic has reduced unnecessary and uncompensated emergency department use and has likely reduced preventable and uncompensated hospital admissions. The researchers discovered that funding for this clinic is understood to always be vulnerable and likely be time-limited as large portions of the funds are generated through a property tax millage.

Disparities in income and healthcare are wide. With help from the philanthropic community and many state and community partners, this program was developed to provide healthcare coverage for approximate 90% of the uninsured adults with incomes below 200% of the Federal Poverty Level. Currently, it is at approximately 65% of its goal for coverage of the county’s low income, uninsured adults. This coverage provides each eligible participant with a stable primary care provider, access to physician specialty services, laboratory and radiology, prescription drugs and limited hospital services. It is reasonable to assume that providing coverage to such a large segment of adults in this community will bring improvement over time in the adult morbidity and mortality rates (Health Management Associates, 2009).

**Conclusion and Implications for Clinical Practice and Future Research**

African American women, ages 24-59 years, valued the primary healthcare they received from nurse practitioners at an urban nurse-managed clinic in the Midwestern United States. These women appreciated the non-judgmental, trusting relationships they developed with nurse practitioners over time. Practicing spiritual care; generic care from family and friends; and receiving holistic, affordable health care from nurse practitioners at the clinic contributed to participants’ health and well being. Discovering African American women’s lived experiences of receiving primary care led to a greater understanding of this group’s cultural beliefs, expressions, and practices and assists nurse practitioners in providing culturally competent, beneficial, and satisfying care to African American women.

These research findings offer knowledge for evidence-based and best practices for nurse practitioners and may be useful for other healthcare professionals. Leininger (1991; 2006a) predicted that knowledge
gained from using the culture care theory would constitute a substantive knowledge base that guides nursing care actions and decisions in the provision of care that is congruent with the patients’ beliefs and practices. This study provides nurse practitioners with holding knowledge about how African American women view the care they receive in a primary care setting.

The findings from this study contribute to the discipline of transcultural nursing by adding to the body of transcultural nursing knowledge and by providing insight into the patients’ emic views of nurse practitioner care. This rich data also contributes to nursing practice by guiding nurse practitioner students and practicing nurse practitioners in providing culturally congruent care actions and decisions for African American women which may lead to improved health, well-being, and more beneficial lifeways for this group.

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REFERENCES
